Clinical Oncology Society of Australia

EXEMPLAR OF EVIDENCE-BASED CARE IN PRACTICE

Navigating nutrition care transitions after treatment – a case study demonstrating use of The CanEAT pathway

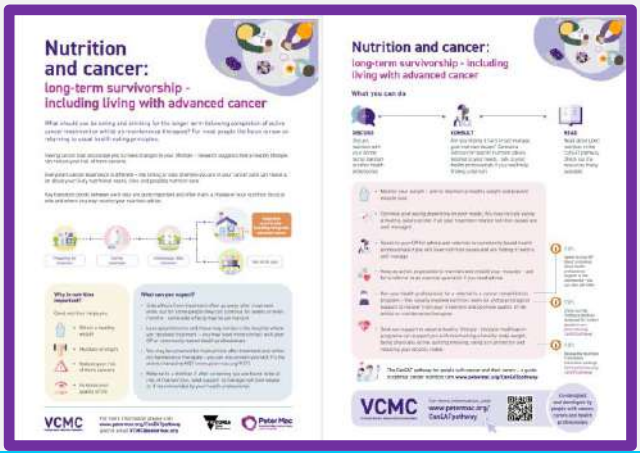
WHAT did the initiative involve?

A 58-year-old male with metastatic skin cancer (neck) completed a course of treatment including local surgical excision and post-operative radiotherapy six weeks ago. The patient has been under the care of the dietitian at the metropolitan cancer treatment centre from week 2 of radiotherapy secondary to a reduced appetite and unintentional weight loss (MST = 3). The patient was assessed as being malnourished (PG-SGA score 14, category B) on initial assessment and only marginally improved throughout/post treatment with nutrition counselling, food fortification and oral nutrition supplements prescribed by the dietitian.

The following resources found in The CanEAT pathway were provided in hard copy to the patient following treatment:

1. The CanEAT pathway postcard (including the main link to the CanEAT pathway)

2. Fact sheets regarding 'immediately after treatment' and 'long-term survivorship, including living with advanced cancer'



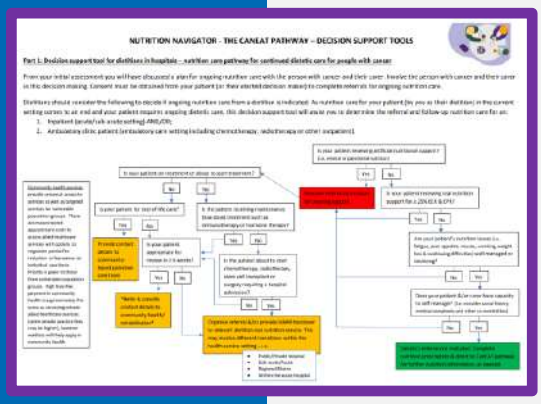
3. Fact sheet on 'How can I improve my appetite?'

The patient lives alone in the outer metropolitan suburbs with a past medical history of hypercholesterolaemia and poorly controlled type 2 diabetes. The treatment centre dietitian and the patient discussed and made plans for his ongoing nutrition care beyond the end of radiotherapy.

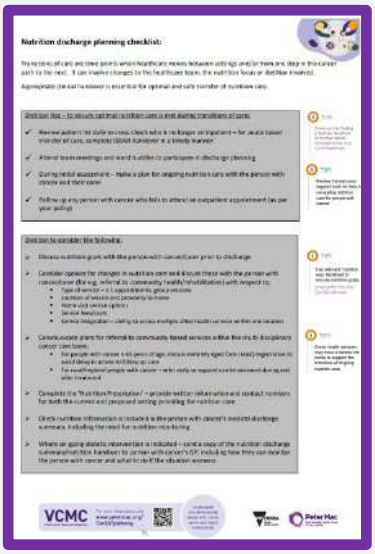
Three key resources found in The CanEAT pathway (health professional pages) were utilised to navigate and support the appropriate next steps:

1. Decision support tool – used to navigate different options for nutrition care and to help decide whether a dietitian was required to support appropriate nutrition care planning (patient and dietitian agreed it was)
2. Discharge planning checklist - completed by the treatment centre dietitian before/during the patient consult and ahead of transitioning to care under the community dietitian
3. Nutrition prescription – completed by the treatment centre dietitian and patient together before transitioning to care under the community dietitian

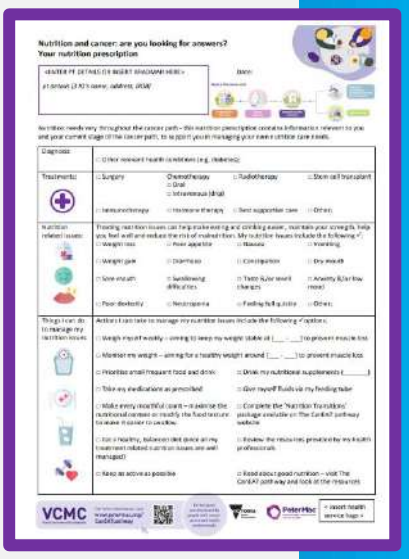
Decision support tool



Discharge planning checklist



Nutrition prescription



Together, the treatment centre dietitian and the patient decided early on that a community health dietitian close to home was the best way to support his ongoing nutrition challenges post cancer-treatment, in addition to optimal management of his diabetes and heart health in the long-term. The treatment centre dietitian made a referral including a detailed handover, links to appropriate CanEAT pathway resources and contact details for liaison if needed. The patient was able to take a copy of his completed 'nutrition prescription' with him to his first appointment with the community dietitian. The patient's nutrition care was transitioned from the treatment centre dietitian to the community dietitian, who was able to best support the patient close to home and with a holistic treatment plan incorporating new long-term health goals.

WHO was involved in the initiative?	Treatment centre dietitian Community dietitian
WHERE did the initiative occur?	Metropolitan community health centre Metropolitan cancer treatment centre
WHO was the target of the initiative?	Adult patient (≥18 years) undergoing surgical and radiotherapy treatment for metastatic skin cancer
WHEN was the initiative undertaken?	During and after treatment
HOW was the initiative undertaken?	Utilising a shared care arrangement Using multiple modalities (e.g., in-person, telehealth, telephone, email)
OUTCOMES	Care closer to home that considers local context Professional networks established between community and treatment centre Improved continuity of care Improved service sustainability Utilisation of strengths and expertise from both community and treatment centre dietitians
REFERENCE	https://www.petermac.org/caneatpathway