The Role of the Colorectal Nurse Specialist

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Colorectal cancer is the second most common cancer death in England and Wales, with nearly 35,000 new cases a year and a 5-year survival rate of less than 40% (Association of Coloproctology of Great Britain and Ireland (ACPGBI) 2001; Centre for Reviews and Dissemination (CRD), 2004). Almost 21,000 of these 35,000 colorectal cancers are in the colon and the remaining 14,000 are in the rectum. (Cancer research UK 2006). Although the incidence of colorectal cancer appears to be on the increase, improvements in surgical technique and adjuvant treatments have contributed to the decline in mortality rates that the UK now experiences (Dunlop, 2001).

The journey of the patient with colorectal cancer is often stressful and worrying, leading to feelings of fear and anxiety. This may be a result of undergoing various investigations before receiving a definitive diagnosis, waiting for treatment to commence or concern as to whether the treatment will be a success.

The Clinical Nurse Specialist (CNS) is usually present at the time a patient is informed of the diagnosis of colorectal cancer. He or she supports and communicates with the patient throughout their care, explaining the diagnosis and the treatment options. Patients newly diagnosed with cancer will require support to deal with the many fears and anxieties they experience. The support offered by the CNS is invaluable in helping patients feel in control, leading to a greater understanding and participation in treatment plans (Sawyer 2000).

In line with the 10 Key Roles set out by the Chief Nurse in the NHS plan (DOH 2000), nurses are developing and extending their role in practice. Research has demonstrated that patients value the opportunity to discuss their anxieties with an expert in their disease and strongly value continuity of care and the reassurance offered at the outpatient consultation (Cox and Wilson 2003, Taylor and Cardy 2003).

This is a complex patient pathway and it is the aim and objective of the nurse specialist to ensure the patient completes this pathway that accommodates their particular needs and requirements.

At Guys and St Thomas’s (GSTFT) NHS Foundation Trust the Colorectal Nurse Specialist provides a diverse service to colorectal cancer (CRC) patients seen and treated in the Trust. The key elements of this service include:

1. Co-ordination of the patient’s journey
In 2007 Guys & St Thomas’s performed approximately 187 resections for new colonic cancers. As such, an enormous amount of co-ordination is required to ensure these patients are treated in a timely fashion and they fulfil the treatment goals set out in the cancer collaborative guidelines. Key roles of the CNS in this process include:

- Using clinical judgement to ensure a patient is re-discussed if further discussion is warranted.
- Management of a sizeable patient caseload.

Within the multi-disciplinary team the CNS is a valuable resource in colorectal services, enhancing the quality of care provided. With adequate training and development of appropriate protocols, independent nurse-led clinics could help to significantly reduce waiting times for newly referred patients and follow-up patients (Lewis M et al 2006).

2. Advice and Support
Although hard to quantify, the colorectal CNS spends a large part of their time providing support to patients and their families. Support includes giving patients and relatives time to express their worries and fears. This can happen at any time during the patient’s cancer journey – from diagnosis to end of life care. It requires clinical judgement to know when to refer on to other disciplines such as The Palliative Care Team, Counselling and Social Services.

Patients’ feedback suggests that they would find it extremely difficult to cope with a cancer diagnosis without the support of the CNS to guide them through what is invariably an extremely difficult time.

3. Information giving
All new referrals are seen in the outpatient clinic by their Consultant surgeon and CNS. This is an opportunity for the patient and their relatives to ask questions of the team and for the team to inform the patient of future plans and treatments. In addition the CNS visits in-patients on a regular basis. The purpose of these visits is:

- To provide support and encouragement to patients
- To liaise with ward staff re histopathology results and MDT plans
- To provide specialist information re colorectal cancer and evidence-based teaching
- To provide written information for patients, relatives and staff as required
- To act as a role model, resource and senior nurse when required

4. Teaching
A fundamental element of the CNS’s responsibility is teaching other professionals. This role is achieved by:

- Informal teaching on the ward to staff and patients
- Teaching and supporting new members of staff on induction programmes
- Teaching medical students on an informal basis
- Teaching other members of the multidisciplinary health care team

It is important as Clinical Nurse Specialists (CNSs) that we provide good, evidence-based, quality care to our patients. In order for us to do this effectively and to fulfil our teaching obligations as above it is vital that we have access to on-going education, both generally and also within our own specialist sphere of nursing.
5. Research and audit
It is essential that the CNS regularly audits her work. For example, in the summer of 2007, I performed a survey by means of a questionnaire to assess the service of the colorectal team. The patient satisfaction survey revealed that:

- 95% of patients were given CNS contact details (the rest were unsure)
- 100% of these patients had had contact with their CNS
- 100% of patients found this contact helpful
- 62% of patients contacted the CNS directly to discuss worries and concerns
- 100% of these patients found this helpful

6. Nurse-Led Clinic
Murray (1997) and Shaw (2000) state that patients view nurses as more empathetic to their needs, have more time to listen to them and perceive them to be better at imparting information and communicating than doctors.

The follow-up of post-operative cancer patients has until recently traditionally been undertaken by the doctor in the out-patient clinic setting. An increasing number of colorectal nurse specialists are now running follow-up clinics based upon a patient-centred supportive model Taylor K, Cardy C (2003), although this continues to be a subject of debate. Follow-up is criticised as being costly with little evidence to support survival benefits, however one study concludes that the benefit of regular surveillance including blood tests, colonoscopies and radiological investigations does have a positive impact on survival rates (Jeffery GM et al 2002).

The Nurse-Led Clinic provides this continuity of care, symptom management, surveillance of disease and psychological support. Follow up protocols for investigations are followed to facilitate early detection of recurrent or metastatic disease.

Out-patient clinics form a large and enjoyable part of my role. Post-operative patients are seen initially four weeks post-operatively, then six monthly in the first year, then yearly for the next four years. During these consultations if necessary I will order investigations as outlined below.

7. Requesting investigations
The colorectal CNS is able to order investigations under the supervision and support of the lead clinician. These include:

- Staging CT of the chest, abdomen and pelvis
- Staging MRI
- Diagnostic colonoscopy, flexible sigmoidoscopy and barium enema
- Staging carcinoembryonic antigen (CEA) levels.

In conclusion
Colorectal Nurse Specialists are an example of patient-based expert practitioners (UKCC, 1994) who are ideally suited and located to develop and enhance nursing services in the area of colorectal disease. It holds great challenges and opportunities for the nurse wishing to expand their knowledge and skills. Swan E (2005) states that within the new proposed health care reforms, nurses are in a good position to respond and embrace their specialist roles.

References:
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7) Gastrointestinal Nursing 4,4 28-33
11) British Journal of Nursing, 6, 13,726-736
13) Scottish Executive, Edinburgh: 48-63