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LESSON OF THE MONTH

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lesson of the month (2)

Delivery of safe and effective care out of hours: the impact of the shared clinical record on a patient's out-of-hours contact with specialist palliative care

Access to adequate clinical information is essential for out-of-hours palliative care teams and general practitioners, specific examples to illustrate and justify this need are surprisingly rare in the medical literature. Without access to the full clinical background the patient in this lesson may have been inappropriately admitted to a palliative care unit and delayed investigations would have misguided the admitting doctor's assessment, planned investigations and management.

Lesson

At 20.00 on a Saturday evening the on-call palliative medicine registrar received a telephone call from a GP requesting admission for a patient to a palliative care inpatient unit. The GP was not the patient's usual physician and therefore only had limited background clinical information available. He reported that the patient was a 52-year-old woman known to have breast cancer who was being managed 'palliatively'. He had no further information about the extent of her disease. The patient had, however, informed him that she recently had undergone chemotherapy and was known to the local oncology centre.

The current problem was nausea and vomiting (which was not controlled on oral metoclopramide), poor appetite and dehydration. The family had telephoned the oncology centre advice line and were told that the nausea and vomiting were unlikely to be related to the recent chemotherapy.

The patient had expressed a preference to be admitted to hospital rather than managed at home and the family had asked the GP to arrange admission specifically to the palliative care unit. The GP was therefore requesting admission for symptom management and evaluation of any reversible cause of the vomiting, such as hypercalcaemia.

The registrar discussed the case with the on-call consultant and agreed to admit the patient. In the interim the consultant remotely accessed the shared electronic oncology and palliative care record to see if any further background information was accessible.

On accessing the Cancer Network Information Cymru (CANISC) record, key further clinical information became apparent. Firstly, the patient did not have advanced disease but had been staged as T2N1MO after a mastectomy and axillary

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node dissection (ER positive and HER-2 negative) and had therefore received postoperative radiotherapy and was receiving adjuvant chemotherapy and endocrine therapy with Arimidex®. Secondly, listed under past medical history was 'intracranial aneurysm' and, thirdly, a further recent entry on the electronic case note mentioned that the patient's husband had telephoned the cancer centre a few days previously because the patient had had an episode where she 'collapsed' on the toilet, had developed slurred speech, urinary incontinence and was behaving 'like she was drunk'. The oncology centre had advised the patient's husband to ask their GP to assess her.

In view of the fact that the patient had localised disease, was receiving active oncology treatment, had the past history of an intracranial aneurysm, and a recent episode of slurred speech and urinary incontinence, the consultant arranged admission to the local medical assessment unit for full assessment and investigation.

The first concern of the admitting medical team was the possibility of an intracerebral bleed. However, the patient's initial investigations revealed a serum sodium of 109 (135–145 mmol/l) which was subsequently found to be due to a syndrome of inappropriate antidiuretic hormone secretion (SIADH: serum osmolarity 248, urine osmolarity 324) and presumed to be secondary to either a recent increase in the patient's dose of venlafaxine, the metoclopramide the patient had recently started, recent chemotherapy or a combination of the above.

The serum sodium was slowly corrected with intravenous normal saline (aiming for a rise of 1.5 mmol per hour) with close attention to fluid balance and a total fluid restriction of 1.5 litres per 24 hours. The venlafaxine was withheld and the metoclopramide changed to domperidone. The patient made an excellent clinical recovery within 48 hours and was discharged home with a serum sodium of 132.

Discussion

The initial clinical scenario appeared appropriate to admit the patient to a palliative care unit, the second was more appropriate to admit her to a general medical unit. The medical monitoring, frequent serum sodium analysis and strict fluid balance may have been difficult to achieve in a palliative care unit at a weekend. Without access to the full clinical background this patient may have been inappropriately admitted to a palliative care unit and delayed investigations would have misguided the admitting doctor's assessment, planned investigations and management.

Access to adequate clinical information is essential for out-of-hours palliative care teams and GPs. While the need for access to patient clinical information to ensure safe and effective care is widely recognised (both in palliative care and in the wider medical context), specific examples to illustrate and justify this need are surprisingly rare in the medical literature.[1–5]

The CANISC patient electronic record is accessible remotely to palliative medicine consultants in Wales out of hours and in this case access proved pivotal to the management of this patient.[6] The palliative care component of the record is under further development (as part of the implementation of the 2008 Welsh Palliative Care Planning Group report[7,8]) to provide a comprehensive record of a patient's involvement with palliative care services and facilitate sharing information, particularly with out-of-hours palliative care teams. This is particularly relevant in conjunction with the development of seven-day working for palliative care services in Wales.

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