The development and audit of a nurse-led urology/oncology clinic

People with cancer in the UK should have access to a full spectrum of services. The role of the clinical nurse specialist is an important part of this development. In the specialty of urology/oncology, this role is still a relatively new development although the incidence of urological malignancy readily compares with other site-specific cancers.

Men’s health is now receiving increased publicity (Courtenay, 2000; Kirby et al, 1999) and the incidence of prostate cancer is predicted to keep rising (Hugosson et al, 2000; Labrie, 2000). It would therefore be prudent to assess the specialist nurse’s role in managing this group.

This paper describes the reasons for developing a nurse-led service for patients with urology malignancy and the audit of its effectiveness. The service provides care from diagnosis to treatment planning and intervention, and ultimately to patient follow-up.

The specialist nurse uses locally developed protocols and guidelines to inform patients of their diagnosis. The nurse then coordinates further investigations, results, and appointments. As a result, the patient’s consultation with the urology/oncology medical staff is more productive and meaningful for both patient and clinician.

Developing the new service Before April 1999, patients who had undergone a transrectal ultrasound (TRUS), and prostatic biopsy and transurethral resection of bladder tumour (TURBT), were routinely given a one-month follow-up appointment for their histology results (Fig 1). Following TURBT, many patients would also have an initial check cystoscopy, usually three months after surgery. Patients with bladder cancer always have a check cystoscopy unless their disease is more advanced, in which case more aggressive treatment is required.

All patients attended a busy general urology clinic with two doctors and about 45 patients per session. This allowed only about eight minutes per consultation. The patients were told about their diagnosis and also about possible treatment, side-effects, investigations, follow-up, and even prognosis. Understandably, due to the nature and volume of the information received, the patient often had an inadequate opportunity to fully absorb and then discuss the implications of the diagnosis.

Investigations to stage their cancer were usually ordered at this appointment and medical staff were unable to provide a definitive treatment plan. The patient had to wait for investigations to be carried out and had another clinic review to receive results and begin treatment.

It could take three months from diagnosis until a definitive treatment plan was started, which resulted in an increase in patient anxiety and uncertainty.

Service redesign Two weeks after the surgery, patients are now given an appointment to attend a nurse-led histology clinic to see the specialist nurse and receive and discuss histology results. Two weeks is the earliest possible time for the results to be processed and available from the pathology laboratory.

The specialist nurse and medical staff discuss the histology results before the clinic appointment and complete a pro forma. In accordance with jointly constructed protocols, medical staff document further investigations and a provisional or definite treatment plan. The patient then attends the nurse-led histology clinic and is allocated a 30-minute consultation.

All of the nurse-led clinics take place alongside a consultant clinic so advice can be sought when needed. The specialist nurse discusses the diagnosis with the patient and investigations are explained and ordered.

Provisional treatment options are also discussed. The patient leaves this visit with an appointment two weeks later for the consultant clinic, irrespective of whether his or her histology is malignant or benign.

If the patient had a diagnosis of cancer, written information was also given, along with a contact number for the specialist nurse. After the consultation, the nurse sends a letter to the GP and a copy to the consultant.

When patients attend the consultant clinic they are already aware of their diagnosis. Results of the staging investigations are also available at this clinic. This allows for a more informed consultation between both parties.

The consultant is able to explain and initiate a definitive treatment plan about one month following biopsy/surgery, and the patient is able to have a more meaningful discussion about all aspects of the diagnosis of their malignancy.

The nurse reviews the patient immediately after the appointment with the consultant. This is to facilitate coordination of treatment or further investigations as well as to provide more information and clarification about the diagnosis and treatment plan.

If a referral to the oncology specialist is required, this is arranged within two weeks. The nurse meets with the patient immediately following the oncology review.

Auditing the service A questionnaire was developed to assess patients’ satisfaction with the service and their response to receiving their diagnosis from a specialist nurse. The patients were asked to assess the information they received about their diagnosis, proposed treatment and follow-up care.

A data collection tool was devised to assess the time-scale of appointments and the adherence to the developed protocols and guidelines.

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REFERENCES
The questionnaire was given to 106 patients after their appointment with the medical team. Of these, 82 (77 per cent) had undergone TRUS and prostatic biopsies and 24 (23 per cent) had had a TURBT. The purpose of the audit was explained to the patients. Questionnaires were completed anonymously and posted back in a pre-paid envelope to the clinical effectiveness facilitator who co-ordinated the audit.

Results The audit found that:
- 16 per cent of patients were not informed that they were attending a nurse-led clinic;
- 79 patients (75 per cent) were reviewed within 30 minutes of their appointment time;
- 100 per cent of patients identified that they were given an appropriate opportunity to ask questions;
- 88 per cent felt questions were always answered in a way they could understand and nine per cent said ‘nearly always’. The other three per cent did not comment;
- 51 patients (48 per cent) were provided with written information. Of the remaining 55, only 18 (33 per cent) felt this would have been helpful. 36 (65 per cent) felt it would not be of any benefit. One patient did not respond;
- 105 patients (99 per cent) were clear about what was going to happen next regarding investigations, treatment, referral or follow-up;
- 80 (75 per cent) received a telephone contact number for the specialist nurse. All patients receiving a diagnosis of cancer were given a contact number before leaving the clinic;
- Most of the respondents felt the quality of consultation when receiving their diagnosis was very good;
- Overall, when asked how satisfied they were with attending the nurse-led histology clinic, 96 patients (91 per cent) were very satisfied, nine (eight per cent) were satisfied and only one (less than one per cent) expressed any dissatisfaction (Fig 2).

Waiting times for clinics The two-week target time from biopsy/surgery to attending the nurse-led clinic was achieved with 84 patients (79 per cent), with 22 (21 per cent) waiting between 3–5 weeks. Overall, referral times from the nurse-led histology clinic to the consultant clinic indicated that only 50 per cent of patients achieved the two-week target and 39 per cent waited more than six weeks.

Of the patients with benign prostatic biopsies, 56 per cent were reviewed six weeks or more after diagnosis. Following TRUS and biopsies, 30 per cent of patients had an overall referral time from biopsy to consultant clinic of more than six weeks.

For patients with a diagnosis of bladder carcinoma, 22 per cent were reviewed after two weeks usually with full staging investigations completed. The remainder (78 per cent) simply required review at their first check cystoscopy, usually three months following diagnosis.

The medical team reviewed all patients diagnosed with prostate cancer and 84 (79 per cent) were seen within two weeks of receiving diagnosis. By three weeks virtually all (97 per cent) had been reviewed with full staging investigations completed. Many of those who required hormonal therapy had already begun treatment.

The New Process for Patients
- Appointment made for nurse-led histology clinic
- Histology meeting
- Patient attends nurse-led histology clinic

About one month for definitive treatment plan and more qualitative approach.

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Overall satisfaction
- 91% very satisfied
- 8% satisfied
- 1% unsatisfied

FIG 1. THE SERVICE THEN AND NOW

FIG 2. AUDIT OF THE NURSE-LED CLINIC

REFERENCES
Discussion  An important part of the urology/oncology nurse role is to provide easy access and prompt availability to all patients diagnosed with urological malignancy. The nurse can provide support, advice, and information that can promote a more holistic approach to care (Raleigh, 1992; Perakyla, 1991; Herth, 1990).

Less than half of the patients received written information and this is now being addressed. However, patients’ information needs are very individual (Sardell and Trierweiler, 1993).

Health care professionals frequently provide patients with written information to enhance their knowledge and understanding. However, some patients find that too much information may be undesirable and this can lead to increased anxiety and confusion. Information should be delivered at a controlled, staged pace that is comfortable and beneficial to each patient (Buckman, 1992).

The audit found that 21 per cent of patients waited 3–5 weeks to receive results. This was attributed in most cases to the specialist nurse or the patient being on holiday. In some cases, the delay was caused by incidental prostate cancer being diagnosed following routine transurethral resection of prostate (TURP), and the clinic referral was not automatically generated.

The overall referral times from diagnosis to medical review did not achieve the intended result in many cases. However, during the audit and as the service developed, patients with a negative TRUS and biopsy who were asymptomatic, and those diagnosed with superficial bladder carcinoma were not automatically given an appointment two weeks later for the consultant clinic. All of these patients were offered a consultant appointment to discuss their results but none of them felt that medical review was required.

The initial proposal stipulated that a consultant review would take place within four weeks. However, it became evident that it took longer to get the results of some staging investigations, which delayed some reviews.

The specialist nurse was unable to review all patients at the consultant clinics due to limited resources and some difficulties in coordination of the service.

At the consultant clinic, results of investigations may be given or further tests arranged. Often definitive treatment will be implemented or at least discussed and there is an opportunity for the nurse to provide further information and clarification. Patients requiring oncology assessment can have their appointment date and time coordinated at this visit instead of having to wait for it.

This is an area where the service has underachieved but it may have delivered the best it was able to with the resources available. With a catchment population of about 400,000 there are nearly 400 new diagnoses of urological malignancy every year. About 350 TRUS and biopsies of prostate were carried out in the past year. It is perhaps understandable that one specialist nurse will be unable to deliver some aspects of a developing service.

Only patients in the care of two of the three consultant urologists took part in the service. The third consultant preferred to wait for the results of the audit.

The oncologist in the team had many reservations about nurses informing patients of their cancer diagnosis. But the consultant urologist whose patients were not included and the consultant oncologist, along with a recently appointed fourth consultant urologist, are now supportive of the new development.

As a result, all patients now receive automatic referral to the nurse-led histology clinic following TURS, prostatic biopsy, and TURBT. Likewise, all patients diagnosed with incidental prostate cancer following TURP are also reviewed in this way.

Traditionally medical staff inform patients of their cancer diagnosis. This appears to be purely historical and it is not surprising that 60 per cent of patients with cancer expressed a desire to be told their diagnosis by a doctor (Meredith et al, 1996).

But as Faulkner (1996) suggests, the responsibility for breaking bad news should be with an individual who can deliver precise information in a suitable environment at a pace and level comfortable to the recipient.

Conclusion  The impetus to modernise health care delivery is outlined in The NHS Plan (Department of Health, 2000). This emphasises the need for a more patient-centred, qualitative approach to providing care. This audit shows how a change in practice can significantly improve the patient’s journey. For people with cancer, quality information, communication, continuity and overall coordination of care are all vital. As well as benefiting patients, this service development has resulted in a radical reform of the urology/oncology service.

The nurse-led histology clinic has had significant benefits for the medical team as well as the patient. The patients attending the consultant clinic are more informed, better prepared and have their staging investigations completed. This allows the consultant to have a more meaningful and productive time with patients to discuss management of their cancer.

We have shown effectively that nurse practitioners are able to deliver the diagnosis and discuss cancer management with patients. Moreover, nurses are able to provide more time removed from the pressures of a consultant clinic, so creating a better environment and promoting a more holistic approach.