THE ROLE OF A REGISTERED NURSE CARE COORDINATOR (RNCC) IN THE EVALUATION DAY UNIT (EDU) : A KEY FOR THE HOLISTIC MANAGEMENT OF CANCER PATIENTS

Christine Mendes[1], Vanessa Puglisi[1], Maya Abbas[1], Marina De Martin[1] , Henia Dadache[1],Lilia Mezyene[1], Céline Richard[1], Stéphanie Jean Baptiste[1] ,Alexis Imbert[1], Florian Scotte[1], Loula Papageorgiou[1]

[1]Patient Pathway Division, Gustave Roussy,Villejuif, France

INTRODUCTION

Care coordination is of crucial importance in the context of oncology, where patients may require a variety of treatments (chemotherapy, immunotherapy, targeted therapy, radiotherapy, surgery etc) and therefore, present a significant need for supportive care. The RNCC plays an essential role in the care of patients with cancer.
This study aims to highlight her/his specific responsibilities and skills as well as the importance of her/his role in care coordination and overall support of patients and their families in the context of the EDU

METHODS

New patients from 5 departments (ENT, pulmonology, endocrinology, neurology, digestive tumors), are asked to fill in a digital auto-questionnaire before their first consultation. This questionnaire aims to detect vulnerabilities and therefore, initiate appropriate supportive care at an early stage.
Patients either are invited to the EDU when two vulnerabilities are detected, or referred by their oncologist who detected various vulnerabilities during the first consultation.

A medical and RNCC assessement is carried out systematically for every patient. In addition, an assessement by two supportive care professionnals appointed according to the patient' prior identified needs, are also carried out during the three hours EDU (dietitian, addictology nurse, physiotherapist, social worker, psychologist) limiting the number to four.

During her/his consultation, new patient needs can emerge, not raised in the auto-questionnaire.

The different roles of RNCC are mainly :

- **evaluation : symptoms, autonomy, lifestyle** : this allows supportive care and treatment to be adapted to the patient's lifestyle and location
- **emotional and psychological support** : helping the patient and his family to cope with the disease and the stress generated and create a bond of trust, essential for better adherence to the treatments and supportive care that will be provided. The patient can confide and sometimes reveal information essential to good care (ex : addiction, belief, apprehension…)
- **education** : how to prevent toxicities, have an active role in the management of their own health
- **coordinate care across the city-hospital spectrum :** RNCC ensures effective communication between the various intra and extra-hospital health professionals and garantees continuity of care.

RESULTS

156 patients were seen in the EDU from 22th may 2023 to 4rd January.
164 of them were refered towards outpatient services (cf table 1) and 150 patients to hospital's supportive care team (cf table2)

Table 1 : distribution towards outpatient services

Towards / Department	Liberal nurse	Health Center, Cityhall services etc...	League against cancer	Care and equipment for home support	Supporting coordination system	Home hospitalization
ENT	18	12	6	12	7	2
pneumology	13	4	7	4	8	5
endocrinology	3	2	5	2	3	0
digestive	12	1	4	1	0	0
neurology	1	3	5	3	2	4
TOTAL N	47	37	27	22	20	11
TOTAL %	28,6	22,6	16 ,5	13 ,4	12,2	6 ,7

Table 2 : distribution towards hospital's supportive care team

Towards / Department	Psychologist	Social Service	Complementary practices	Addictologist	Physiotherapist	
ENT	18	12	11	10	5	
pneumology	15	16	4	9	2	
endocrinology	7	3	6	0	0	
digestive	7	5	4	1	1	
neurology	2	7	3	0	2	
TOTAL N	49	43	28	20	10	150
TOTAL %	32,7	28 ,7	18 ,7	13,3	6,6	100%

Since January, we have broaden our activity to post-allogeneic transplant ang gynecology patients, and soon, all new patients or patients with a new cancer diagnosis, will be able to benefit from this personalized supportive care pathway.

CONCLUSION

RNCC contributes to improving patients' quality of life and their overall experience of the oncology care pathway, as well as that of their loved ones. It makes it possible to create and maintain a link between home and the hospital, which is a fundamental element for optimizing the patient journey.

We could consider multi-level pathways dedicated to the follow-up of our patients (advanced practice nurse, pathway RNCC) and expand, further improve their follow-up via digital applications.

It's also important to develop primary supportive care, in order to limit the patient's visits to the hospital, which sometimes accounts as a significant source of fatigue, especially when the patient lives far away or after oncological treatment.