SURGICAL NAVIGATOR

The role of the surgical nurse navigator: A case scenario

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INTRODUCTION AND BACKGROUND

The purpose of this brief article is to outline the different tasks that encompass the role of a nurse navigator in surgical oncology at the Ages Cancer Assessment Clinic (CAC) and highlight the tools that are used to streamline care to make it an agreeable experience from referral through the post-operative period for the patient and their family. It is anticipated this information could be of interest to other cancer programs that are considering improvements in their surgical oncology patient experience.

It is estimated that approximately 26,800 Canadians were diagnosed with colorectal cancer in 2017 (Canadian Cancer, 2017). To streamline the time to diagnosis and treatment, Ontario has implemented diagnostic assessment programs (DAPs) to improve quality and accessibility of care, advance a person-centred approach, drive integrated care delivery, and maximize the value of care delivered (CCO, 2015).

In 2007, our regional cancer program opened a colorectal DAP called the Cancer Assessment Clinic (CAC) to provide a single point of access to a multidisciplinary team, coordinated testing and navigational support for patients. The CAC accepts more than 450 consults with colorectal surgical oncology patients. Colorectal referrals received at the CAC are reviewed, triaged and accepted by the nurse navigator. The nurse navigator role at CAC includes assessing patients, providing education, expediting care and being the point of contact for the patient, family and multidisciplinary team. Strategies that enable and support navigation include medical directives to coordinate appropriate staging and consultations, tools for patient tracking, and coordinating visits with surgeons. Medical directives enable the nurse navigator to order imaging, bloodwork (BW) and send referrals to the different specialties (e.g., medical/radiation oncology, hepatopancreatobiliary [HPB] specialists, internal medicine and psychosocial program) that will be taking part in the patient’s course of treatment as an interdisciplinary team approach.

Multiple materials are used for informational and educational purposes to help the patient and family prepare for their journey ahead. The nurse navigator at the CAC offers an educational session to the different patients of the Local Health Integration Network (LHIN), who are undergoing future colorectal surgery, together with an enterostomal therapist available to meet with patients and family for information regarding stomas and marking for surgery.

The nurse navigator calls all patients referred to the colorectal CAC clinic. This is the first patient contact. The call is important for the patient to understand the process and what to expect in the weeks ahead regarding their new diagnosis. The nurse navigator will also explain the staging process, the different tests and calls for appointments to expect, assess the patient’s symptoms and provide her contact information. Providing contact information for the nurse navigator helps patients and families deal with the stress and anxiety that can be caused by the waiting period between test and appointments. It also provides the patient direct access to speak to the nurse navigator and be assessed and guided to the right area in case of emergencies.

The following case study will highlight the role of the nurse navigator in providing system navigation for the patients and their families to ensure timely access to specialized care for colorectal surgical oncology patients.

CASE STUDY

The referral was received for Lara, a 68-year-old female whose first colonoscopy, for FOB + ⅔, showed a positive pathology result for adenocarcinoma. She was notified of the colonoscopy results by her family physician. Lara was then referred to the CAC by her gastroenterologist, contacted by the nurse navigator, assessed and screened for urgent symptoms. She was slightly anxious and had questions about what to expect, would she need chemotherapy, and what the survival was, but felt relieved after the contact call.

The history of her present illness revealed that she had been having mild right lower quadrant (RLQ) pain, some abdominal bloating after meals, and fatigue for approximately two months. She was having regular bowel movements, but her stool had been darker than usual but with no obvious bleeding.

The nurse navigator then reviewed with Lara what to expect in the upcoming days. Following the medical directives, a CT abdomen and pelvis, chest x-ray and BW were ordered for initial staging. Family and patient questions regarding staging and future appointments were answered and contact information was given.
Investigations were reviewed by the nurse navigator and revealed normal CBC except for slightly low hemoglobin of 110, electrolytes were normal with some elevation in LFTs and a CEA assay of 7.8. Pathology showed a moderately differentiated adenocarcinoma and CT abdomen/pelvis showed some bowel thickening in the cecum and an incidental finding of two hypodense lesions on the liver. An MRI of the abdomen and liver was then ordered by the nurse navigator and Lara was called and informed of findings and upcoming imaging.

Lara was then scheduled for consultation with a colorectal surgeon. She filled a self-reporting history and Edmonton Symptom Assessment Scale (ESAS) that showed she still has some anxiety (5/10), fatigue (5/10) and constipation (4/10), but no pain or nausea. The ESAS was reviewed by the nurse navigator and the surgeon. When needed the patients at the CAC are approached for smoking cessation.

Her history disclosed that she had hypertension and had been on medication for a few years, had type 2 diabetes mellitus, and had had an appendectomy in 2000. Otherwise she was healthy. Her family history showed that her father died at age 69 of CAD and her mother died age 72 of ovarian cancer. There was no family history of colorectal cancer. She was married and lived with her husband, had two children and five grandchildren. The family members were all very supportive.

After Lara was seen by the surgeon, the plan of care was reviewed, educational resources were provided to her and any questions were answered. Since the CT scan revealed lesions in the liver she was referred to medical oncology and hepatopancreatobiliary (HPB) surgeons.

She met with the HPB surgeon and the medical oncologist. A PICC line for chemotherapy was inserted. She receives four cycles of chemo (5FU), one cycle every two weeks. An MRI was repeated after the fourth cycle of chemo, which showed that the liver lesions appeared smaller and no new lesion were evident.

She followed up with the HPB surgeon and, since she had had a good response to chemo and the location of the lesion was operable, she was consented for a liver lobectomy to be done in combination with the colon resection.

Lara followed up with the colorectal surgeon at the CAC and was consented for right hemicolectomy. The ESAS was reassessed and educational resources on surgery were provided including the clinical pathway. The patient’s and family’s questions and concerns about surgery and length of hospitalization were answered and Lara and family were booked for a 45-minute educational group session.

The surgery went well and Lara had an uncomplicated recovery. She was discharged home post-op day five. After being home for three days she called the nurse navigator at the CAC because she was concerned about incisional drainage. A telephone assessment was done: the drainage was minimal and serous and the patient denied fever, redness or induration. She was told if she had any other concerns she could see her family physician.

She followed up with the colorectal surgeon at the CAC four weeks after surgery. The incision was assessed and appeared clean and intact. Her bowel habit was back to normal, so was her diet and general wellbeing. Patient and family questions were answered regarding future plans of care; in regards to adjuvant chemotherapy and colorectal follow-up guidelines. The nurse navigator ensured Lara had a follow-up appointment with HPB and the medical oncologist.

The surgical oncology nurse navigator at the CAC works closely with all members of the multidisciplinary team to ensure expeditious, coordinated and holistic approach to colorectal cancer patients and their families.

REFERENCES