Older adults with cancer are often over-treated or under-treated with cancer therapy, putting them at high risk for adverse events and negative outcomes. To enhance the cancer care older adults receive, the geriatric oncology demonstration project team at Princess Margaret Cancer Centre in Toronto, Canada, launched the new older adults with cancer clinic (OACC) in July 2015. The first year of our demonstration project aims to provide a comprehensive geriatric assessment (CGA) for vulnerable older adults with a genitourinary (GU) cancer, to decrease toxicity and increase tolerance to cancer therapy by (a) providing the treating oncologist with recommendations for individualised cancer treatment based on the CGA findings for patients without an established treatment plan, and (b) establishing an enhanced supportive care plan for high risk older adults with cancer for patients at any point in their cancer journey. Other project goals are (c) to evaluate the utilisation and performance of vulnerable elders survey (VES-13) frailty screening tool in identifying high-risk vulnerable older adults; (d) to conduct a needs assessment of the oncology nurses and physicians in the GU disease site, and (e) to build capacity in providing geriatric care within the GU disease site, by providing education and support.

Our interdisciplinary team consists of one geriatric oncologist, two part-time geriatric oncology advance practice nurses, and a part-time social worker. To meet our identified evaluation outcomes for the first year, Rana Jin and I shared the nursing responsibilities of case finding, triaging referrals, contacting appropriate patients, clinic bookings and organisation; telephone assessment (i.e. intake). We also conducted the CGA assessment in the clinic along with the geriatric oncologist, Dr Shabbir Alibhai.

Our day-to-day work as project leaders consists in gathering project data to analyse trends and identify risks to the success of the project, which enables our team to make adjustments to our approaches and process along the way, and to ensure project goals are met. In order to build capacity in caring for older adults with cancer in the GU cancer disease site, we design and deliver geriatric oncology educational programmes to meet the identified learning needs of the GU oncology nurses and provide ongoing clinical support.

The geriatric oncology nurse plays a pivotal role in optimising the health of vulnerable older adults with cancer. Geriatric oncology nurses can positively impact the cancer care plan for older adults by providing ongoing symptom management, medication titration, accessing community resources when needed, collaborating with patients’ oncology care teams, and coordinating care through close telephone assessment and monitoring. Providing close telephone follow-up increases accessibility to care for vulnerable older adults, who often have poor social support, decreased mobility, and transportation issues. Geriatric oncology nurses are attuned to the barriers older adults are faced with when attempting to navigate and access complex health systems on their own. These barriers to care are broken down through the assistance, support, and advocacy of the geriatric oncology nurse. By incorporating frailty screening and specialised geriatric assessment in our cancer centre, the geriatric oncology demonstration project is changing current structural barriers and allowing for greater access to specialised care for vulnerable older adults with cancer.

Allison Loucks and Rana Jin are nurses in Geriatric Oncology at Princess Margaret Cancer Centre in Toronto, Canada.
As a nurse, my clinical function is geriatric oncology care coordinator in the Cliniques Universitaires Saint-Luc in Brussels, Belgium. Geriatric oncology is a clinical activity aimed at optimising care of older patients with cancer. It is the result of an active collaboration between oncologists, geriatricians, general practitioners and all other professional healthcare workers involved in the assessment of the patient, and in the conduct of his or her treatment. Some older patients have a robust health status and can benefit from standard cancer treatment. But other older patients present geriatric problems such as functional decline, malnutrition, cognitive impairment, falls, pain, fatigue, which have to be detected in order to propose a tailored cancer treatment and a personalised geriatric care plan. I am the reference person for this new approach of holistic care in older patients with cancer.

Most of the time, I meet the patients after a phone call or email from the oncologist or from the patient’s oncology care coordinator. I give an appointment or I join the patient directly after the visit to the cancer specialist. Firstly, I complete the G8 screening tool with the patient. If the result is normal (score > 14/17), the patient has no geriatric risk profile. If the result is less or equal to 14/17, I immediately proceed with a standardised geriatric assessment.

The geriatric assessment we use includes:

- Demographic and social support data
- Katz index, Lawton scale, a fall questionnaire – timed up and go, to assess functional status
- Visual analogue scales to assess pain and fatigue
- Questions about sleeping, vision, hearing, chronic wounds, recent hospitalisations, perception of health and quality of life
- Mini-mental state examination to assess cognitive status
- Geriatric depression scale to assess emotional status
- Mini-nutritional assessment to assess nutritional status
- Zarit-burden scale to assess the burden to the family member(s)
- Mini-melody index
- A questionnaire about polypharmacy.

It takes roughly 45 minutes to complete all the questionnaires with the patient (and his or her family). At the end of the interview, I give a short feedback to the patient about the detected geriatric problems and available resources. I inform the patient that we will establish a personalised care plan taking into account the detected frailties.

For each patient with a geriatric assessment, I prepare a report including:

- a summary of the medical history of the patient
- the proposed oncological treatment
- the results of the geriatric screening and assessment.

Based on this report, I present the case of each patient at our weekly multidisciplinary geriatric oncology meeting in the presence of our dedicated geriatrician, oncologist and pharmacist. The aim of this meeting is to write the personalised geriatric oncology care plan, which includes an opinion on the proposed oncological treatment and the recommended geriatric interventions. This document appears in the electronic medical file of the patient, and is sent to the oncologist and to the general practitioner.

Following on from the previous steps, I actively coordinate the implementation of the proposed patient’s care plan. I put the patient in contact with every necessary professional healthcare worker, e.g. physiotherapist, dietician, social worker, psychologist, etc. Finally, around three months after the multidisciplinary geriatric oncology consultation, I do a short follow-up assessment of the patient by phone or based on the medical file.

The data about our patients is collected in order to perform a scientific analysis.

Next to my clinical function, I also have research and teaching activities related to care for older patients with cancer.
“CARING IS THE ESSENCE OF NURSING”
Cindy Kelly

Being a geriatric oncology nurse practitioner has been a tremendous positive experience for me. Not only do I feel like I am growing professionally, but more importantly, I believe that this vocation is creating conditions to help me expand personally and spiritually. I have been offered this position to work on a research team led by Dr Arti Hurria, an internationally recognised leader in geriatric oncology, to improve the care of older oncologic patients at The City of Hope in Duarte, California, USA. Her research focuses on improving the care of older adults with cancer, and one of many studies she is actively researching is advancing screening and treatment for older patients with cancer. My involvement in this particular nurse-led study is to see if, by obtaining a thorough geriatric assessment prior to the initiation of chemotherapy, we can improve outcomes of the patients that receive the nurse-led and other interdisciplinary interventions while they receive their chemotherapy. The interventions range from offering the services of a geriatric oncology nurse practitioner to follow up to assess for toxicities, and to counsel on sleep, hygiene, fatigue, pain management and psychosocial and spiritual concerns. Additional interventions include physical and occupational therapy, supportive care consultation, social work, nutritional consultation, urinary consultation, advance directive planning and pharmacy review, and also to ensure greater collaboration with the patient’s primary care physician and their oncologist. Our goal is to decrease chemotherapy-related toxicities and hospital and emergency admissions, to improve quality of life while receiving chemotherapy and to obtain advance directives.

There is a constant flux of new information that I feel I need to know – not only in oncology, but in the optimal management of older patients. Working with older adults that also have a cancer diagnosis can be challenging. The process of ageing itself can present vulnerabilities, but then there is the burden of the cancer diagnosis that magnifies the vulnerabilities of this population. If there is one quality that I feel is essential to performing this work, it is sensitivity. This is needed to be empathic to the losses and changes that can be experienced during this time. I feel that the core role of being a geriatric oncology nurse practitioner is to care. Caring is the essence of nursing. To care requires the knowledge of what is the optimal course of action for what is happening at that moment. Knowledge comes in many dimensions, from understanding the current practice guidelines to being able to trust one’s intuition. It is paying exquisite attention to our patients’ speech, body and family, and my body and mind. It means to truly listen and to have the openness to be with uncomfortable situations. Knowledge means being certified as a gerontology nurse (I am actively working towards this), and it also means being aware and compassionate as I communicate with others.

One of the unexpected skills that I have had to learn in this position is the ability to be diplomatic with my interactions and responses with the physicians, the healthcare team (nurses, therapists, social workers, dietitians and schedulers) and the patients and their families. My role as a geriatric oncology nurse practitioner can be viewed as a consultant by the medical oncology team that we are working with. So in this role, my position is to make recommendations and provide guidance on best practice. It has helped me to become more pliant in the manner that I interact with others. I would like to think that it helps me to see what is the best course of action for the patient, the primary oncology team and our research team.

I am grateful for this role. For the majority of the time that I interact with patients, I feel more relaxed, because I am usually seeing patients while they receive chemotherapy. There is not the demand of having to get them out of the room so that the next patient can be seen. I work at the same medical facility as Betty Ferrell and Peggy Burhenn – this is good karma! I have learned that the power of an interdisciplinary team can make a difference in our patients’ lives. I also see that everyone that I meet is teaching and helping me. (It may not be in the manner that I expect, but there is a connection that is helping us both to understand the life we have been given.) This population has many needs and concerns and it is with this energy of kindness, compassion and expertise by each of the disciplines that makes this work. Nursing is one of the forces that honours the processes of living amidst the realities of sickness and ageing.