**TREATMENT PLAN: MARGARET**

|  |  |
| --- | --- |
| **Name of patient**  Margaret | **Diagnosis**  Bowel Cancer: recto-sigmoid adenocarcinoma (Dukes C). |
| **Basic details**  **Date of diagnosis:** 10th August 2006  **Date of birth:** 01/04/1945  **Age:** 61  **Ethnicity:** White British Roman Catholic  **Gender:** Female | **Career and lifestyle goals**  Margaret has caring responsibilities for her grandson and has a strong sense of self linked to being busy and active. She wants to maintain these activities as much as possible during any treatment. |
| **Individual needs (including culture, religion, disability):**  **Age:** Although Margaret is 61, and in later adulthood, her mobility and independence level are very good. She does have hearing problems and wears two hearing aids, although this does not cause her any difficulties. She also has lost some sight and wears glasses which enable her to read most text. She does occasionally forget things and get confused but gets around this by making notes on important things in her diary.  **Religion:** Margaret is a practicing Roman Catholic and attends Mass every Sunday. She would want to continue with this during her treatment and recovery as far as possible.  Sacraments and blessings by a Catholic priest are highly important, especially before surgery or whenever there is a perceived risk of death. The sacramental requests most often made by patients are for "Sacrament of the Sick" (what some Catholics may think of as "Last Rites").  Margaret and her husband paid into their teacher pensions and are financially secure in their retirement.  Margaret does not suffer from any other disorders which might impact on her treatment.  She does not have any other individual needs which might affect her treatment. | |
| **Patient history – how was the patient diagnosed?**  Margaret presented at the GP in July 2006 with bleeding from the rectum. She had been treating herself for piles with over the counter medication, but her symptoms were not responding.  The GP referred Margaret for a colonoscopy at North Manchester General Hospital and a series of biopsies were taken. The results of these biopsies showed some abnormal tissue and Margaret was then referred for a barium enema and X-ray as well as a CT scan of the abdomen and pelvis on an urgent basis.  When the results came through, the Consultant Colorectal Surgeon diagnosed Margaret with recto-sigmoid adenocarcinoma (Dukes C). | |

**Care Needs Assessment**

|  |  |  |
| --- | --- | --- |
| **Care Need** | **How might this affect the patient’s everyday life?** | **Outcome they are hoping to achieve** |
| Stop bleeding and pain from rectum. | Anxiety about cause. Pain on passing stools and avoiding eating large meals. Difficulty carrying out everyday tasks. Avoiding social events with large meals. | Clear diagnosis and treatment plan. Symptoms resolved. |
| Remove cancerous tumour and affected localised lymph nodes. | Anxiety and stress surrounding treatment options and prognosis. Feeling vulnerable. | Remission from cancer. |
| Lack of knowledge about Bowel cancer and its treatment. | Does not understand what the treatment may involve. Feels powerless and loss of control. Adds to stress and anxiety. | Clarity on options and plan. |
| Emotional stress and anxiety surrounding diagnosis and prognosis. | Impact on sleeping and eating habits. This could lead to poor concentration. Loss of weight. Possible link to depression. Impact on husband and family. | Emotional support throughout treatment. Finding others who also have been through it. |
| Sense of self – linked to work or volunteering or “keeping busy”. | Unable to attend clubs and carry-out volunteering opportunities. Worries about loss of independence and lifestyle. Concerns about losing social contact and support and missing groups and activities – feeling lonely, getting low mood and depressed. | Acceptance of period of time in life where treatment takes priority and finding alternatives ways of maintaining social contact and support. E.g. support group and other sufferers. |
| Loss of independence and unable to help with caring responsibilities for grandson. | Time to look at and discuss alternatives with family. Financial impact on daughter. Worries about letting other people down, including daughter who works. | Arrange alternative that suits everyone for a few months. |
| **Which of these care needs are the most important to the patient? Why?**  Removal of all cancer from the body and peace of mind that it is all gone. Avoid spread to other body systems. Remission from cancer long term. This will resolve the other care needs such as getting back to normal activities, volunteering and charity work. Patient wants to go on living, enjoy her retirement and see her grandson grow up. | | |
| **Other information:**  No need for Social Care support as Margaret and her husband are financially secure and he will be her main carer. Margaret has family including daughter nearby who can also help and support Margaret. She also has a strong support network through friends and the local Church community. | | |
| **Margaret’s Overall Aim of the Treatment Plan:**  Removal of all cancer from the body and peace of mind that it is all gone. Avoid spread to other body systems. Remission from cancer long term. Full input and agreement from Margaret and rest of MDT for Care strategies. | | |

**Local Authority Care Needs Assessment**

|  |  |  |
| --- | --- | --- |
| **Eligibility outcomes checklist** | **Does Margaret have this need?** | **Details / evidence** |
| Managing and maintaining nutrition | Yes - during chemotherapy treatments | Margaret is very poorly after surgery and chemo treatments and is unable to make her own meals, however, she lives with her husband who will care for her during these times. |
| Maintaining personal hygiene | No | Even during treatments Margaret is able to maintain her personal hygiene |
| Managing toilet needs | No | Even during treatments Margaret is able to maintain her toilet needs |
| Being appropriately clothed | No | Even during treatments Margaret is appropriately clothed |
| Being able to make use of the adult's home safely | No | Even during treatments Margaret is able to make use of her home safely |
| Maintaining a habitable home environment | Yes with support from husband during treatments | In between treatments Teresa is able to maintain the home herself |
| Developing and maintaining family or other personal relationships | No | Teresa is able to maintain family and friends by telephone and in person during and in between treatments |
| Accessing and engaging in work, training, education or volunteering | Yes | Margaret has had to give up her volunteering until her surgery and Chemotherapy treatments have finished |
| Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services | Yes with support from husband during treatments | Margaret can get to the shops by foot or with a lift from her husband when she is unwell. |
| Carrying out any caring responsibilities the adult has for a child | N/a | Margaret does not have any caring responsibilities when she is undergoing treatments. |

Margaret does not meet the requirement of **two outcomes** due to her needs being restricted to period of chemotherapy treatment and the support of her husband and family during these short-term periods.

**Condition 3:**

Due to the temporary nature of her treatment and the support of her family and friends, Margaret’s needs do not impact on her in a significant way and she would not qualify for support from social services.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Margaret’s Care Needs** | | **How might this affect the patient’s everyday life?** | **Outcome the patient is hoping to achieve** | **Treatments and** **Care Strategies (1o, 2o, 3o)** | **Advantages** | **Disadvantages / Limitations** |
| **Emotional** | Emotional stress and anxiety surrounding diagnosis and prognosis. | Impact on sleeping and eating habits. This could lead to poor concentration. Loss of weight. Possible link to depression. Impact on husband and family. | Emotional support throughout treatment. Finding others who also have been through it. Cope very well. | GP and surgery (Primary care). Diagnosis and ongoing support and medication. | Local and easy to access. Has developed good relationship with patient over the years. Initial diagnosis and prompt referral. Can prescribe medication to ease side effects of treatment such as painkillers and anti-nausea drugs. Can refer to other agencies such as Stoma care, Macmillan Cancer Support, Counselling, the Wig fitters and Social care support. This would alleviate some of the **emotional stress and anxiety surrounding diagnosis and prognosis.** | Cannot carry-out surgical procedures or chemotherapy treatments. Limited knowledge and expertise in cancer treatments. Limited range of medications they can prescribe. |
| Macmillan Cancer Support (Voluntary sector) | Macmillan offer information and advice to help patients make the best decision about treatment, and guidance about dealing with its effects.  Macmillan Helpline is available 7 days a week and website with Specialist Advisors. Macmillan Nurses are available to come to the home and discuss all aspects of treatment and support. | May feel awkward at first and need encouragement to access the services. |
| The Christie Hospital | Whole hospital is set-up to make the experience as positive as possible for cancer sufferers. There is a range of Complementary Therapies available including massage and colour therapy. Counsellors are also available for 121 and group sessions. | Travel and transport to The Christie. |
| **Social** | Sense of self – linked to work or volunteering or “keeping busy”. | Unable to attend clubs and carry-out volunteering opportunities. Worries about loss of independence and lifestyle. Concerns about losing social contact and support and missing groups and activities – feeling lonely, getting low mood and depressed. | Attend as many social activities as possible during treatment. Recover from Bowel Cancer as quickly as possible and get back to normal activities. | Macmillan Cancer Support (Voluntary) and The Christie (Tertiary) Support Groups. | Macmillan local support groups – survivors and sufferers meet to offer each other advice and support. Macmillan’s Online Community – patients can ask questions and get advice 24 hours a day. The Christie Hospital have support groups with regular social activities. | May not feel well enough to attend events. Travel and transport to The Christie. Barriers to computer access due to lack of IT skills. |
| Loss of hair during Chemotherapy treatment. | Could make Margaret feel self-conscious and avoid leaving the house and attend fewer social situations. | Feel as normal as possible during treatment and still get out and about. | Referral to Wig fitter by GP (Private sector). | Wig can be designed to mimic patients own hair as closely as possible before Chemotherapy treatment begins. Patient can slowly adjust to wearing wig for short periods of time. Will boost confidence and allow patient to attend social events with confidence. | May be expensive for patient. Time to adjust. |
| Loss of independence and unable to help with caring responsibilities for grandson. | Time to look at and discuss alternatives with family. Financial impact on daughter. Worries about letting other people down, including daughter who works. | Arrange alternative that suits everyone for a few months. | The Christie Hospital appointments and support groups (Tertiary care). | Opportunity to meet other sufferers and get social and emotional support. | Travel and transport. |
| **Intellectual** | Lack of knowledge about Bowel cancer and its treatment. | Does not understand what the treatment may involve. Feels powerless and loss of control. Adds to stress and anxiety. | Get clarity and reassurance on treatment options and plan. | Macmillan Cancer Support (Voluntary) | Macmillan offer information and advice to help patients understand their diagnosis, make the best decisions about treatment, and guidance about dealing with its effects. | Accessing through computer may be off putting for Margaret. |
| Colorectal Nurse Specialist (Secondary care) | The Colorectal Nurse Specialist would educate Margaret on the surgery and all aspects of the recovery. | Travel and transport to North Manchester general Hospital. |
| **Physical** | Resolve symptoms - stop bleeding and pain from rectum. | Pain on passing stools and avoiding eating large meals. Difficulty carrying out everyday tasks. Avoiding social events with large meals. Anxiety about cause. | Clear diagnosis and treatment plan. Symptoms resolved. | Consultant colorectal surgeon and Colorectal Nurse Specialist at North Manchester General Hospital (Secondary care). Surgery to remove cancerous tumour and affected localised lymph nodes (Anterior resection) and follow-up - | Specialist expertise, equipment and facilities. Very successful at removing cancerous tissue. Other departments on hand to deal with emergencies and other complications. Radiology and laboratory facilities are on site. Within 5 miles from Margaret’s home, convenient for visitors. | Recovery time from serious abdominal surgery, with risks and complications. It will involve a six to eight-week recovery time. Time away from other responsibilities. Expensive for the NHS/ society. Surgery to remove lymph nodes can lead to lymphedema.  Lymphedema is when lymph fluid builds up and causes swelling and pain. |
| Remove cancerous tumour and affected localised lymph nodes. | Anxiety and stress surrounding treatment options and prognosis. Feeling vulnerable. | Remission from cancer. |
| Chemotherapy nurse specialist at The Christie Hospital (Tertiary care). Insertion of Hickman line for intravenous chemotherapy (day case). | A central line can be used to give you treatments such as chemotherapy, blood transfusions, antibiotics, intravenous (IV) fluids and liquid food if you’re not able to eat.  It can also be used to take samples of your blood for testing. This means that you won't need to have needles put in every time you have treatment.  A central line can be left in for weeks or months. It will be put in by a specialist Chemotherapy nurse at the hospital. This is usually done under a local anaesthetic, but a general anaesthetic is sometimes used. | It’s possible for an infection to develop either inside the central line or around the exit site. It’s possible for a blood clot (thrombosis) to form in your vein at the end of the line. Air in the central line: it’s important not to let air get into the central line. It's important that the central line is not broken or cut. It's not very common to get a cut or split in the line. If this happens, it may need to be removed. |
| Consultant Medical Oncologist and Chemotherapy nurse. Six months of chemotherapy at Department of Medical Oncology at The Christie Hospital (Tertiary care) due to Lymph nodes effected. | Very effective at killing cancerous cells and enabling the body to make a full recovery from cancer. Evidence-based and well-established treatment. Lots of support surrounding patients who are undergoing chemotherapy. The Chemotherapy Nurse would educate Margaret on all aspects of the treatment. The Christie Hospital is a world leader specialist in cancer therapies and treatments. Can be tailored to the individual – the number of rounds and dose can be adjusted dependent upon the health of the patient and their response to the treatment. | Severe side effects following each treatment which last all week. A series of treatments needed over six months. More susceptible to infection and illness while undergoing Chemotherapy. Loss of hair and stomach upset. Fatigue. Long term damage to nerve endings is possible including numbness in the hands and feet, loss of taste and smell, heart and lung problems, memory and attention can also be affected. |
| Consultant Colorectal Consultant and Colorectal Nurse Specialist at North Manchester General Hospital (Secondary care). 5-yearly colonoscopies and bowel testing kits with follow up appointments. | Recurrence of cancer following treatment is most common in the first 2 to 3 years after surgery. Routine follow-up can ensure that any recurrence is identified early, polyps can be removed regularly. These investigations provide reassurance, and staff can offer counselling (advice screening for family members) and provide psychological support to the patient.  Bowel testing kits can be carried out at home and sent through the post. Also offers further reassurance and peace of mind for the patient. Margaret could get back to her normal activities and responsibilities as soon as possible and this would minimise theloss of independence and enable her to help with caring responsibilities for grandchildren. | Screening cannot detect all bowel cancers. Rarely, a bowel scope test or a **colonoscopy** can cause bleeding or a tear in the bowel. |
| **Review Date:** | | Margaret’s Treatment Plan will be reviewed if there are any changes to her condition, if there are any serious problems with her treatment or care, or if there are any changes to service provision locally.  It will also be reviewed annually, starting August 2007. | | | | |

**Reliability and validity of sources used to choose Treatment or Care Strategy**

|  |  |
| --- | --- |
| **Choose ONE Care strategy:** Surgery to remove cancerous tumour and affected localised lymph nodes (Anterior resection). | |
| **Definition of reliability**  Reliability is a measure of the methods used to generate information. The means the degree of trust you have in the source of information. If it was an experiment, whether you could repeat the experiment and obtain the same results. | **Definition of validity**  Validity is defined as a measure of the quality of the information and how it is used. This means whether the information is legitimate and true. In an experiment, whether what has been measured is accurate and valid. |
| **Source 1: Details for Bibliography** NICE Guidelines, Colorectal Cancer <https://www.nice.org.uk/guidance/ipg514/chapter/4-Efficacy> | |
| **Details of evidence to support choice**  A case series of 56 patients with low rectal cancer treated by transanal total mesorectal excision (TaTME) reported an overall survival rate of 96% (54/56) of patients at 5‑year follow‑up (calculated using the Kaplan–Meier estimator); 2 patients with synchronous liver metastases died of metastatic evolution, 1 at 24 months and the other at 37 months after the procedure. The study reported a disease‑free survival rate of 94% (53/56) at 5‑year follow‑up (Kaplan–Meier estimate); 2 patients developed metastases and 1 developed local recurrence. | |
| **Origin of the source:** NICE website | |
| **Author or organisation:** NICE guidelines are based on the best available evidence. Their recommendations are put together by experts, people using services, carers and the public. Guidelines are developed through this process:   * We review the evidence relevant to the guideline. This is developed by agreeing on review questions. * Review questions help define literature searches, inform the planning and process of the evidence review, and act as a guide for the development of the recommendations. * A literature search is carried out. This may result in stakeholders providing additional evidence. * A summary of the evidence (known as an evidence review) is prepared. * The impact that the guideline will have on costs is then considered. * The evidence is considered by a committee made-up of practitioners, professionals, care providers, commissioners, those who use services and family members or carers. | |
| **To what extent do you trust this source to give reliable and unbiased information? Why?**  I fully trust this source to published reliable and valid information.NICE is well respected, credible and trusted by the public, clinicians and other stakeholders, in part due to its impartiality and independence, a review of NICE has concluded. (<https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2015-07-21/HCWS170/>) | |
| **Source 2: Details for Bibliography** SIGN Guidelines: <https://www.sign.ac.uk/assets/sign126.pdf> | |
| **Details of evidence to support choice**  “Surgery remains the definitive treatment for apparently localised colorectal cancer. Both radiotherapy and chemotherapy can improve survival rates after potentially curative surgery.[7]” | |
| **Origin of the source:** [*Diagnosis and management of colorectal cancer*](http://www.sign.ac.uk/assets/sign126.pdf); Scottish Intercollegiate Guidelines Network - SIGN (December 2011) SIGN 126 • Diagnosis and management of colorectal cancer. | |
| **Author or organisation:** Scottish Intercollegiate Guidelines Network – the Scottish equivalent of NICE. | |
| **To what extent do you trust this source to give reliable and unbiased information? Why?**  I fully trust this source to published reliable and valid information. SIGN with a network of clinicians, other health and social care professionals, patient organisations and individuals to develop evidence-based guidelines. Their guidelines are based on a systematic review of the scientific literature and are aimed at aiding the translation of new knowledge into action. | |

**CARE PLAN REVIEW MARGARET**

|  |  |  |
| --- | --- | --- |
| **Name of patient:**  Margaret | | **Disorder:**  Bowel Cancer |
| **Date of Review:**  March 2014  **Age:**  75  **Gender:**  Female  **Ethnicity:**  White British Roman Catholic | | |
| **What lifestyle changes have happened?**  Margaret has not experienced any significant lifestyle changes during this time, except for moving into a Nursing Care Home. She is still married and still regularly sees her children and grandchildren when they visit. | **How has this affected your disorder?**  Margaret’s lifestyle has not had a major influence on her disorder. | **Possible changes to care strategies**  None |
| **How have your symptoms progressed?**  Margaret had the tumour removed and the operation went very well. She underwent 6 months of Chemotherapy and this was successful. She was declared 1 year cancer free in 2008, but unfortunately her symptoms returned in 2012. This time the treatment was not as successful as the cancer had spread to the liver. She was declared terminal late 2013. | **How has this affected you?**  Margaret was cared for at home by her family and friends but her husband has struggled to cope due to his own health issues. He was diagnosed with dementia two years ago. Margaret has been very stressed about the impact on her daughter who has two teenage sons and carries most of the burden for looking after them both. | **Possible changes to care strategies**  Margaret needs palliative care at the Residential care home. Palliative care aims to:   * Provide relief from pain and other distressing symptoms * Help Margaret stay as active as possible * Provide emotional and spiritual support * Help Margaret live a full life and treat dying as a natural process * Offer support to her family to help them cope * Support her spiritual wishes – Mass and Sacrament of the Sick when the time comes. |