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Case Report Open Access

Skin Cancer Nurses - A Screening Role

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Abstract

Skin cancer nurses play a vital role in the management and education of their patients. Many nurses also assess skin lesions at follow up visits but have not progressed to a primary screening role. Having completed a structured training package a nurse practitioner successfully took this step. The safety of the transition was assessed by studying her assessment of 100 unselected patients seen in the skin cancer clinic. The assessment was compared to that of a consultant dermatologist. The main question asked for each patient was whether their lesion was definitely benign or whether there was an element of doubt. In every case the nurse's assessment accorded with that of the consultant. We believe this indicates an adequate level of safety to allow the nurse to see and discharge patients with lesions she deems to be benign.

Introduction

Nurses are increasingly taking a leadership role in refining and improving patients care pathways (National Cancer Action Team, 2010) and skin cancer nurses are extending their roles (Godsell, 2009). Advanced nursing has been found to correlate with high patient satisfaction (Wong and Chung 2006).

A conventional nursing diagnosis is defined as a clinical judgement focusing on an individual's response to actual or potential health (Nanda International, 2009), whereas a medical diagnosis focuses on the disease process. We planned for our nurse to use both approaches in her role. Following her training we tested whether her understanding and powers of discrimination would make it safe for her to see unselected patients and screen out those whose lesions were definitely benign.

Report

The nurse had 3 years prior dermatology experience. The training package is outlined in Table 1. She also completed an MSc module in clinical examination and case management of skin cancer and attended a nurse surgery course.

For this study she saw 100 patients in skin cancer clinics. Selection was by taking the next set of case notes for the clinic. After taking a history and examining the patient she documented her response to 3 questions. Does the lesion look definitely benign such that the patient could be discharged? – This was documented as 'do not refer to the consultant'. Secondly are there any features to suggest the lesion is possibly or definitely malignant? – documented as 'do refer for consultant opinion'. Thirdly the nurse documented her preferred diagnosis and treatment plan.

Type of activity	Number of occasions	Timescale
Observing skin cancer clinics	> 40 clinics	4 months
Taking histories and presenting cases in clinic	> 80 clinics	2 years
Assisting at operations	> 200	4 years
Practical procedures supervised (all finalised through DOPS) • Injecting local anaesthesia • Cryosurgery • Curettage and Cautery • Shave excision • Punch biopsy • Elliptical incision and excision biopsy	> 40 >30 >30 >30 >30 >30	9 -12 months 9 -12 months 9 -12 months 9 -12 months 9 -12 months 9 -12 months
Visiting skin cancer nurses in other centres	3 days	
Network site specific group meetings	2	
Attending MDT	25	2 years
Visiting radiotherapy, plastics and maxillofacial units	1 day each	
Cancer user group	2 meetings	
Cancer support centre	1 day	

Table 1: Summary of training as skin cancer nurse.

One of two consultants then saw every patient and without reference to the nurse's comments recorded their answers to the same 3 questions.

From the 100 cases there were 53 that the nurse and doctor agreed should be seen by the consultant. In 16 cases there was agreement that referral was not required. In 31 cases, the doctor forgot to document whether he felt referral was indicated. However in 30 of these the diagnosis and treatment plan specified by the nurse was identical to that of the doctor. In one case the nurse had decided to take a biopsy whereas the doctor thought it best to review in three months. Of these 31 cases the decision was not to refer in 12 of them. Therefore overall there were 28 cases out of 100 which did not need to be seen by a doctor. There was 100% concordance for the key question of whether it was safe for the nurse to discharge the patient without a doctor's opinion.

Discussion

Many dermatology clinics are struggling to keep up with referrals for suspected skin cancer. Skin cancer nurses are playing an increasingly active role and often examine patients looking for recurrence of disease and evidence of new disease in addition to their role with education and health promotion. They ask for a medical opinion if they see a suspicious lesion and are therefore acting as diagnosticians or screeners by being alert to unusual features in skin lesions. The jump from this

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role to acting as a primary screener for new patients is not great. When combining all her experience in theatre and outpatients it is estimated that she had been in a skin cancer diagnostic and therapeutic environment for about 400 hours. This compares well with general practitioners in training who may get as little as 30 hours to cover the whole of Dermatology. Despite this the intention was not to produce a great diagnostician but a safe screener.

We previously reported the training for one individual to develop a screening role in a skin cancer clinic (Goyal and Colver, 2007). In Australia, Katris et al conducted a double blind observation screening study comparing the performance of nurses to plastic surgeons in a skin cancer screening program. The role of the nurse was not to diagnose skin cancer, but to not miss lesions that required further specialist examination. From a total 256 screened individuals, plastic surgeons felt 77 (30%) individuals had suspicious lesions whereas nurses were concerned about 73 (95%) of these 77 cases.

This concise report documents a more recent and extended programme to train an individual in all aspects of skin cancer nursing and to include a screening role. With suitable training it is possible to develop a safe environment in which a nurse practitioner can see new patients with suspected skin cancer and only seek a medical opinion in selected cases. Patients with harmless lesions can be reassured and discharged; those with minor sun damage can be counselled. Those with malignancies may only need a short time with the consultant, the rest of the explanation and treatment plan being given by the nurse. This is a cost effective use of resources in an increasingly stretched environment. Currently there are three clinics per week which include target patients. Figures based on four months clinic activity show an income of £27920.

Learning Points

- Skin cancer nurses play a crucial role in out patients
- Extended roles must be backed by extensive, multi-stranded training
- A screening role is possible but must be shown to be safe
- The numerous benefits include patient satisfaction and financial savings.

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