



Kent and Medway Cancer Network

## Network Guidance Document

# Managing Nurse Led Chemotherapy Pre-Assessment “Guidelines”

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## CONTENTS

Aim:.....	3
Desired Patient Outcome:.....	3
Referral: .....	3
Criteria for referral:.....	3
Training Requirements:.....	3
Registered nurse:.....	4
Health Care Assistant / Support Worker: .....	4
Managerial / Supervisory Requirements: .....	4
Learning Outcomes:.....	4
Competency:.....	4
Professional, Trust and Legal Requirements .....	5
CLINIC STRUCTURE .....	6
Clinic Times.....	6
Clinic process.....	6
Prepare notes for clinic: .....	6
Patients will book into the clinic with the HCA, who will obtain appropriate bloods, weight and inform them of any waiting time .....	6
The patient will be called into clinic by the identified nurse .....	6
Assessment to include: .....	6
New Patient and Clinic Summary/Checklist: .....	7
Patient Cancer Journey Process Map for “Nurse Led” Chemotherapy Service	9
Cancer Waiting Times Targets.....	10
Patient Cancer Journey Process Mapping Part 1 .....	11
Part 2.....	12
Patient pathway from the point of referral .....	12
Part 3 Patient pathway for each subsequent visit .....	13
Competency Declaration Form .....	14
References and acknowledgements .....	24

# **Nurse Led Chemotherapy Pre-Assessment Clinic**

## **Aim:**

The aim of this clinic is to provide a multi-professional approach to the care of patients receiving chemotherapy. The clinic is fully supported by the multi-professional team; however *overall responsibility for the care of the patient will remain with the consultant oncologist / haematologist.*

The focus of this document is on the role of the nurse within the identified clinic.

## **Desired Patient Outcome:**

The identified nurse will review patients receiving chemotherapy. Benefits as well as complications of treatment will be monitored. The patient will be assessed holistically. Assessment of chemotherapy related toxicities, their management, appropriate blood tests and physical, psychosocial and spiritual well-being will be discussed with the patient. Any concerns relating to the above, including disease progression or complications whilst on treatment, will result in the appropriate multi-professional referral.

## **Referral:**

The oncologist/haematologist will delegate the care of all chemotherapy patients to the pre-assessment clinic using the action sheet, clearly identifying when the senior medical review (s) will take place.

## **Criteria for referral:**

- Patient requires chemotherapy treatment.
- The oncologist/haematologist will see all patients receiving chemotherapy at specified intervals in their chemotherapy pathway as stated on the action sheet.
- All patients seen in the pre-chemotherapy clinic will be reviewed as per the Nurse Led Chemotherapy Pre Assessment Clinic Protocol.

## **Training Requirements:**

### **Registered nurse:**

The minimum academic requirement is the attainment of a qualification directly related to the care of the patient receiving chemotherapy through a recognised university for example: Care of the Patient Receiving Cytotoxic Drugs available at Canterbury Christ Church University College.

The nurse should have declared competence in the administration of cytotoxic drugs and have had a minimum of three months consolidation experience in this area.

The nurse will complete the self directed training pack, attend a training session on blood count interpretation, and manage at least three short day case clinics under supervision in each of which they must achieve the required competencies. Arrangements may be made to visit other hospital sites for observation and or supervised practice.

### **Health Care Assistant / Support Worker:**

Minimum requirement that they have performed 10 successful venepunctures and have undertaken a competency assessment. Additional oncology/haematology training and education will be provided by the senior nursing team.

### **Managerial / Supervisory Requirements:**

The nurse undergoing training will require a supervisor – This will need to be negotiated locally but should be a senior member of staff who is competent assessing patients at this level and able to provide the support and supervision required.

### **Learning Outcomes:**

- To effectively assess chemotherapy side effects and identify appropriate treatment and advice.
- To recognise symptoms of disease progression.
- To establish appropriate referral processes.
- To effectively organise a busy clinic
- To identify treatment benefit i.e. reduction of pain, Tumour markers
- To have awareness of anticipated treatment outcomes i.e. curative / palliative.
- To recognise the patients and relatives need for psychosocial and spiritual support.

### **Competency:**

Competency will be measured against the competency standards. The supervision of at least three clinics must be completed prior to a declaration of individual competency. The mentor/supervisor will initially oversee the process of obtaining evidence of the nurses' competence.

An individual can deem themselves competent after managing at least three supervised clinics.

A portfolio of evidence should be submitted containing the following:

- Completed self directed learning pack.
- Evidence of attending training or having clear understanding of the interpretation of blood results and parameters.

- A signature from the mentor/ supervisor to state that in their opinion the nurse has attained the minimum competency level.
- Three completed competency standard forms (one for each supervised clinic).

A nationally developed competency framework for cytotoxic chemotherapy is available at:

[http://www.skillsforhealth.org.uk/view\\_framework.php?id=72](http://www.skillsforhealth.org.uk/view_framework.php?id=72)

Learners, mentors and assessors should refer to this during the period of supervised practice and assessment.

### **Professional, Trust and Legal Requirements**

The professional position is the NMC Code of Professional Conduct : Standards for Conduct, Performance and Ethics (2004), which places specific responsibility on registered nurses / midwife practitioners. The registered nurse / midwife is personally accountable for their practice and in the exercise of his or her accountability must acknowledge any limitations in their knowledge and competence. They must also decline any duties or responsibilities unless they are able to perform them in a safe manner.

The Trust position is that it accepts liability for the action of those practitioners who have completed the identified training for this skill and are deemed competent by their clinical supervisor, and who have updated their knowledge and skills according to policy.

## CLINIC STRUCTURE

### *Clinic Times*

1. The clinic will be held .....The clinic will be held in .....room.
2. The clinic will be run by an identified, and appropriately skilled named nurse.
3. The first patient will be booked in at ..... in the morning clinic.
1. The last patient will be booked in at ..... in the morning clinic.
2. The first patient will be booked in at .....in the afternoon clinic.
3. The last patients will be booked in at ..... in the afternoon clinic.
4. In the event of the named identified nurse being on sick or annual leave, alternative qualified staff will manage the clinic.

### *Clinic process*

#### **Prepare notes for clinic:**

- Check action sheet and consent are present.
- Check for when senior medical review is due and complete review request letter.
- Insert the correct proforma and date correctly.
- Nursing documentation to be given to HCA for recording patient's weight.
- HCA to ensure completed blood forms/requests are ready for clinic.
- Complete "notes only" ( patients who are not required to attend for clinic review) patients and ensure all information is present and correct.
- Give "notes only" notes to the Oncology/haematology pharmacist prior to commencing the clinic.

**Patients will book into the clinic with the HCA, who will obtain appropriate bloods, weight and inform them of any waiting time**

**The patient will be called into clinic by the identified nurse**

#### **Assessment to include:**

1. Full general health assessment to be obtained from the patient or relative including:
  - Any recent changes to medical condition
  - Drug history to date, including new allergies
  - Adverse effects of chemotherapy
  - Any noticeable benefits from chemotherapy
  - Psycho - Social history changes
2. Full assessment of chemotherapy induced side effects using the WHO toxicity score and complete MRC Performance status.
3. Document any changes and review interventions
4. Review of routine blood assay for patients on chemotherapy.

Ensure that:

- Blood Chemistry profile has been taken.
  - Full Blood Count has been taken.
  - Tumour markers have been taken if required
  - Other requested bloods have been taken.
5. Discuss with the Oncologist/haematologist any problems re:
    - Need for dose reduction
    - Evidence of disease progression
    - WHO Toxicity's and MRC performance status above 2
    - Lack of patients' understanding
    - Psychological impact of treatment
    - No consent
    - Any postponement of treatment
  6. The nurse will refer to, or liaise with any other members of the MDT as appropriate i.e. CNS , clinical trial nurses etc, medical team if clinical review required (different to senior medical review) i.e. infection, generally unwell and co-ordinate hospital admission if required.
  7. The identified nurse will tell the patient their blood assay results and explain if a Consultant opinion is required.
  8. Patients will be given ample opportunity to ask questions.
  9. The nurse will ensure that the patient has Contact numbers for the Chemotherapy department and on call nursing team.
  10. The identified nurse will check the patients appointment. If the treatment has been postponed the patient will be advised to alter their appointments with the Chemotherapy Co-ordinator / ward clerk/or reception desk
  11. The nurse will ensure that everything is documented on the multi-professional sheet as well as the assessment tools.
  12. The nurse will notify pharmacy aseptic of any postponements or delays
  13. The nurse will contact patients who have not attended and rearrange alternative appointments as appropriate.
  14. The nurse will hand over any significant changes to the nursing team prior to treatment.

### **New Patient and Clinic Summary/Checklist:**

All patients referred will be booked in for a new patient assessment with a chemotherapy nurse. The Action sheet initiating the first cycle of any course of chemotherapy must be completed by a Consultant Haemato- oncologist or Oncologist. Should a Haemato- oncology or Oncology Registrar complete the first action sheet this should be countersigned by the relevant consultant. Subsequent treatments can be prescribed by Haemato-oncology Registrar, Specialist Staff Grade and SPR level.

The patient and his/her carer will be given time to ask questions and the nurse will:-

- Ensure that the Action Sheet referral is completed correctly identifying the regime required, any variance to protocol and review timescales
- Ensure all specific investigations have been completed and results available
- Conduct a comprehensive assessment of the patients physical, social, psychological, emotional and spiritual needs
- Nutritional assessment, weight and height
- Conduct baseline clinical observations
- Identify co-morbid conditions that may impact on treatment
- Note any Past Medical History including allergies
- Note medication record
- Assess WHO performance status and overall fitness for treatment
- Assess venous access as appropriate and discuss options i.e. Central Venous Access Devices and make appointments for insertion as necessary
- Give verbal and written information to the patient regarding treatment, support available (CNS, Social Worker, Out of hours advice line, District Nurse etc) and make any appropriate referrals
- Ensure consent form is signed. Complete informed consent checklist and reconfirm the patient's compliance to treatment and receipt of generic written information.
- If the patient consents to a photograph being taken, the nurse will take it to be placed in the patients notes as an extra form of identification

***NB. Each pre printed treatment proforma clearly outlines the laboratory blood test and investigational parameters to be fulfilled prior to starting chemotherapy.***

Before subsequent cycles of chemotherapy the patient attends the Nurse led pre-chemotherapy assessment clinic where blood assays and any tests pertinent to that cycle will be performed and the nurse will:-

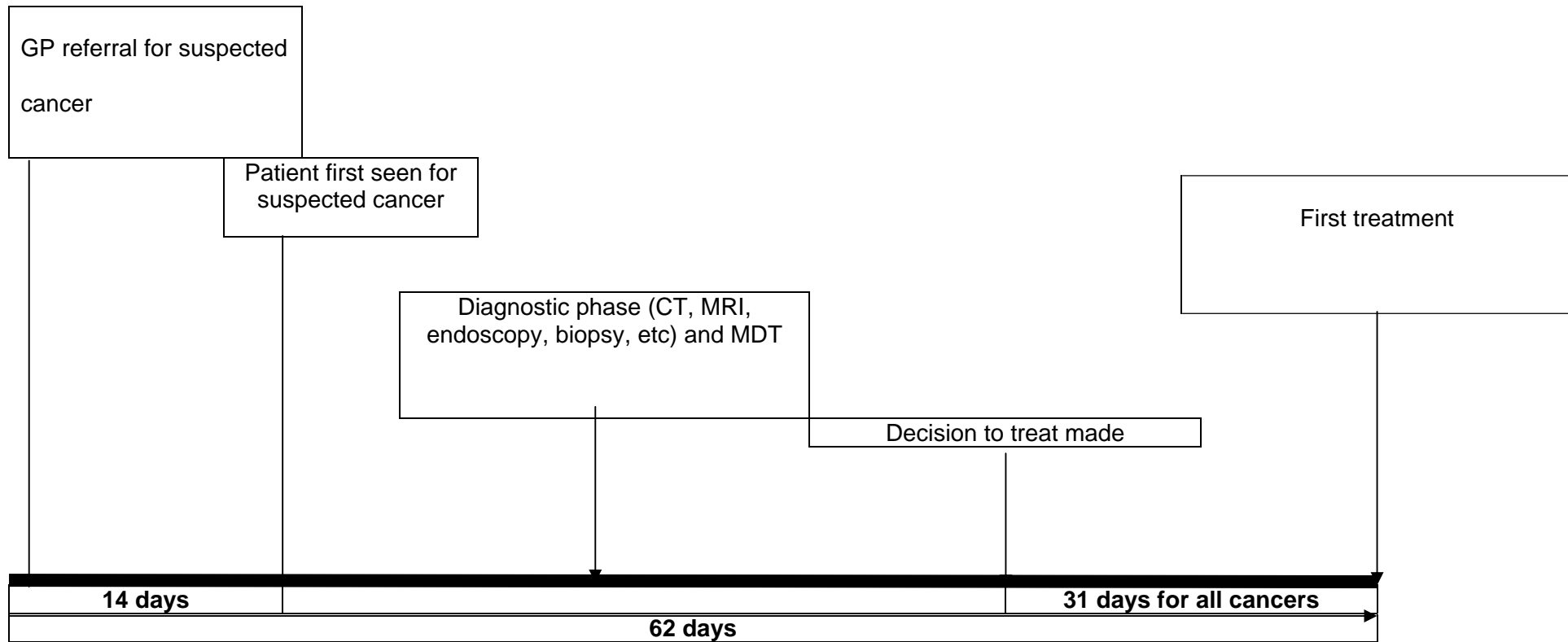
- Discuss the patients experience of the previous treatment, side effects and concerns
- Assess psychological, social and spiritual needs and advise and or refer on as necessary
- Assess physical toxicities using the WHO toxicity score
- Assess blood results, ensuring that they are within the agreed parameters to continue with treatment
- Record weight, calculate BSA and ensure no dose modifications are required.



## **Patient Cancer Journey Process Map for “Nurse Led” Chemotherapy Service**

This Section describes the patient cancer journey in from the point of referral to the service to the start of the first cycle of chemotherapy treatment for inpatient and outpatients in part one. Part two describes the patients' journey from arrival for the start of the first cycle to completion of the final cycle of a course of chemotherapy for outpatients. Part three describes the patient pathway for each subsequent visit. The national cancer waiting time targets run along side of the local pathway.

## Cancer Waiting Times Targets



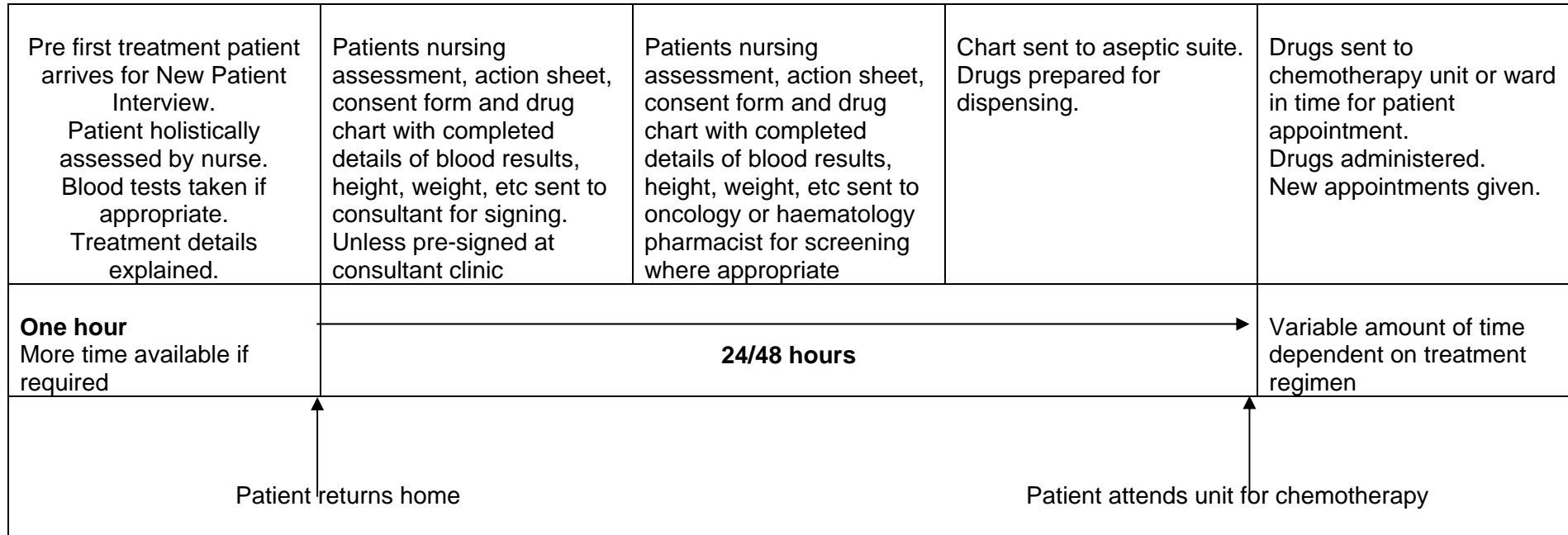
**Patient Cancer Journey Process Mapping Part 1**

Patient pathway from the point of referral to the service, to attendance for the start of the first cycle of a course of chemotherapy for inpatient and outpatient/ambulatory chemotherapy. There may be some local variation in the order of these events.

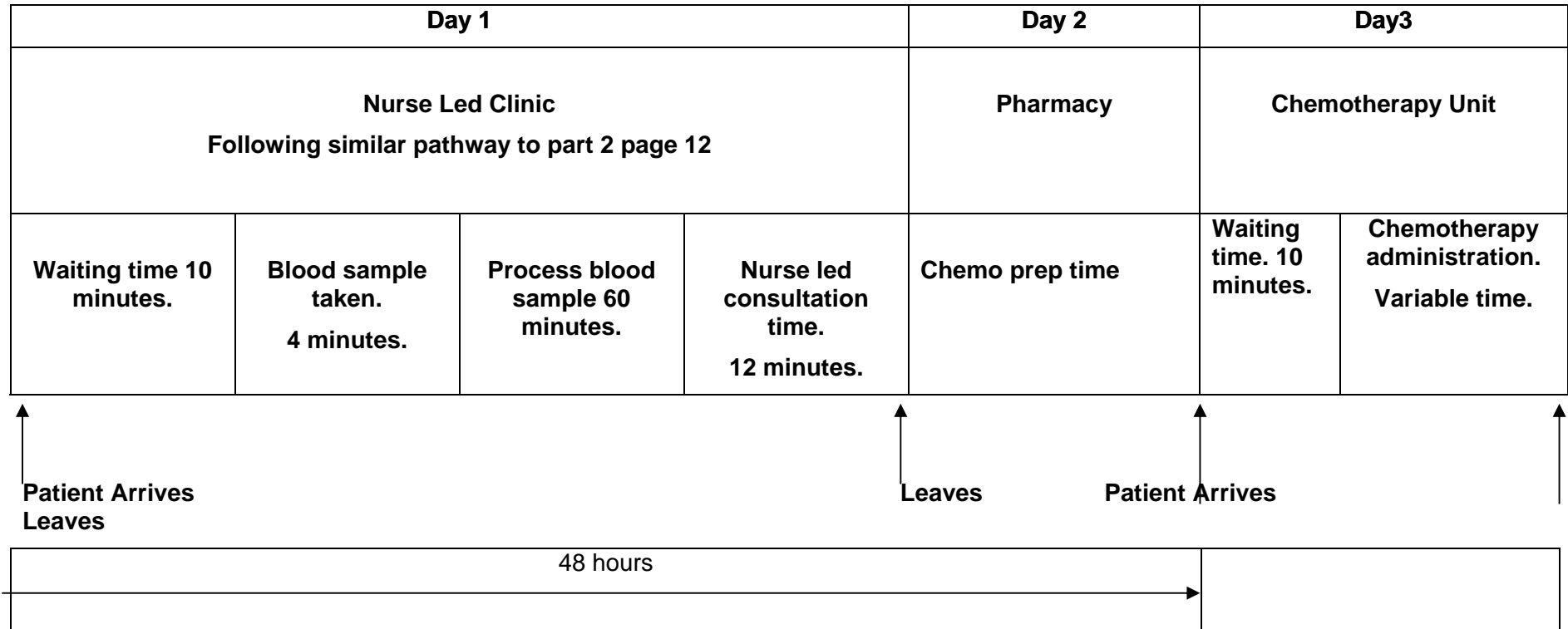
Patient is referred to consultant Oncologist or Haematologist	Appointment sent to patient	Patient attends clinic to see consultant. Treatment options discussed. Inclusion in clinical trial explored.	If treatment plans to include chemotherapy then Action Sheet generated. Patient consented	Action Sheet sent to appropriate chemotherapy Unit or Haematology inpatient ward Or scheduler	Appointments booked. One for New Patient Assessment and one for first Chemotherapy treatment within time specified on Action Sheet
Pre-diagnostic tests performed		Patient may be seen by appropriate Nurse Specialist and referred to other support services		Appointments may be made if required at this point for Insertion of Central Venous Access Device and Pre Chemotherapy tests such as Echo, EDTA etc	
Patient discussed at Multidisciplinary team meeting					

**Part 2**

**Patient pathway from the point of referral** to the service, to attendance for the start of the first cycle of a course of chemotherapy for inpatient and outpatient/ ambulatory chemotherapy.



**Part 3 Patient pathway for each subsequent visit for assessment and chemotherapy.**



# Competency Declaration Form

The professional position is the NMC Code of Professional Conduct, which places specific responsibility on registered nurse / midwife practitioners. The registered nurse / midwife is personally accountable for their practice and, in the exercise of his/her accountability, must acknowledge any limitations in their knowledge and competence and decline any duties or responsibilities unless they are able to perform them in a safe manner.

The Trust position is that it accepts liability for the action of those practitioners who have completed the identified training for this skill and are deemed competent by their clinical supervisor, and who have updated their knowledge according to the policy

I confirm that I am competent to practice chemotherapy pre-assessment clinics and understand that I am responsible and accountable for my practice.

I have;

- Undertaken supervised practice in Chemotherapy Nurse led clinics and demonstrated competent practice.
- Completed the Administration of cytotoxic drug competencies and had a minimum of 3 months consolidation experience.
- Completed the self-directed learning pack for Chemotherapy Nurse led clinics
- Read the accountability, policy and procedure documents.
- Kept updated with current nursing issues related to nurse led clinics and chemotherapy.

I understand that I am responsible and accountable for keeping my practice up-to-date, that I am advised to read policies and procedures yearly as they are reviewed, and seek to update my practice as necessary, but particularly if I do not undertake an element of practice in 1 year.

Signed.....Date.....

Print name .....

Please photocopy this document 2 times  
1 copy to place in your personal professional portfolio  
1 copy to your ward/ unit manager

Level of Performance	Level of supervision / support	Level of practice	Conditions of practice for the achievement of clinical competencies	
			Competence achieved	Competence not achieved
<b>Independent</b>	Practices without direct supervision whilst recognising the limits of own ability and seeking appropriate support and advice when required	Proactively plans activities & demonstrates initiative in so doing.  Acts as a role model for practice, stimulates & informs others	<p>Practice is consistently safe, accurate &amp; effective within each competency</p> <p>Performance is skilled, co-ordinated and confident with economical use of time</p> <p>Focuses primarily on the patient (rather than the task)</p> <p>Demonstrates responsive interpersonal skills</p> <p>Is self directing &amp; offers cues to assist others whilst achieving competency</p> <p>Evaluates the use of the evidence base for practice</p>	<p>Omissions or inaccuracies are evident in performance</p> <p>Lacks skill or co-ordination in performance of the competency</p> <p>Demonstrates a lack of focus on patient needs</p> <p>Demonstrates inappropriate interpersonal skills</p> <p>Requires directive or supportive cues</p> <p>Cannot articulate the evidence base for practice</p>

Competency Statement Administer and provide oral chemotherapy (KSF Competency CHEM 1/7/8)		Assessment		Student to provide summary of evidence to demonstrate Independent Practice (e.g. this may include reference to a situation in which you showed initiative / problem-solving skills, demonstrated a skill or discussed the competency with your Supervisor	Practice Supervisor's Signature
		Dependent	Independent		
1	Ensure that the appropriate consent procedure has been completed				
2	Read the patient's notes, prescription and relevant regimen protocol and identify any special instructions, investigations (including abnormal blood test results) or issues for which you need to seek advice				
3	Greet and accurately identify the patient. Introduce yourself and any colleagues involved in the treatment to the patient and / or carer				
4	Review the patient's history since their last attendance				
5	Assess the patient's physical condition and their fitness for treatment and seek advice from an appropriate team member if required				
6	Assess the patient's psychological and emotional state and respond appropriately including referrals to appropriate agencies and personnel				



7	<p>Explain the treatment and potential side effects and their management to the patient and / or carer and accurately answer any questions at a level and pace that is appropriate to:</p> <ul style="list-style-type: none"> <li>• Their level of understanding</li> <li>• Their culture and background</li> <li>• Their preferred ways of communicating</li> <li>• Their needs</li> </ul>				
8	<p>Check that the patient and / or carer understands the treatment to be given and any potential side effects together with their management</p>				
9	<p>Determine whether or not the patient is willing to proceed</p>				
10	<p>Check the treatment drugs against the treatment plan, protocol, regimen, prescription and patient</p> <ul style="list-style-type: none"> <li>• Patient's identification on prescription chart and on labelled drugs</li> <li>• Critical test results</li> <li>• Regimen and individual drug identification</li> <li>• Names of drugs</li> <li>• The drugs' fitness for administration</li> <li>• Strength and concentration</li> <li>• That supportive drugs have been given</li> <li>• Dose</li> <li>• Administration route and duration</li> <li>• Frequency of administration</li> <li>• Cycle number</li> </ul>				

	<ul style="list-style-type: none"> <li>• The administration as per the schedule within the cycle</li> <li>• Expiry date</li> <li>• The date the drugs are due to be administered</li> </ul>				
11	Undertake a final check of the treatment drugs against the prescription and the patient's identity before administration				
12	Observe the patient taking the drugs (first dose only)				
13	Monitor the patient for indications of discomfort or any allergic or hypersensitive reactions and act appropriately				
14	Ensure sufficient supply of the medication to complete the treatment cycle				
15	Advise the patient how to safely dispose of contaminated waste				
16	Instruct the patient to return any unused drugs to the pharmacy according to local guidelines, once the treatment cycle is completed or stopped				
17	Instruct the patient on the dangers to others from contact with their chemotherapy medication and the precautions required				
18	Remind the patient and / or carer of the information and advice they have already been given with regard to lifestyle and side effects and respond to any questions or requests for information				
19	Confirm the details of the next appointment and any prior investigations or tests with the patient and / or carer if appropriate				

20	Provide information on how to obtain help at any time				
21	Ensure the patient and / or carer has all additional medication to take home and understands how to handle, take and store them				
22	Record the details of the treatment in the patient's notes, prescription chart and patient held records, as appropriate, according to local guidelines				
23	Communicate with appropriate professional colleagues as required by local guidelines				
24	Recognise when you need help and / or advice and seek this from appropriate sources				

Competency statement: Undertake an assessment or re-assessment of a patient for chemotherapy		Assessment		Student to provide summary of evidence to demonstrate Independent Practice (e.g. this may include reference to a situation in which you showed initiative / problem-solving skills, demonstrated a skill or discussed the competency with your Supervisor)	Practice Supervisor's Signature
		Dependent	Independent		
1	Identify, access and evaluate all relevant patient / carer information and consult with colleagues so that you clearly understand the care pathway, changes in the patient's care needs, circumstances, choices and preferences				
2	Arrange for an independent translator / interpreter if you have reason to believe this will assist the patient's understanding				
3	Ensure you have sufficient time to complete the assessment				
4	Ensure that the assessment is undertaken within an appropriate timescale after admission / referral				
5	Ensure the environment provides for maximum possible privacy, dignity and comfort throughout the assessment and determine whether the patient wishes to have any other person present				
6	Take action to pre-empt and prevent interruptions from communication devices and visitors to the room				
7	Read the patient's notes, prescription – if previously prepared – and protocol, and identify any special instructions. Review				

	the results of all relevant investigations (including blood test results) and identify any issues on which you need to seek advice				
8	Greet, accurately identify the patient and introduce yourself and any colleagues present to the patient and / or carer				
9	If a carer is present, ensure that the patient consents to their presence throughout the assessment and is willing for them to receive the same information as that given to the patient				
10	Select and use the assessment process, and documentation appropriate to the patient's care needs, circumstances, the procedure to be performed and national and local guidelines				
11	Undertake the assessment within your own sphere of competence and involve the patient and / or carer in the assessment as appropriate (as per the clinic protocol)				
12	Determine the patient's and / or carer's understanding of their current circumstance in a manner which reassures the patient that you are familiar with their history				
13	Review the patient's history since their last attendance				
14	Assess the patient's physical condition and their fitness for treatment and seek advice from an appropriate professional colleague if required				

15	Assess the patient's psychological, emotional and spiritual state and social circumstances and respond appropriately including referrals to appropriate agencies and personnel				
16	Use visual clues to add to your understanding of the patient's care needs, circumstances, choices and preferences				
17	Throughout the assessment balance additional information against the overall picture of the patient's and / or carer's care needs, circumstances, choices and Preferences				
18	Ensure that the patient understands their right to choose and support them in making an informed choice as appropriate				
19	Ensure the patient understands the choices available to them and ensure they are happy to continue				
20	Confirm the details of the next appointment and any prior investigations or tests with the patient and / or carer if appropriate				

21	Provide information on how to obtain help at any time				
22	Record any modifications which are made to the agreed assessment process and documentation and the reasons for the variance				
23	Record and report your findings, recommendations, patient and / or carer's response and issues to be addressed according to local guidelines				
24	Inform the patient's multi-disciplinary team on the outcome of the assessment				
25	Seek advice and support from an appropriate source when the needs of the individual and the complexity of the case are beyond your competence and capability				

## References and acknowledgements

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EKHA Nurse Practice Development. (2004) Policy for Assessment of Competency.

Stephens K – Nurse Educator – CCHHD - East Kent Hospitals NHS Trust – 2008

NMC The Code of Professional Conduct: Standards for Conduct, Performance and Ethics 2008

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