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

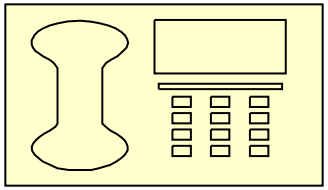
Triage assessment

- 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

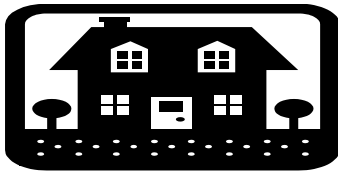
Triage Practitioner

Triage and log Sheet

Attend for assessment WPH or A&E



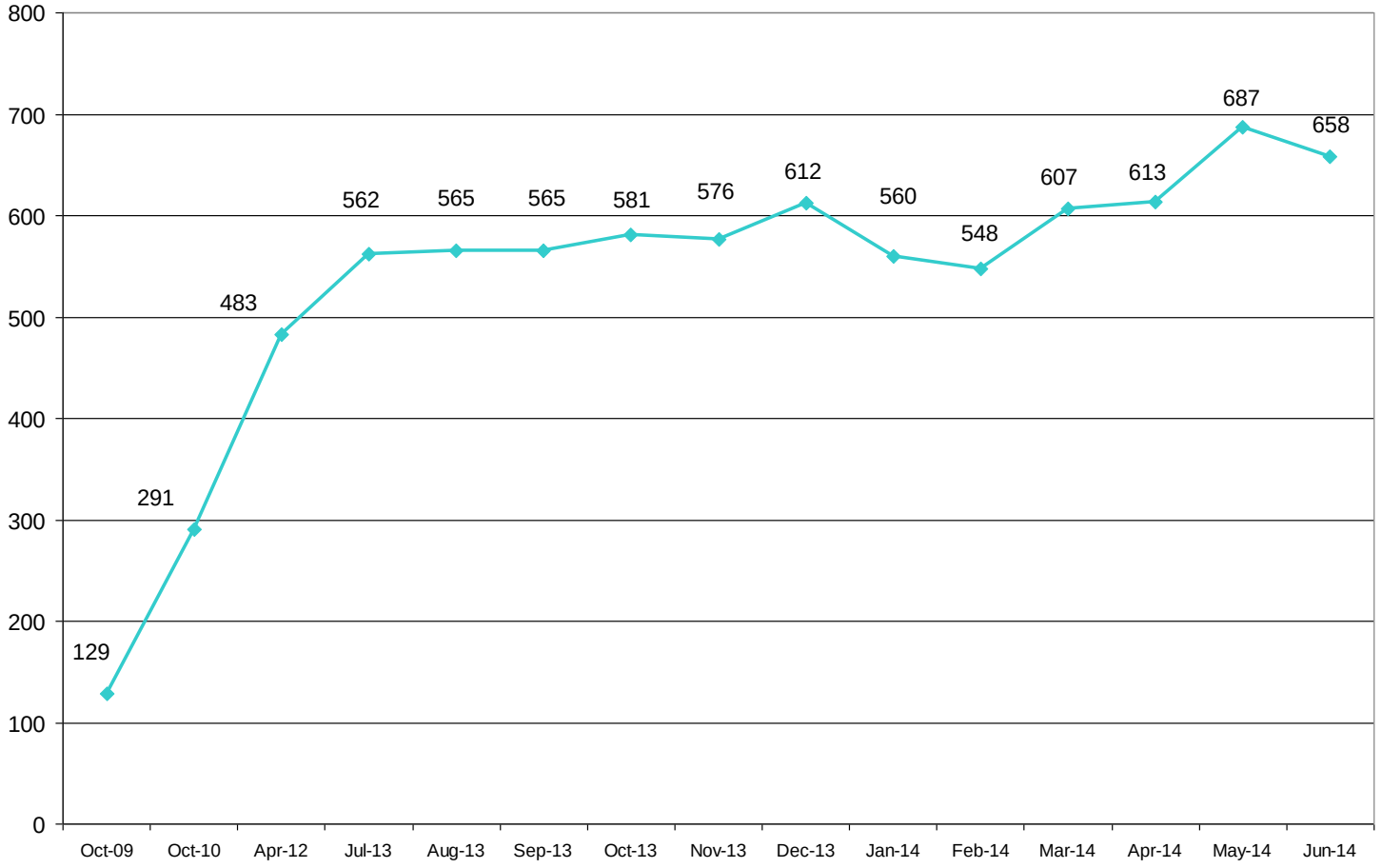
Follow assessment guidelines - advice on appropriate care location/service. e.g. pharmacy, GP, self monitor



Advice/reassurance

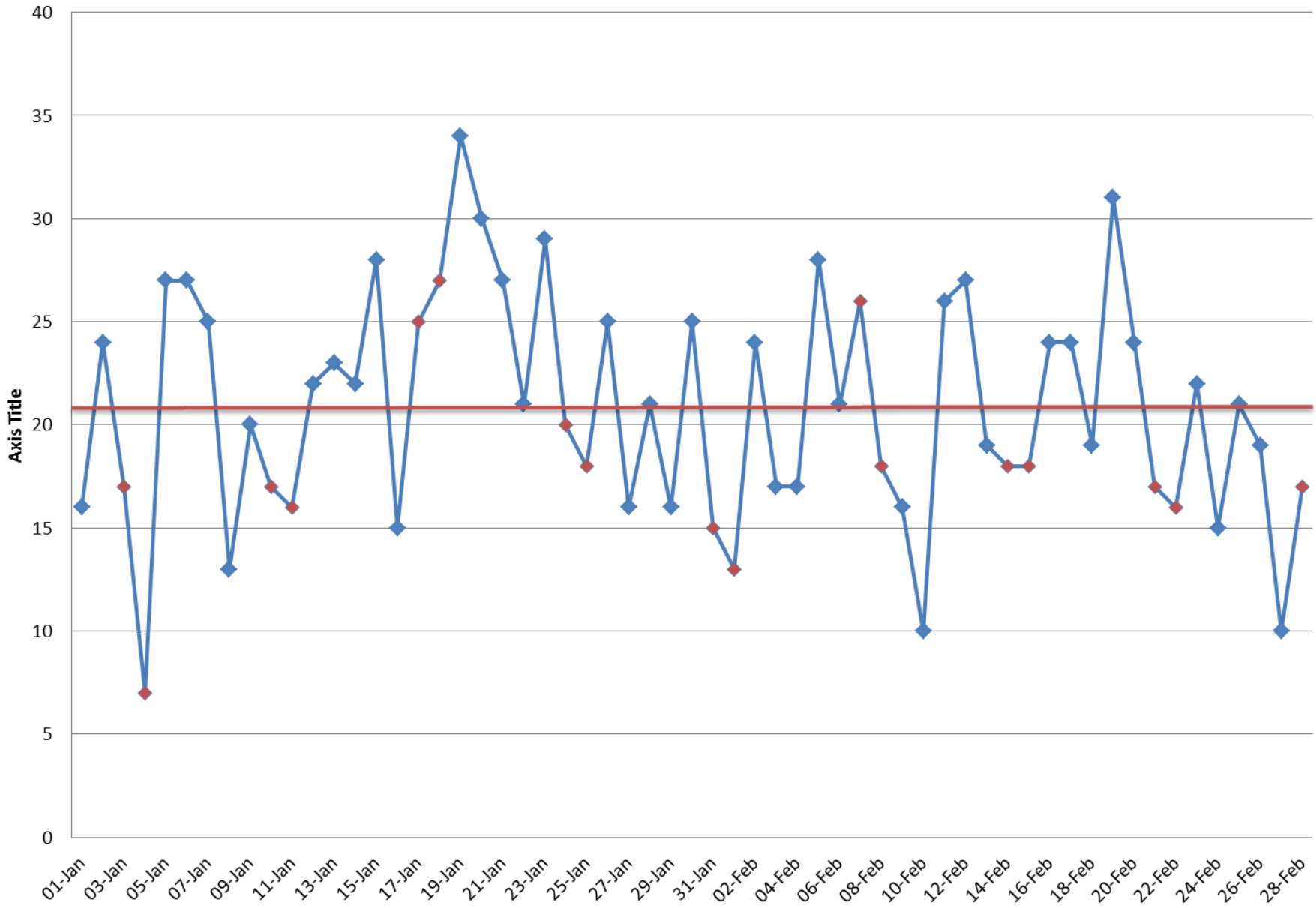
Who is using the service?

How many calls do we receive – from early days (Oct 2010 to June 2014)

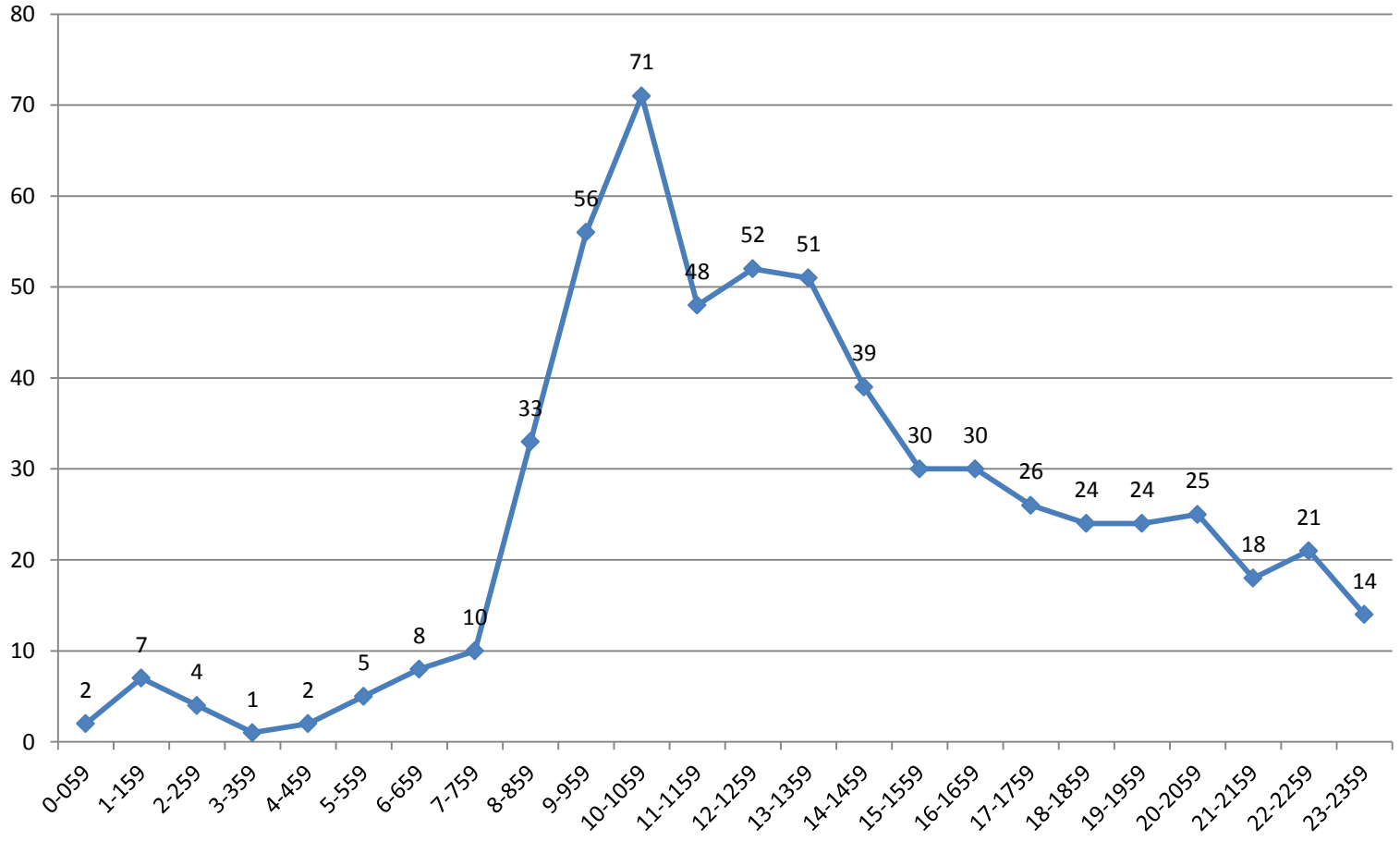


Number of calls

January 2017	791
February 2017	723
March 2017	709
April 2017	789
May 2017	735
June 2017	771
July 2017	667
August 2017	667
September 2017	650
October 2017	694
November 2017	660
December 2017	711
January 2018	713


Number of calls per day, Jan and Feb 2015
Axis Title
40
35
30
25
20
15
10
5
0
01-Jan
03-Jan
05-Jan
07-Jan
09-Jan
11-Jan
13-Jan
15-Jan
17-Jan
19-Jan
21-Jan
23-Jan
25-Jan
27-Jan
29-Jan
31-Jan
02-Feb
04-Feb
06-Feb
08-Feb
10-Feb
12-Feb
14-Feb
16-Feb
18-Feb
20-Feb
22-Feb
24-Feb
26-Feb
28-Feb

Time of day calls were received January 2015

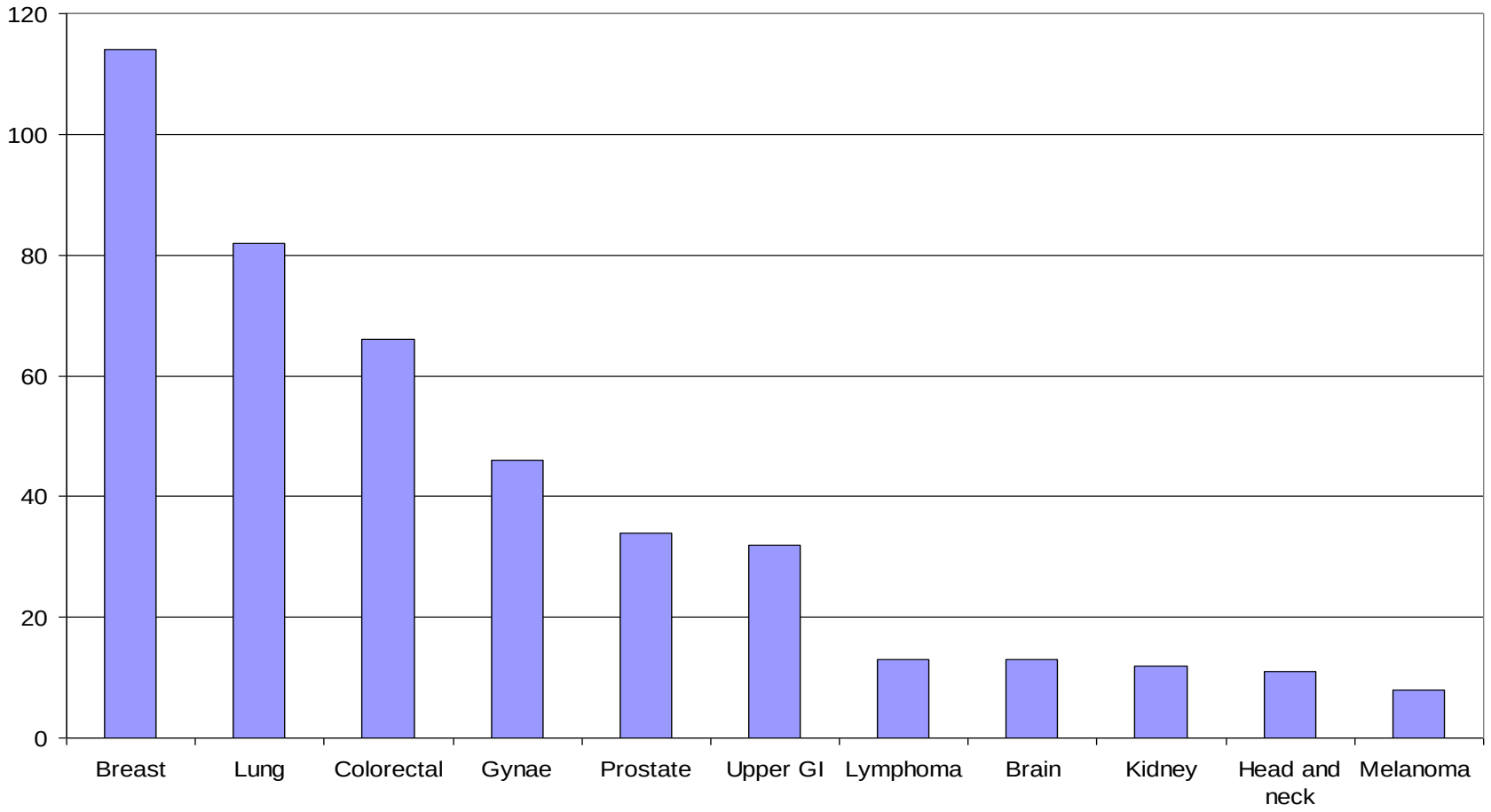


Challenge of unpredictable demands

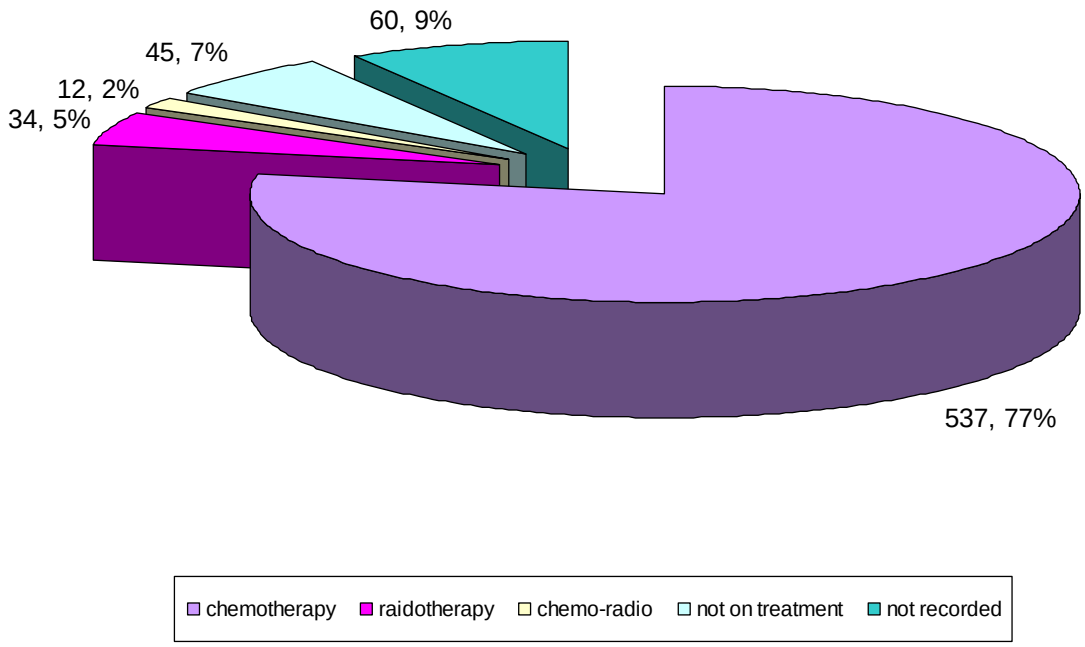
- There is a wide variation in volume of telephone calls each month and each day
  - We did not find a pattern
- The service need to meet a highly unpredictable workload
- This presents a challenge faced when trying to plan and deliver oncology telephone triage services

Which patients use the phone service

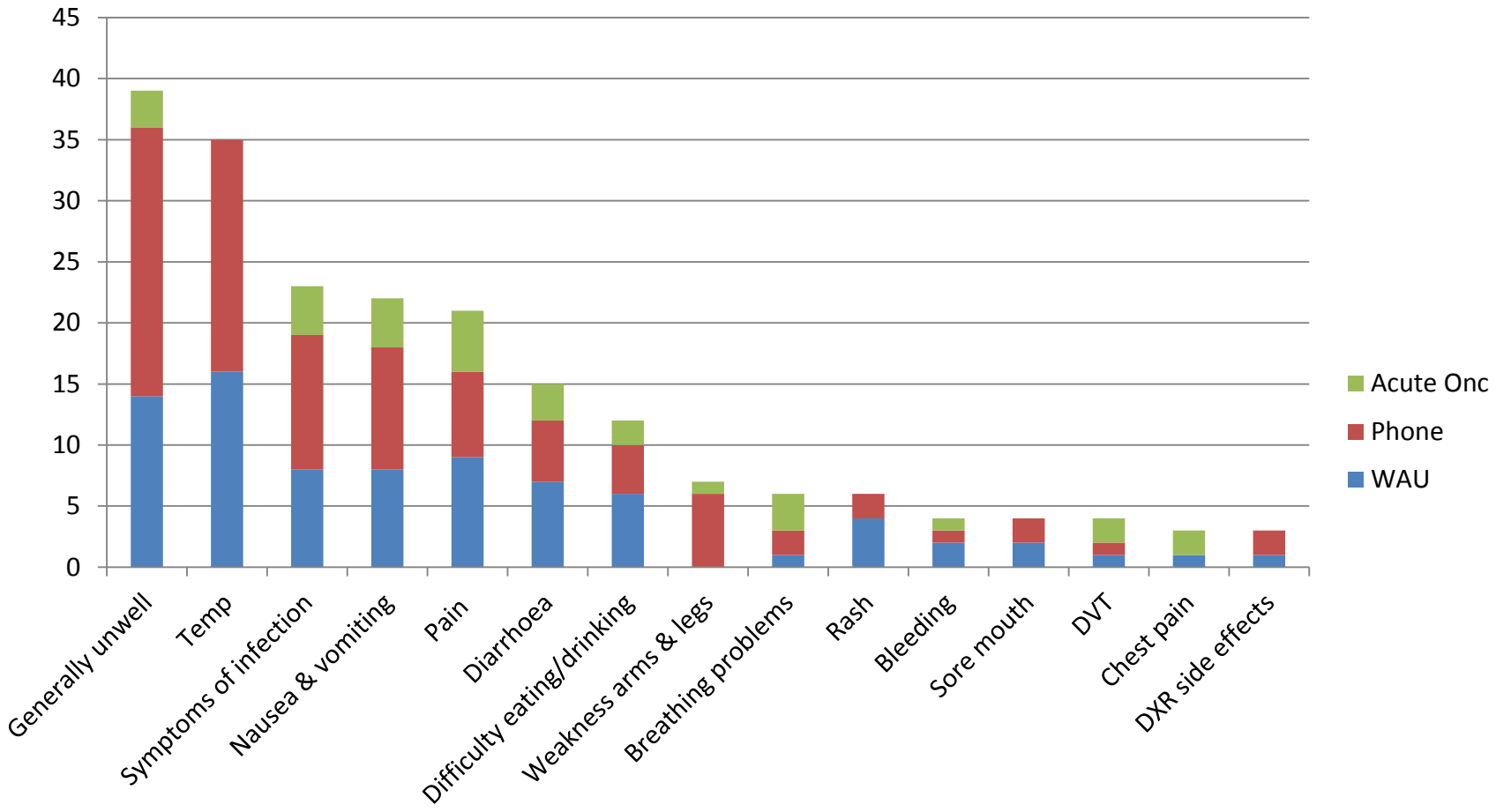
Primary diagnosis of patients



Recent treatment



Reasons for contacting the service

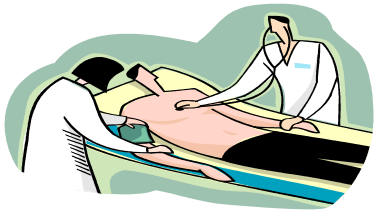


Other common reasons for ringing (all patients)

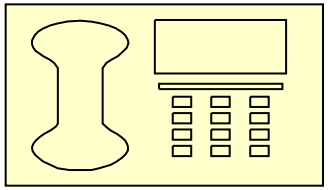
- Major illness
  - E.G. chest pain, deranged U&E, bowel obstruction, spinal cord compression, sudden confusion
- Medicines advice
- Minor ailments
  - E.G. Small bleed, infected toe, constipation, sore eye
- General query
  - E.G. DN fax, appointment query, dental advice

- What happens when a patient or relative rings for advice?

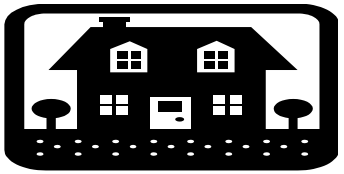
Triage Practitioner



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

<u>Temperature 37.5ºc or more, OR symptoms of infection OR feels generally unwell</u> ***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

Nausea 1.How long have they had nausea? 2.Are they taking anti-emetics as prescribed? 3.What is their oral intake? 4.Are there any signs of dehydration e.g. decreased urine output, thirst, dry mucous membranes, weakness, dizziness, confusion? 5.Do they have any other symptoms e.g. stomach pain, abdominal distension, diarrhoea? *(If yes, refer to appropriate guidelines)*	**Able to eat and drink, managing a reasonable oral intake** 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.	**Can eat/drink but intake reduced, no signs of dehydration** Arrange medical review of anti-emetics. **May** not need to attend WPH if appropriate to contact GP for new prescription of anti-emetics or S/C or IM anti-emetics ***If on capecitabine discuss dose reduction/ discontinuing with on call registrar/ patients medical team.***	**Patient symptomatic of dehydration /haemodynamic instability or patient unable to take adequate oral fluids** Arrange urgent medical review at WPH. If no bed available at WPH send to local A&E. Phone A&E to inform staff of chemotherapy related antiemetic protocol ***If on capecitabine or 5FU infusor discuss discontinuing with registrar/patients medical team.***

<u>Palmar- plantar (hand-foot) syndrome (PPE)</u> 1.How many days? 2.What areas are affected? 3.Is there any pain? 4.Is the skin broken? 5.Does it interfere with mobility/normal activity? 6.Is the patient on oral medication likely to be causing this – i.e. capecitabine, Sunitinib, Sorafenib	**Numbness, tingling, painless erythema, swelling, not disrupting normal activity** Advise use of emollient cream. (e.g. Diprobase, or E45)	**Painful erythema and swelling, discomfort that affects normal activity but still able to perform them** 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.**	**Moist desquamation, ulceration, blistering, severe pain, unable to perform normal activities** Organise admission and medical review **If on capecitabine or other medication that can cause PPE discontinue and discuss with registrar/patients medical team.**

AOS assessment and treatment guidelines

- Local guidelines have been developed
- Cancer services guidelines are accessible on the intranet

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WESTON PARK HOSPITAL
SPECIALIST CANCER SERVICES GROUP

CHEMOTHERAPY INDUCED NAUSEA AND VOMITING

Nausea and vomiting are common side-effects of chemotherapy agents. Almost all regimens include prophylactic 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 /52 of chemotherapy or disease related immunosuppression. 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, PO_4,
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	Moderate: Grade 2	Severe: Grade 3	Severe: Grade 4
1-2 episodes/24hrs	3-5 episodes/24hrs	>6 episodes/24hrs	>10 episodes/24hrs Can be **life-threatening** – requires urgent intervention

Mild to moderate:
If significant reduction in oral intake: check U+Es 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 ($5HT_3$ antagonists such as ondansetron or granisetron can cause this)

Moderate (grade 2): If taking oral anti-cancer therapy, with-hold 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

Severe:
No significant intake
Admit patient for IV fluids. Check U+Es and vital observations.Replace electrolytes as appropriate.

Treat as per mild to moderate symptoms but often unable to manage anti-emetics via oral route and patients will require anti-emetics IV or via a syringe driver (see below).

Exclude other causes such as disease, electrolyte abnormalities, bowel obstruction.

If taking oral anti-cancer therapy, stop anti-cancer therapy treatment.

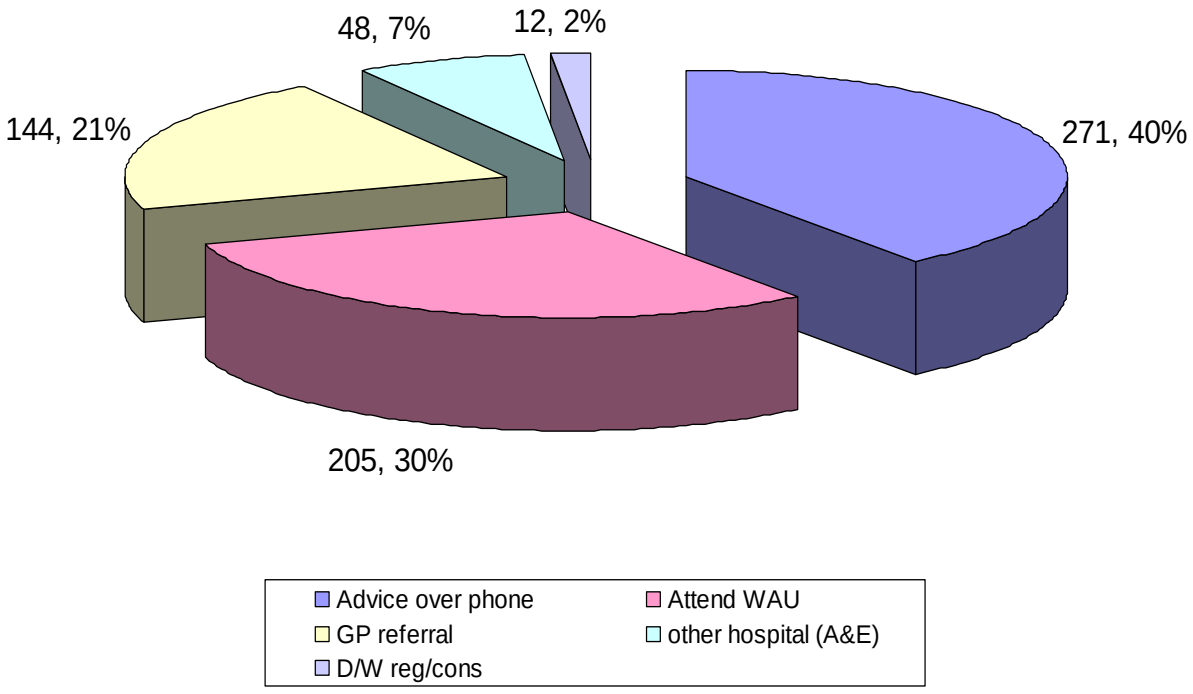
Discuss with oncology/haematology treating team or on-call oncologist/haematologist via STH switchboard.

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

If refractory to above, consider use of Haloperidol 1.5mg nocte 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?

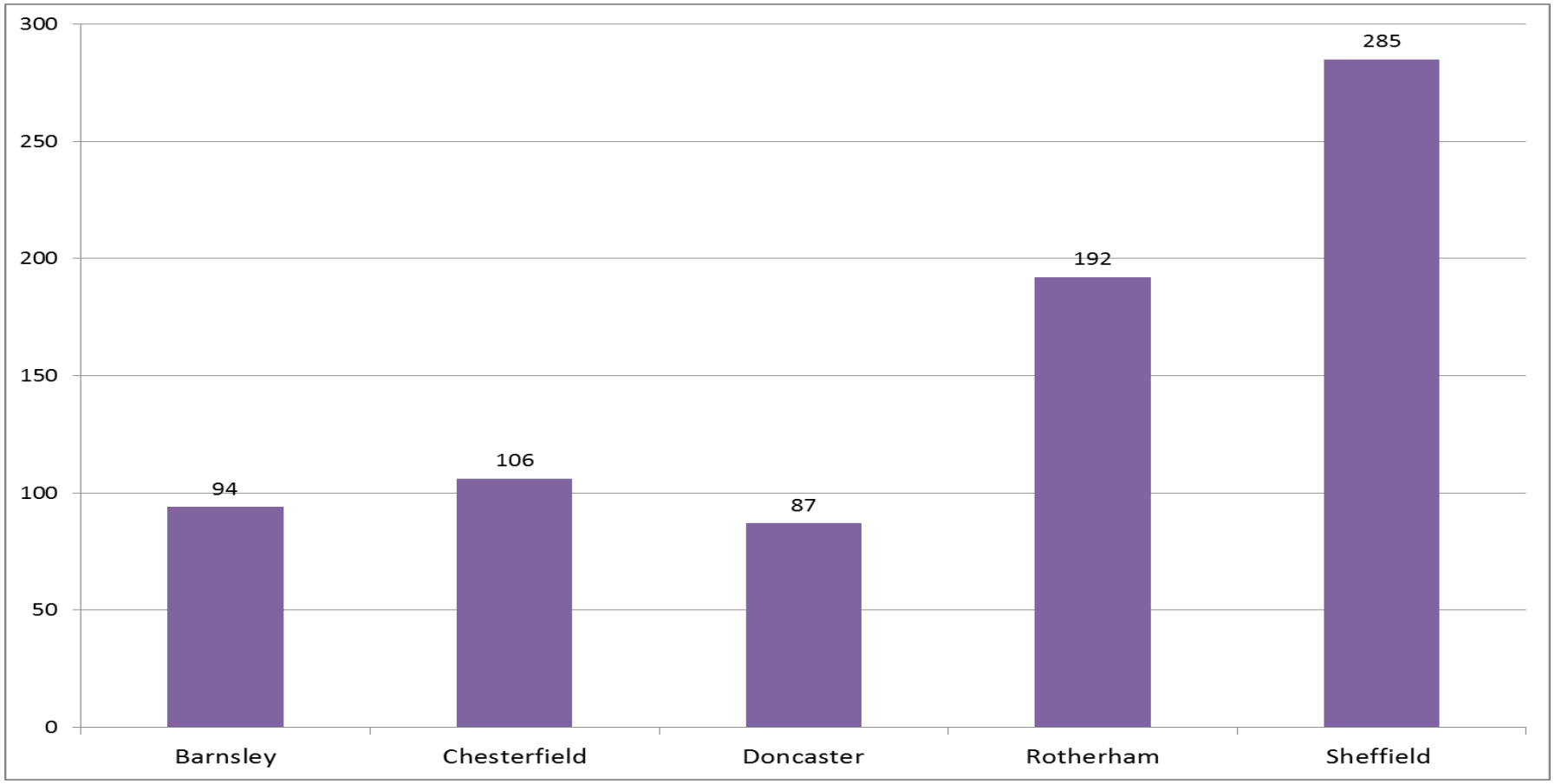
Outcomes of calls



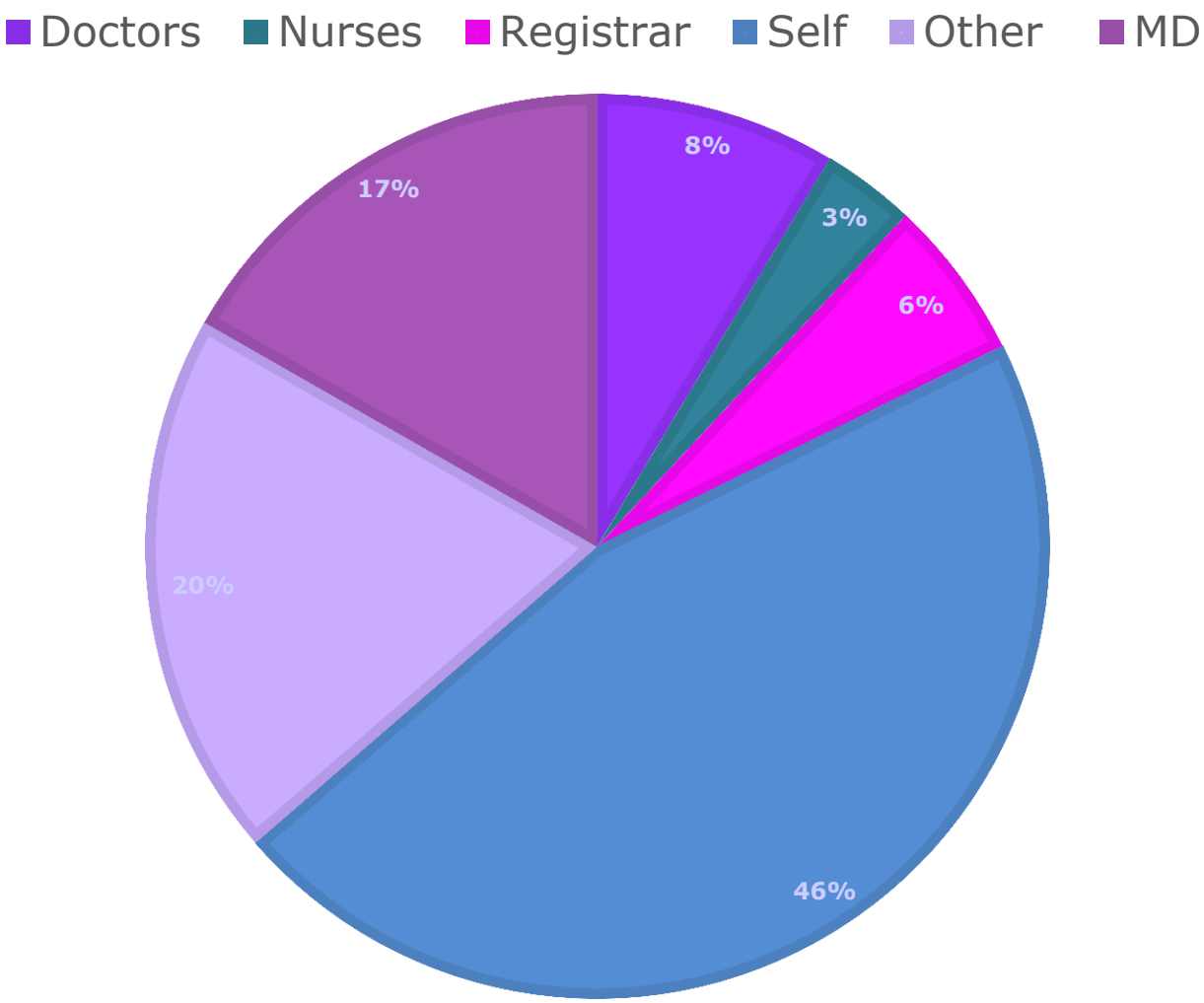
- Which patients attend the cancer centre for review?
  - WAU Monday to Friday – 8am to 8pm
    - 8 chairs and 4 beds
  - Wards out of hours and weekends

Where do patients live

Emergency admissions to WPH by patients nearest hospital 2017
total = 764 admissions

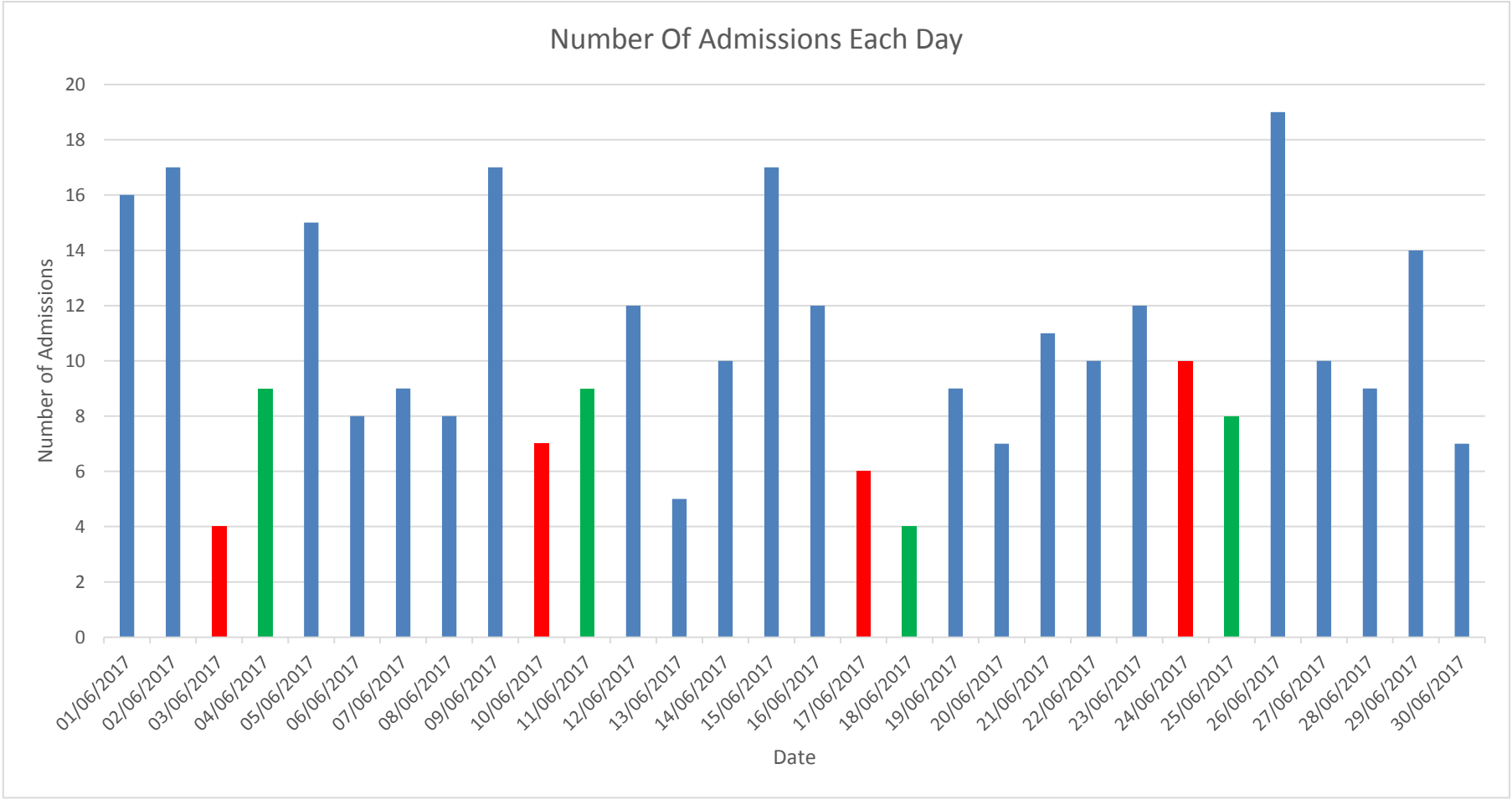


Who referred them?

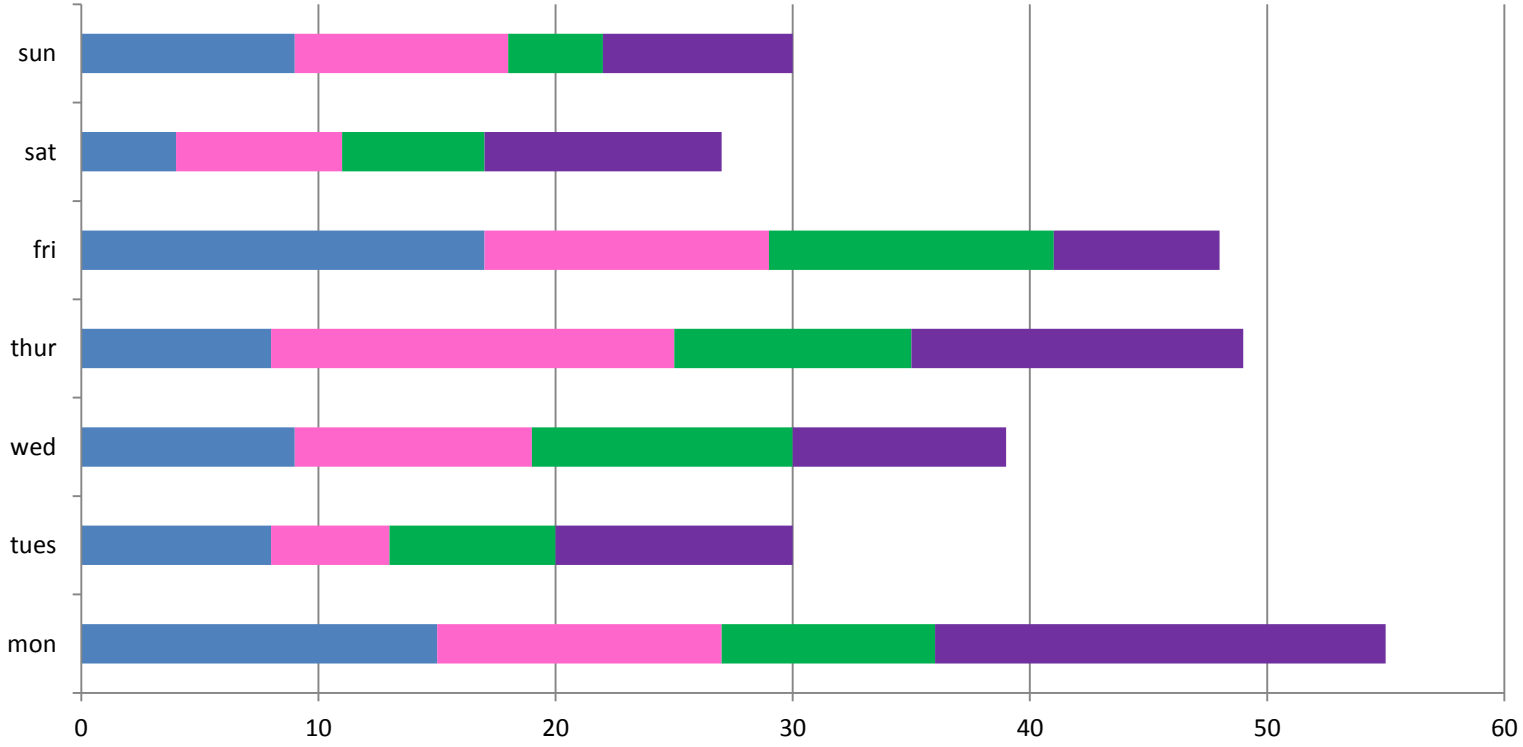


July 2017

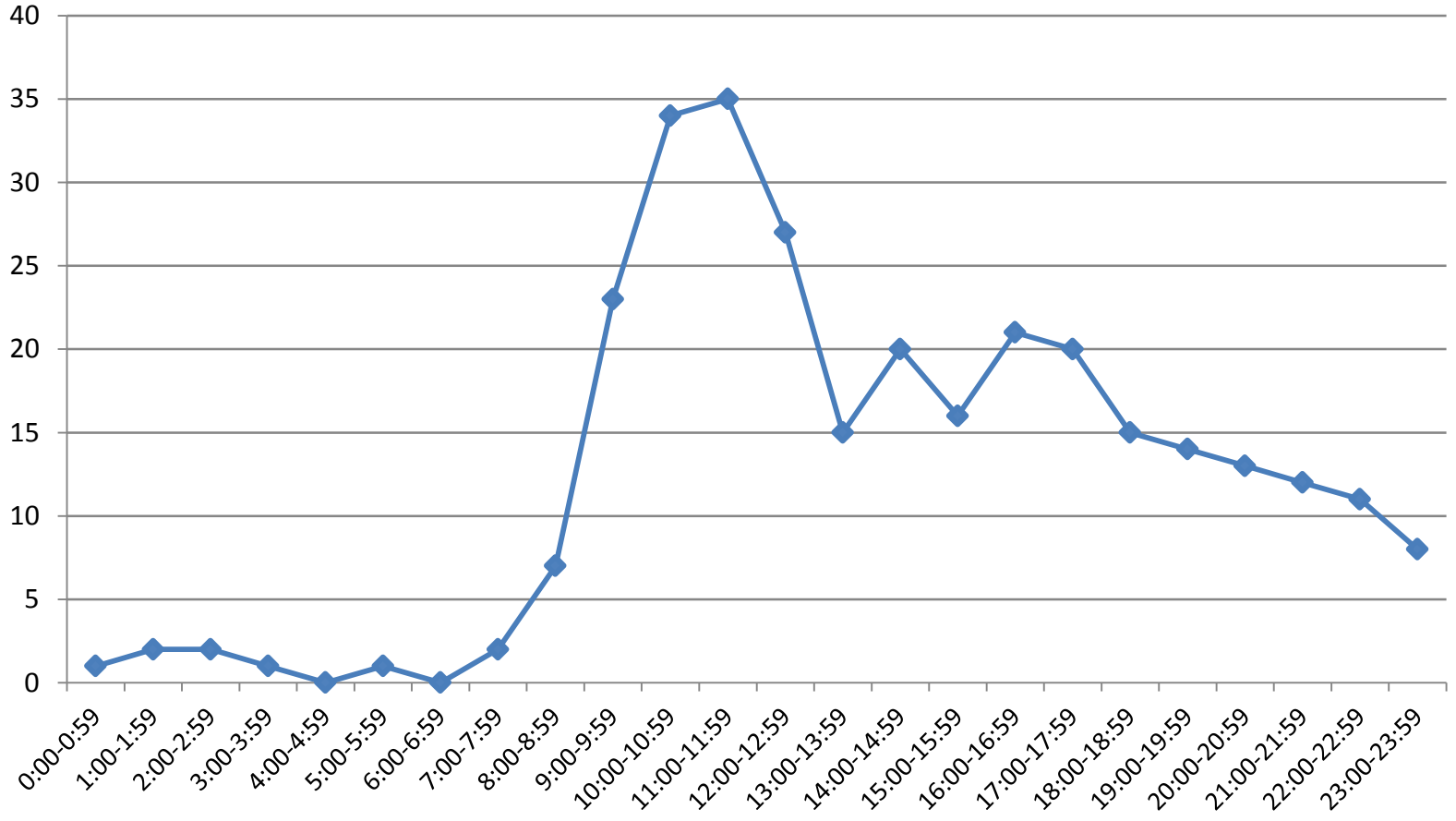
red = Saturday, green = Sunday



Number each day of the week for 4 weeks (July 2017)



Time of day of admissions



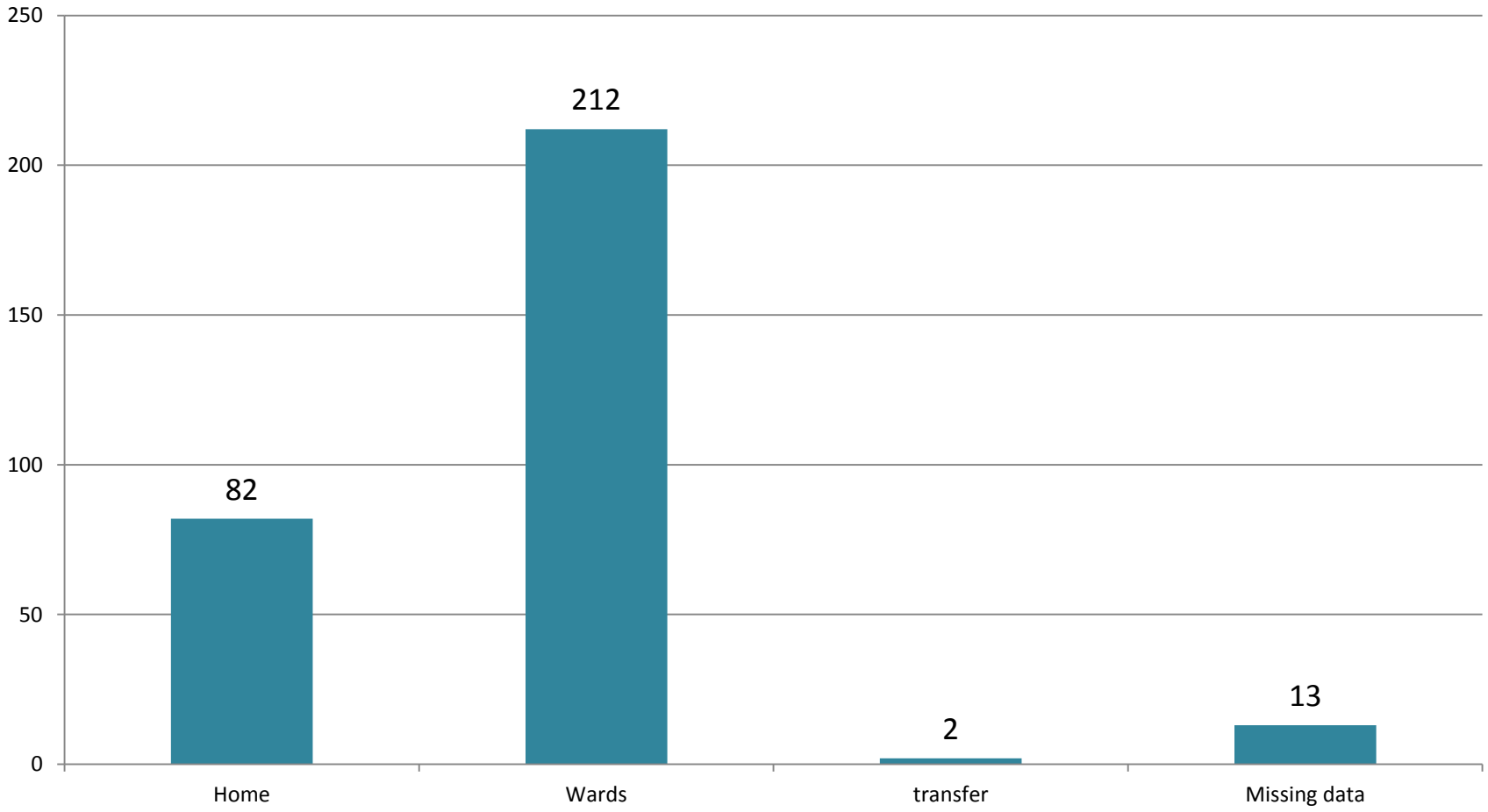
Top 6 reasons for treatment related admissions

- 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)



Feb 2017 review
How would you rate the service

	Excellent	Good	Fair	Poor	Not documented
Telephone triage	32	15	1	1	3
Assessment unit	34	11	2	0	2
Acute oncology service	11	5	0	0	2
Total	77 (68.75%)	31 (27.6%)	3 (2.7%)	1 (0.9%)	7 (NA)

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