

PROTOCOL FOR: Nursing Responsibilities of the Radiation Oncology Nurse
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**PURPOSE:** To delineate the general role responsibilities for the nurse caring for patients in the Department of Radiation Oncology

**SUPPORTIVE**

**DATA:** The Radiation Oncology Nurse has a primary responsibility for providing comprehensive, skilled, and compassionate care to all patients in the Department of Radiation Oncology. In addition to managing the patients' physical, emotional, social, and educational needs, the nurse must work collaboratively with other care providers within the department and Health System, the community, and the patient's family/significant other(s). The environment of care must be managed and maintained in order to insure that patients' medical, nursing, and safety needs are met and equipment and testing are functional, timely, and accurate.

- POLICY:**
1. The nurse in Radiation Oncology will wear his/her own film badge at all times while in the department and in addition, a ring badge during implant procedures.
  2. The Radiation Oncology Nurse will determine the daily schedule for the provision of nursing care using the following policies and protocols and communications with other care providers, both within and outside the department, to provide guidance for meeting patient care needs.
  3. All new patients commencing external beam radiation therapy treatment will receive a nursing assessment within the first three treatment days. (Exceptions: Patients receiving a single treatment to prevent Heterotopic Ossification and those receiving Stereotactic Radiation Therapy).
  4. All patients receiving more than three days of treatment will be evaluated and referred to appropriate UCHC or community resources, according to their needs.
  5. All patients receiving more than three days of radiation therapy will receive written educational materials and educational assessments and interventions, as per appropriate "Teaching Plan" for a particular treatment site. (Exceptions: Patients receiving a single treatment to prevent Heterotopic Ossification and those receiving Stereotactic Radiation Therapy).
  6. Patients who require laboratory studies will receive instruction regarding medication adjustments and general care and follow-up based on study results, if needed.
  7. All in- or out-patients receiving infusions of IV fluids, medications, hyperalimentation, blood products, and chemotherapy, tube feedings, and oxygen therapy will be monitored as needed.
  8. Patients needing a pelvic examination will receive assistance

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from the nurse as needed.

9. Patients needing assistance with transfers will receive assistance from the nurse as needed.
10. All patients completing more than 3 days of treatment will receive a completion nursing assessment on the final day or up to 2-3 days prior to completion day. (Exceptions: Patients receiving a single treatment to prevent Heterotopic Ossification and those receiving Stereotactic Radiation Therapy).
11. The Radiation Oncology Nurse will assist with the follow-up care and managing clinical problems for patients who have completed treatment, in collaboration with the Radiation Oncologist.
12. The crash cart will be stocked, available, current, have properly functioning oxygen and suction, and an adequate supply of oxygen at all times.

DESIRED PATIENT

- OUTCOMES:
1. Patient identifies access to the Radiation Oncology Nurse, i.e. when starting and completing treatment, needing questions answered, or when new symptoms or problems are experienced.
  2. On-treatment patient verbalizes understanding regarding their overall plan of care and specific self-care behaviors needed to manage their symptoms.
  3. Patient symptoms are monitored and managed to an acceptable level for the patient.
  4. Patient verbalizes knowledge acquisition as per appropriate teaching plan.

FILM BADGE:

1. Apply film badge upon arriving to department daily.
2. Wear film badge on outer clothing so that it faces outside and the clip sits inside the clothing item.
3. Wear ring badge provided by Radiation Safety Department, whenever caring for a patient receiving an implant.
4. If a film or ring badge (new or replacement) is needed, contact the Radiation Safety Office/Officer.
5. A report on exposure is documented and will be sent on a regular basis as per safety regulations.

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NURSING

- SCHEDULE:
1. Review daily treatment and physician schedule to identify patients' care needs, which will determine the nursing care requirements and help to plan/schedule the day. Focus on:
    - Patients starting treatment to a new site, for nursing assessment and teaching.
    - Patients completing treatment, for nursing assessment and teaching.
    - Patients receiving a GYN implant (see protocol as per page 1).
    - Patients who need site care or will receive or complete Stereotactic Radiation Therapy.
    - Patients who will receive treatment for prevention of heterotopic ossification.
    - Patients who may require dressing changes or skin/wound care, laboratory studies/follow-up, nursing re-assessments, an evaluation for response to nursing or medical interventions, and/or educational interventions.
    - Patients who will need GYN or fiberoptic exams.
  2. Review schedule with Radiation Oncologist and Radiation Therapists as needed, to assist in identifying patients' care needs and the nurse's schedule.
  3. The nurse will indicate a patient's status and nursing interventions needed on the schedule for the following day, next to the patient's name, for a covering nurse.

- CRASH CART:
1. Perform a daily crash cart inspection (see checklist on code cart).
  2. Document inspection, sign/initialize, and date crash cart checklist daily.
  3. Call Pharmacy several days prior to expiration date of cart, for replacement.
  4. Call Respiratory services for replacement oxygen tank if less than  $\frac{1}{2}$  full.
  5. Call Clinical Engineering for problems with suction apparatus.

- LABORATORY STUDIES:
1. Fill out Laboratory Requisition completely when MD has ordered a laboratory study. Give to patient/significant other or have delivered to laboratory for patient.
  2. Some specimens, such as a urine culture, may be obtained in the department.
  3. Follow-up/monitor laboratory results.

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4. Print, review and initial hard-copy of laboratory results, and forward to MD.
5. Communicate results with patient/significant other if medication changes or other follow-up or care must occur as a result of the laboratory finding, or patient/significant other request knowledge about results.
6. Report abnormal or unobtained laboratory results to MD.

CLINICAL  
ASSESSMENT AND

CARE: New Patient Assessments and Care:

1. Review patient's department medical record for MD Consultation Note (history, physical exam, and plan), Progress Notes, Treatment Plan, Diagram, and Prescription (includes MD orders), MD Order Sheet, Laboratory and Diagnostic Studies, and if any, old records from previous encounters with the department.
2. Ensure patient identity by comparing patient's face with photograph in chart when calling patient for assessment visit.
3. Obtain baseline height and weight.
4. Obtain a patient history, review of systems, confirm current medication and medication allergy. This review should include a pain assessment and skin assessment.
5. Perform selected relevant aspects of a physical examination. Include assessment of any surgical site, observable lesion, and skin that will be in the treatment field. Recommended by treatment site to also include the following exams, but not be limited to:
  - CNS: neurologic
  - Head and Neck: oral, pulmonary
  - Chest/Esophagus: cardiac, pulmonary
  - Breast/Chest Wall: pulmonary, and if patient's left breast, cardiac
  - Abdominal: gastrointestinal
  - Pelvic: gastrointestinal
6. Initiate appropriate teaching plan for patient's treatment.
7. Conduct nutrition screening on all patients and refer the following patients to the dietitian:
  - All patients receiving treatment to the head and neck, chest/esophageal, abdominal, and pelvic fields;
  - And, any other patient who meets nutritional screening criteria for referral.
8. Obtain MD orders, as needed (i.e. dressing changes, new

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medications, dietitian referral, etc).

9. Refer patients to appropriate support services within and outside of UCHC. If MD referral is needed, consult with MD prior to referring.
10. Document assessments in the Nursing Database (core and Rad/Onc) and care on appropriate forms.
11. Reinforce radiation treatment plan.

On-Treatment Nursing Care:

1. Initiate nursing care plan and revise as patient's status changes, with special attention to pain and skin status.
2. Monitor patients' response/side effects from treatment and effectiveness of nursing interventions and patients' self-care behaviors, once a week if possible, unless assessment determines need for more frequent monitoring. Prioritize assessing those patients at high risk for significant side effects, i.e.:
  - Patients treated for head and neck, lung, esophageal, pancreatic and some pelvic cancers
  - Unstable or debilitated patients
  - Patients who have recently received or are receiving chemotherapy concurrently
  - Patients having other confounding medical, emotional, or social problems
  - Patients who may be reaching the peak of their side effect spectrum (dependent on treatment site and overall dose to be given).
3. Monitor weekly weights on all patients receiving treatment and refer to dietitian as needed.
4. Provide dressing changes and other skin or wound care measures as determined in the ongoing plan of care.
5. Obtain MD orders, as needed (i.e. changes in dressing or wound care, new or changing doses of medications unless documented by MD in progress notes, etc).
6. Continue appropriate teaching plan for each patient.
7. Continue to coordinate patient care with other health care providers, as needed.
8. Follow care for stereotactic, heterotopic ossification, and GYN implant patients.

Treatment Completion:

1. Assess patients completing treatment for: response/side effects

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from treatment and effectiveness of nursing interventions and patient's self-care behaviors.

2. Continue appropriate teaching plan.
3. Refer patients to appropriate support services within and outside of UCHC. If MD referral is needed, consult with MD prior to referring.

Follow-Up for Patients who have Completed Treatment:

1. Provide patient care for those who have completed treatment, as identified in appropriate protocols, i.e. GYN Implant and Stereotactic patients.
2. In collaboration with Radiation Oncologist, assist with identification of problem(s) and plan of care for patients who come in for follow-up visits.
3. In collaboration with Radiation Oncologist, assist with identification of problem(s) and plan of care, and providing or planning nursing care as needed, when calls are received from or about patients expressing questions, concerns, or problems.

Report the following to the Radiation Oncologist:

1. Patient's/significant other's inability to understand, accept, or comply with the overall plan of care and/or self-care behaviors.
2. Discrepancies between information gathered from the patient, significant others, other health care providers, and the medical record, i.e. medications.
3. Patient's refusal of educational or nursing interventions.
4. New or progressive symptoms or side effects.
5. Lack of acceptable response to medical/nursing interventions or patient's self-care behaviors in managing symptoms or problems.

PREVENTION  
HETEROTOPIC  
OSSIFICATION:

1. Communicate patient's status and care needs with in-patient nurse (if appropriate) prior to patient's arrival in department, and with Radiation Oncologist. Ensure adequate pre-medication with systemic analgesics.
2. Ensure that patient has received "Information for Patients Receiving Radiation Therapy to Prevent Bone Overgrowth in the Joint" educational handout.
3. Assess patient's comfort level and need for comfort measures.
4. Provide nursing care, as needed, i.e. monitor vital signs, intravenous fluids, oxygen.

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5. Ensure that abductor pillow is placed between the patient's legs and is secured for patients who have had a total hip replacement (THR).
6. Assist with transfers as needed (particularly, with patients who have received a THR).
7. Obtain MD orders for and perform dressing changes as needed.

PHYSICIAN'S

- ORDERS:
1. Physician's Order Sheets are kept in the Progress Note Section of the department record and must be signed and dated by the Radiation Oncologist for the medical plan of care which includes but is not limited to orders for:
    - dressing and wound care,
    - medication changes (unless MD has documented medication change in progress notes),
    - stereotactic screw site care,
    - and, referrals to the dietitian and other services.
  2. For DOC out-patient population: If a medication or medical therapeutic is needed at any time while the patient is in the holding area of the DOC unit, it can only be administered by the in-patient staff if a Doctor's order is present and current on the unit as per hospital policy, i.e. every 72 hours, a new order for a narcotic analgesic must be signed and dated by the Radiation Oncologist and sent or faxed at x 1049, in order for the patient to receive medication.
  3. Physician's Orders for patient care can be mailed or Faxed to the responsible institution or community agency and should be discussed with a responsible care provider at that institution prior to initiation.

- PELVIC EXAMS:
1. If assistance is needed for patients receiving a pelvic exam: prepare exam room with Lubricant, 2 pair of unsterile gloves, and a speculum; if a PAP is being performed, prepare 2 slides and a double slide jacket, spray fixative, and cytobrush or swabs.
  2. Explain procedure to patient and assist patient as needed to change into hospital gown. Provide a sheet for patient's lower extremities.
  3. Prepare table with stirrups and assist the patient into the lithotomy position maintaining comfort, privacy and modesty. Assist patient as needed, with relaxation and breathing techniques.
  4. Donning unsterile gloves, assist physician with exam as needed. If cytology is being sent and the specimen has been smeared on slides, spray fixative on slides and let dry. Label specimen

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properly, place in sealed plastic bag, complete pathology/cytology requisition, and send to pathology.

5. Assist patient out of table position and give wet and dry towels for cleansing. Assist as needed to prepare to leave exam room.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 3/02

REVISION DATE: