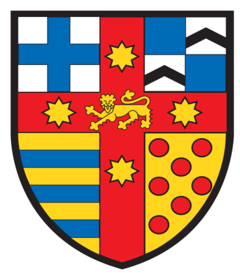

FOBT Clinic – Introduction a nurse-led, streamlined bowel cancer screening service

Health
Western Sydney
Local Health District

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Introduction

Colorectal cancer is the second highest cause of cancer related mortality in Australia. Faecal Occult Blood Tests (FOBT) together with colonoscopy and polypectomy reduces colorectal cancer incidence, morbidity, mortality and health care related costs[1]. The National Bowel Cancer Screening Program (NBCSP) was introduced in 2006. Since then, screening uptake in NSW has been less than optimal, with 38% of invited patients completing a colonoscopy[2].

Areas identified for improvement

- Long waiting time for colonoscopy appointments at Westmead Hospital
- Busy medical clinic
- Patients less likely to receive important education on diet and bowel preparation, resulting in higher rates of inadequate examinations

Aim of the Project

To implement a nurse-led, rapid access clinic to streamline bowel cancer screening at Westmead Hospital.

This project is aligned with National Standard 1, 5 and 6, as well as Western Sydney Local Health District Nursing and Midwifery strategic priorities: Healthy People; and Integrated Research, Education & Clinical Care.

Method

A project team consisting of nursing and medical staff, developed a new patient centred, complete care clinic model (Figure 1).

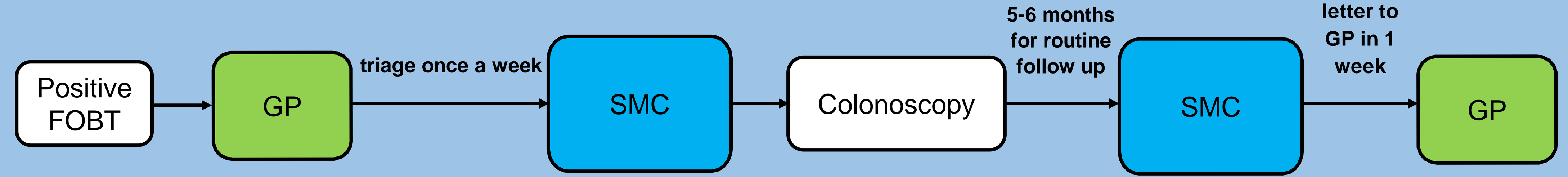
This model included:

- a streamlined referral system
- a new clinical pathway
- patient centred education resources
- standardized evidence-based GP feedback

Of the patients accessing this service, 44% required interpreters and 86% of these were Mandarin or Cantonese speaking. As a result of this, diet and bowel preparation education instructions were developed in simplified Chinese.

We also developed an FOBT website and electronic referral form, as well as a database to track key quality outcomes.

Previous standard medical clinic (SMC) pathway

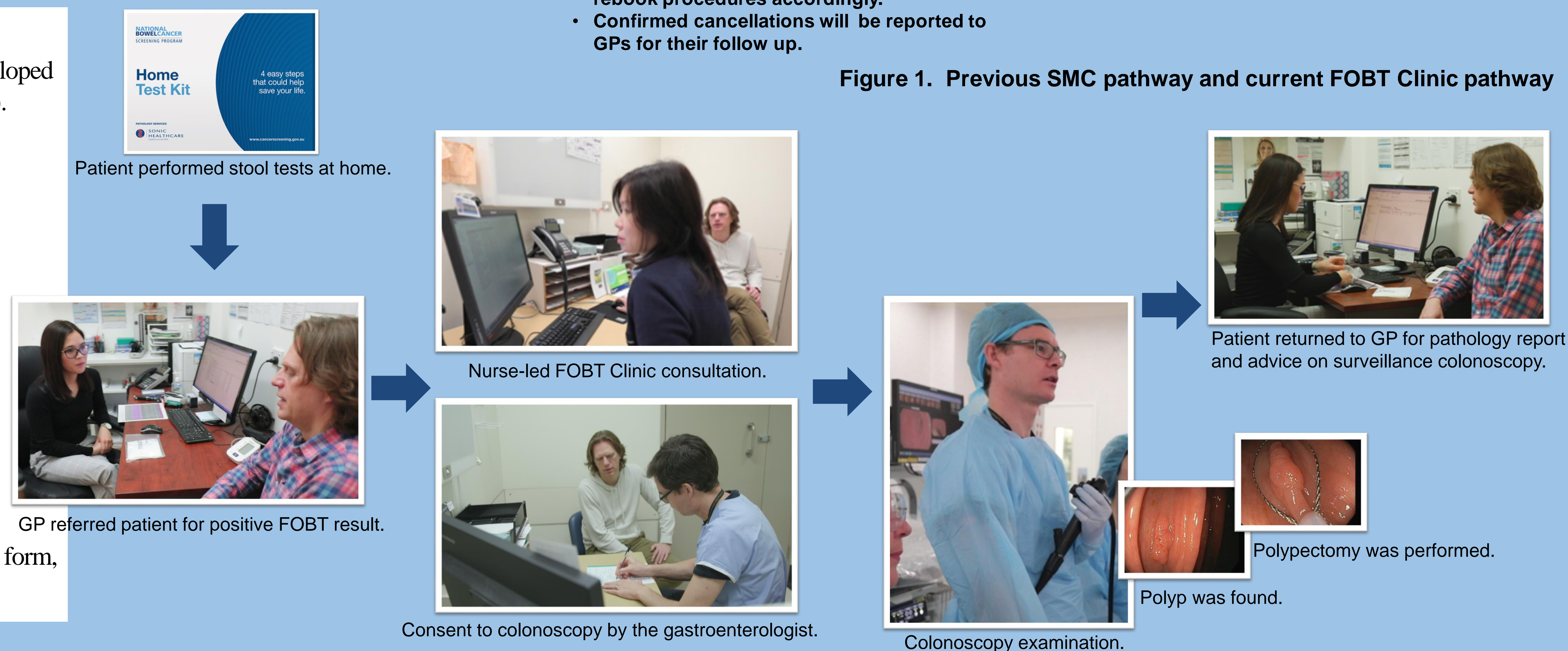


Current FOBT Clinic pathway

- Nurse-led clinic consultation.
- Education on diet and bowel preparation.
- Educational pamphlets.
- Phone contact and support for patients.
- Single point of contact for GPs.
- Contact other specialists for advice if necessary.
- Follow up on unexpected cancellation or no show cases, provide support and rebook procedures accordingly.
- Confirmed cancellations will be reported to GPs for their follow up.

- GPs receive procedure reports and pathology reports directly from the FOBT Clinic.
- Written discharge instructions and advice on surveillance colonoscopy as per NHMRC guidelines are provided.

Figure 1. Previous SMC pathway and current FOBT Clinic pathway



Patient performed stool tests at home.

GP referred patient for positive FOBT result.

Nurse-led FOBT Clinic consultation.

Consent to colonoscopy by the gastroenterologist.

Colonoscopy examination.

Polyp was found.

Polypectomy was performed.

Patient returned to GP for pathology report and advice on surveillance colonoscopy.

Results

To examine the impact of the new model, we compared retrospective data from the standard medical clinic (SMC) pathway (January 2013 – August 2015) to prospective data from the FOBT Clinic in its first 18 months (January 2016 – July 2017) (Figure 2-5). 98 patients were seen in the SMC period and 298 in the FOBT Clinic period.

This increased productivity showed that GPs and patients were finding the clinic accessible and that clinical need was being met.

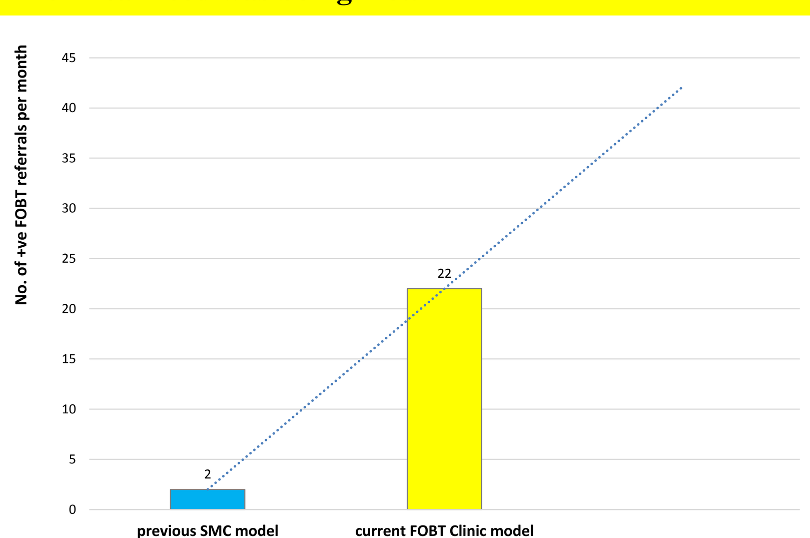


Figure 2. Increased in positive FOBT referrals

This efficiency gain was due to CNC feedback to GPs and significantly reduced the burden on the standard medical clinics.

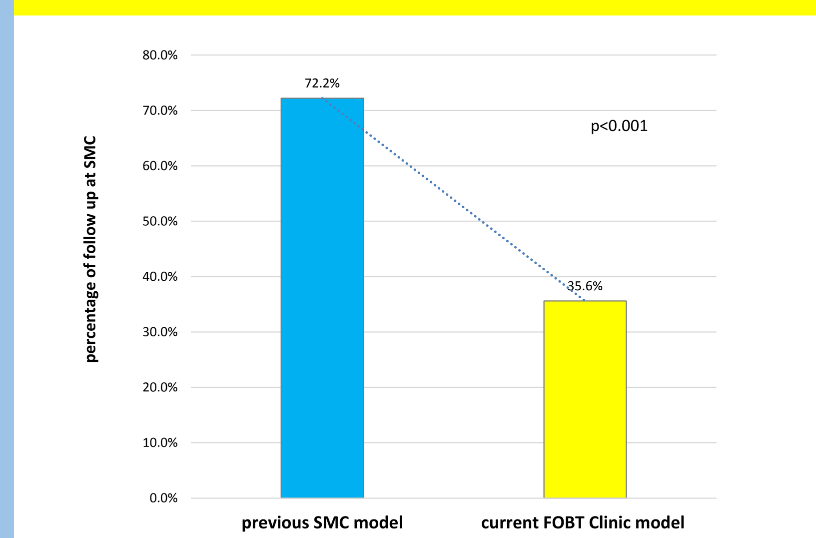


Figure 3. Significant reduction of follow ups at SMC

This indicated that nurse-led education and support strategies for consumers were effective.

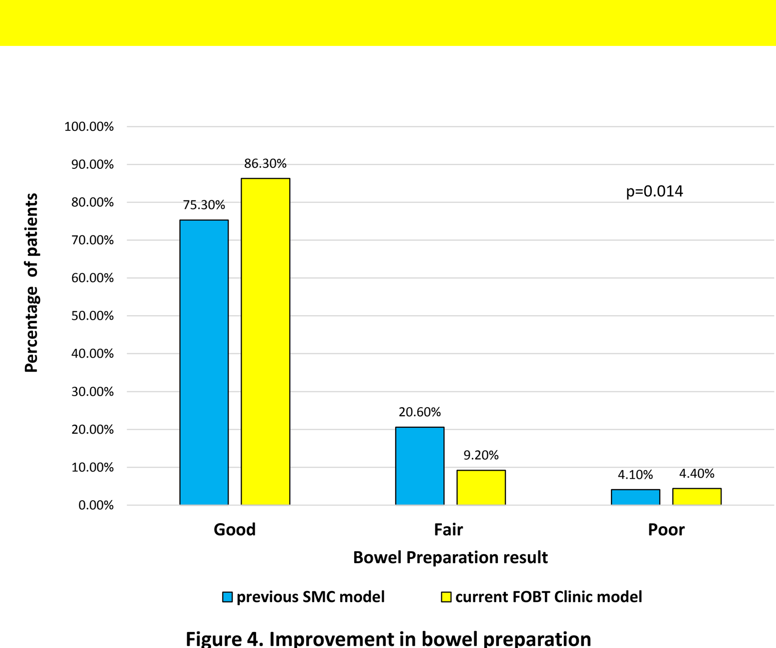


Figure 4. Improvement in bowel preparation

This feedback benefits patients, GPs and gastroenterology teams.

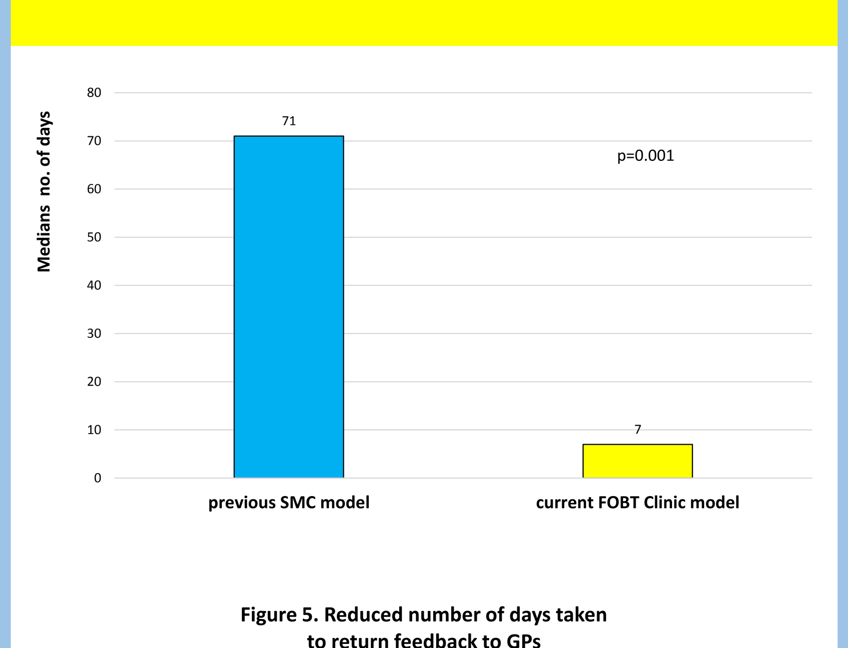


Figure 5. Reduced number of days taken to return feedback to GPs

Future Focus

To increase capacity in future, we have developed clinic templates, pathways and resources for telephone triage. Telephone triage systems have been trialled in other parts of Australia[3] but are difficult to implement in LHDs with high cultural and language diversity (CALD) populations. Only 15% of our WSLHD group were eligible for potential direct access colonoscopy by phone triage, with the remainder coming to the well-established FOBT Clinic.

Conclusion

Our novel and effective approach is suitable for the diversity and comorbidity present in WSLHD. We have demonstrated clear improvements in hospital efficiency, process and patient outcomes.

This model and the resources developed have been of considerable interest to other hospitals looking to develop similar clinics in their LHDs.

Reference

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