BSWRICS
Barwon South Western Regional Integrated Cancer Service

BSWRICS Cancer Link Nurse Project **February 2011**

Western District Health Service Cancer Link Nurse Report

Background

Phase 1 Mapping of cancer services identified a gap to psychosocial care. This was the impetus for the development of a nursing role that provided the link between the multiple services and the BSWRICS team located in Geelong. The BSWRICS Cancer Coordination project began in 2006. It involved appointment of Cancer Coordinators (CCs) to map complex cancer journeys that provided data on patient needs, referral pathways and gaps in the delivery of cancer care and support. The CCs were based in Geelong for the Barwon region and in Warrnambool for the South West region.

Phase 2 The data from the initial phase from 2006 to 2007 was analysed and the highest needs identified by the 215 cancer patients was for psycho-social care and cancer information. Expansion of this CC model in the South West saw a BSWRICS office opened in Warrnambool in 2008. In addition to the Cancer Coordinator two part-time Supportive Care Project Officers were appointed to address the supportive care and cancer information needs of patients in the South West. A Cancer Information project and Screening for Supportive Care Needs research was conducted in Geelong.

Phase3 The highest gap in cancer services identified from phase one was access to specialist nurses. This evidence has informed the development of *phase 3* of the Cancer Coordination project, the introduction of Cancer Link Nurses (CLNs). A Link Nurse is recruited locally by participating health service undertakes specialist cancer education and attends a mentor program at the Andrew Love Cancer Centre. A Cancer Link Nurse (CLN) Pilot project was conducted in 2009 in partnership with Colac Area Health (CAH). Following a report to the BSWRICS Governance Group the project was expanded in January 2010. CLNs are now located at South West Healthcare, Western District Health Service as well as Colac Area Health and Portland District Health. By August 2010 there were 4 CLNs within the BSW region.

The nurses attend orientation and training at Barwon Health and Peter MacCallum Cancer Centre as well as relevant observational placements. The roles are underpinned by a supportive care model where psycho-social assessment and care coordination are the focus. To date the outcomes of the Cancer Link Nurse project include:

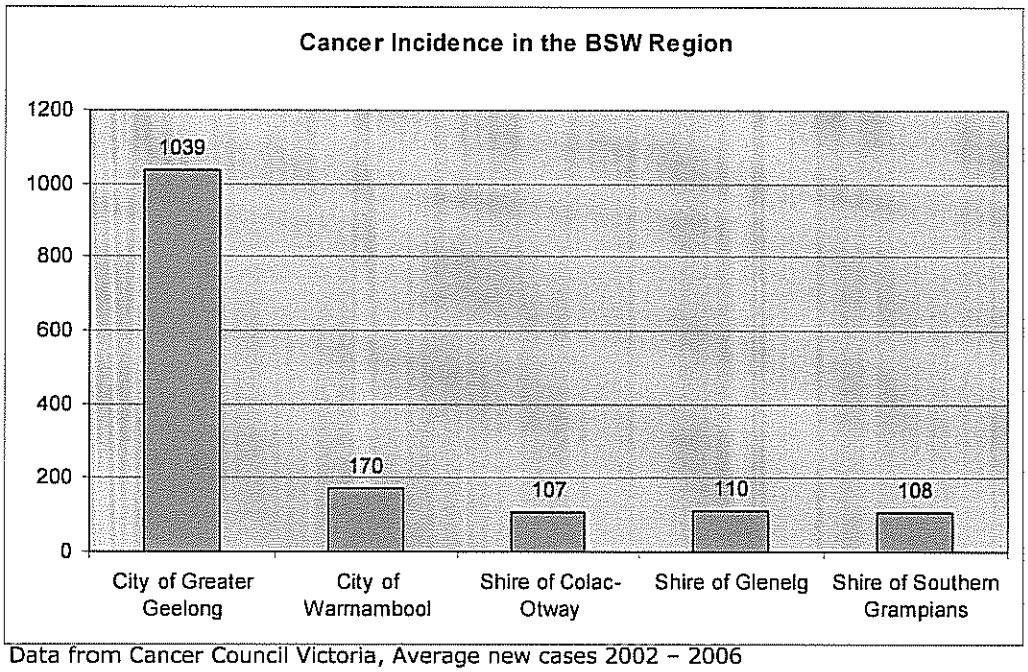
- Creation of new referral pathways
- Improved communication between treatment teams
- Early identification of patient needs
- Provision of supportive care

Link nurses communicate via the web based secure database sharing updated patient and multidisciplinary meeting information in real time.

Video conferencing into education forums has assisted the nurses in overcoming some of challenges associated with distance and travel.

Data from the below figure one from the Cancer Council Victoria indicates that on average there are 110 new diagnoses of cancer in the shire of Glenelg per year.

Figure 1.



Data from Cancer Council Victoria, Average new cases 2002 – 2006

The following set of graphs provide information on the activity of the Western District Health Service Cancer Link Nurse covering the period from April 2010 to February 2011. Data source BSWRICS CC database.

Analysis of Western District Health Service Cancer Link Nurse data of 48 patients from April 2010 to February 2011.

Figure 2 provides details of the number of patients referred to the CLN by tumour stream. The highest tumour was Lower GI/Colorectal followed by Breast and Haematological.

Figure 2.

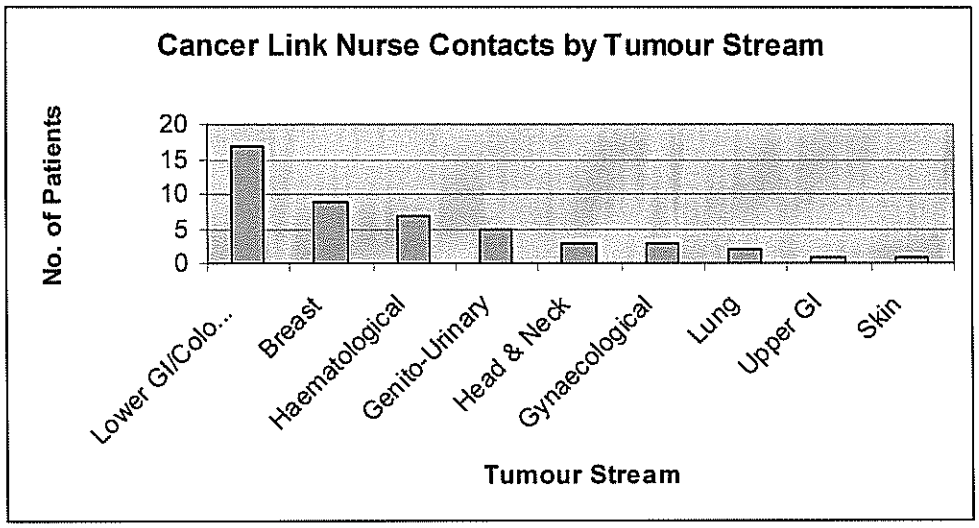
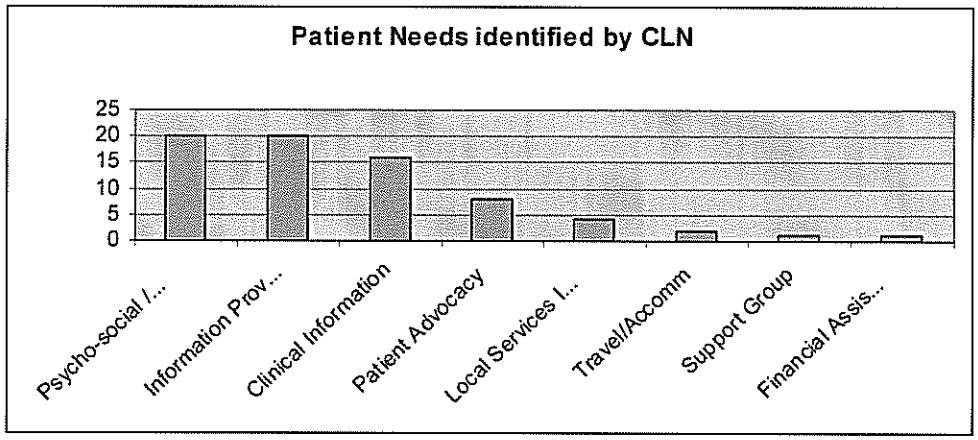


Figure 3 illustrates patient needs identified by the Cancer Link Nurse.

Figure 3.



Follow Up
Each patient is assessed for supportive care needs and triaged into one of three categories.

Low = No need to follow up. Further contact is patient initiated as required.

Medium = Follow up as required to provide support and ensure referrals are made and links occur.

High = Follow up several times as required to provide information and further links to services.

Figure 4 identifies the referrals from the CLN to various clinicians and services.

Figure 4.

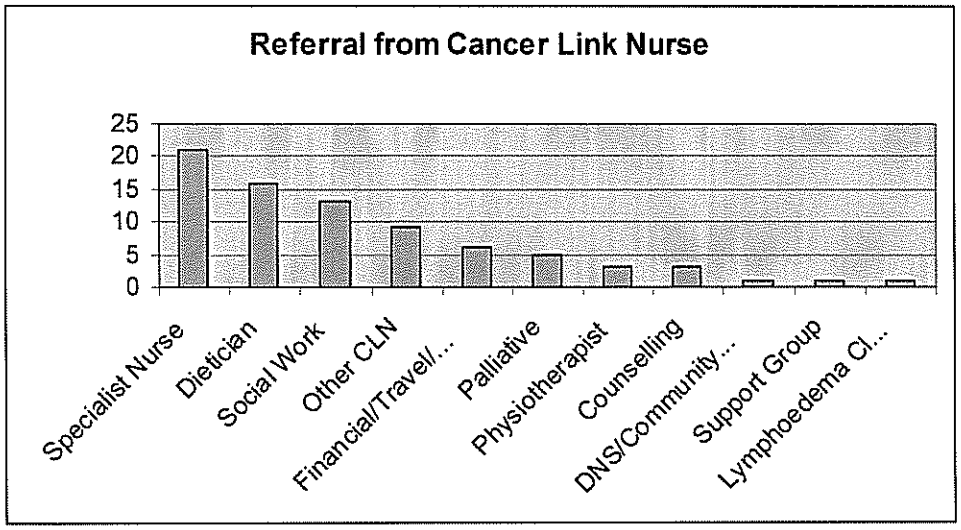


Figure 5 illustrates the stage of disease at referral to CLN.

Figure 5.

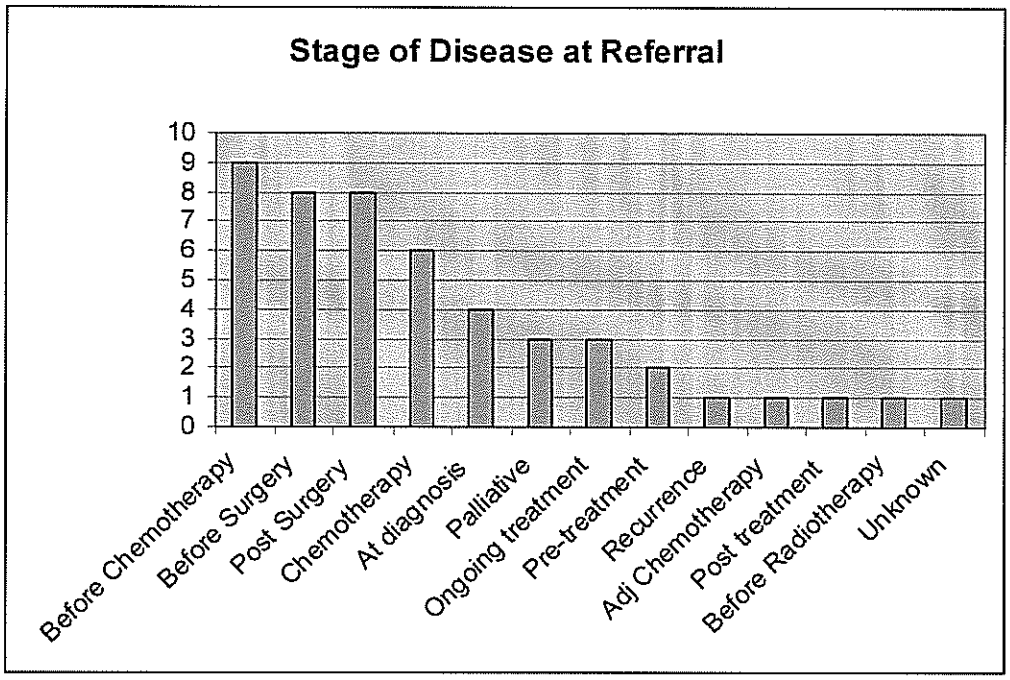
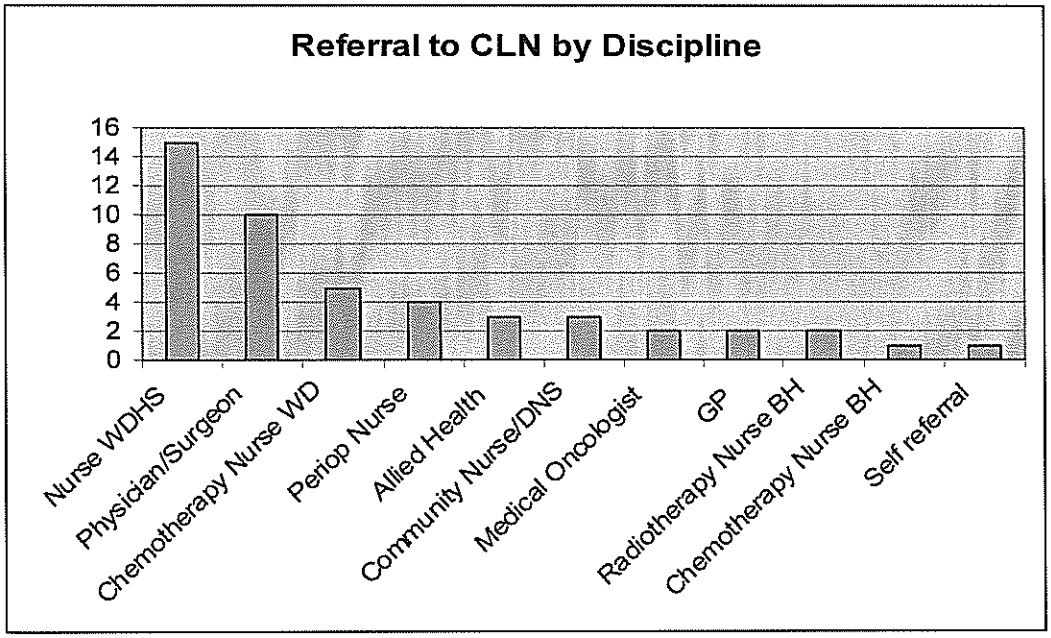


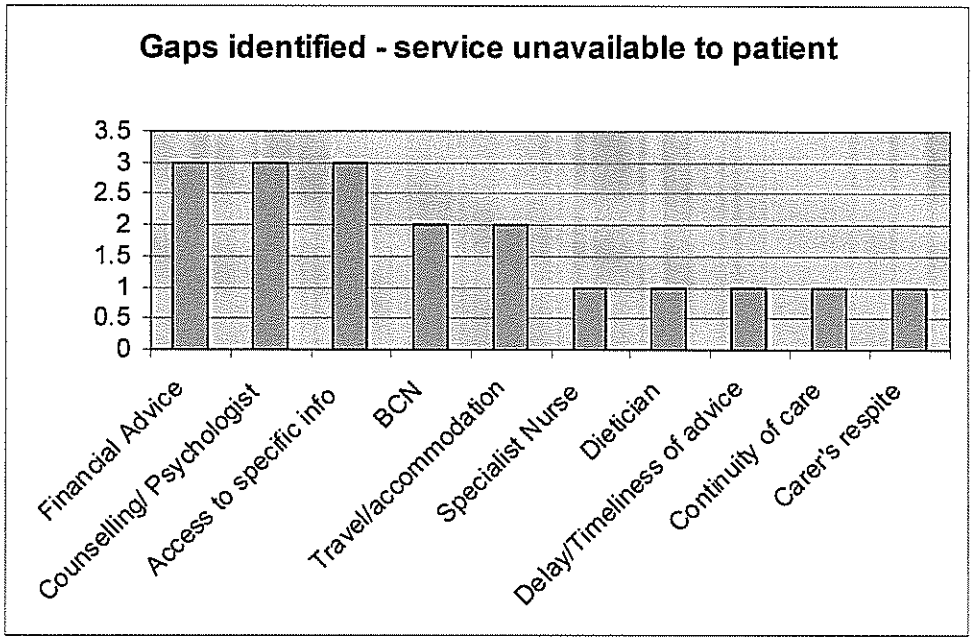
Figure 6 provides the details of who referred to the CLN.

Figure 6.



Total number of patient contacts for the Western District Health Service CLN in the first 10 months was 48, these include initial assessment and follow up contacts.

The main gaps in services were also recorded by the CLN. A gap was recorded if access to a service at time of initial assessment impacted upon the patient journey. Gaps recorded by the Western District Health Service CLN:



This new nursing role is important for enhancing communication links for treatment teams and providing up to date information, education and support at a local level thus improving patient journeys. The data demonstrates that the Western District CLN role is providing successful access to Supportive Cancer Care.

Maggie Stowers
Cancer Coordination Manager
BSWRICS