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Oral Anti-Cancer Therapy Monitoring

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A Nurse-Led Model for Safer, Smarter Cancer Care

Discussion

- Discuss the oral SACT nurse led model.
- What makes oral monitoring different.
- Monitoring , intervention early and support.
- Impact of a nurse led model.
- Scale and sustainability.
- Key messages.

Background

- Demand for cancer services is growing. Increased cancer diagnoses, improved survival rates, and an aging patient population in the region, increase the burden of care on oncology services

- Which may not be sustainable with an aging oncology workforce, limited graduating new practitioners and few fellowship positions

- The projected deficit in medical oncologists to support future oncology services this presents an opportunity for others such as Nurse Practitioners, oncology nurses, pharmacists, and nurse navigators to play larger roles in care management

The Problem/audit

Oral therapy shifts accountability into the home — without always shifting support with it

>100%

Increase in oral SACT patients
2020 → 2024 (53 to 107 pts)

43%

of patients had NO treatment plan documented

37% received NO follow-up call after starting therapy

Why oral therapy demands a designed model

Complex regimens — Multiple dosing windows, pill burdens, strict compliance — without nursing oversight at each administration.

Toxicity at home — Significant side effects (haematologic, GI, hypertension, fatigue) can occur between visits — invisible to the team.

Drug interactions — Oral SACTs interact with complementary medicines, antacids and common co-medications — often undisclosed.

Delayed escalation — Patients under-report or wait. A Grade 2 toxicity becomes Grade 3 before clinical contact is made.

Adherence failure — Both under- and over-adherence carry risk: suboptimal response vs severe toxicity and early cessation.

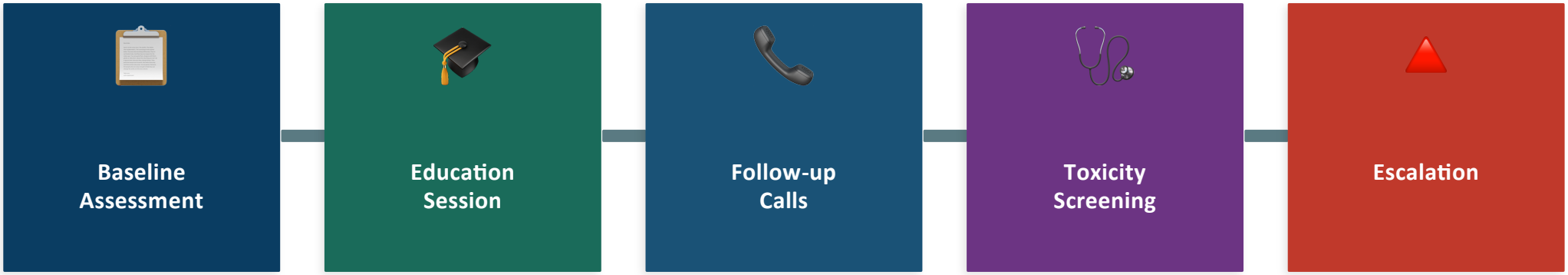
What Makes Oral Monitoring Different

Contrast with IV chemotherapy follow-up — the differences demand a new model

Aspect	IV / Traditional Chemotherapy	Oral SACT
Observation	Nurse sees administration, vitals, allergic reaction in real time	**Administration happens at home — nurse cannot observe**
Adherence	Adherence is 100% by default (nurse gives the drug)	**Adherence depends entirely on the patient — both under- and over-dosing occur**
Side effects	Acute reactions detected and managed at once in clinic	**Toxicity develops over days to weeks, mostly at home, often under-reported**
Timing	Fixed clinic appointment schedule drives clinical contact	**Contact must be nurse-initiated, proactive, scheduled by the team**
Education	Patient present at every dose; ongoing reinforcement opportunity	**Patient educates once then manages independently; one robust session is critical**
Escalation	Patient is already in clinic when unwell — no delay to intervention	**Patient must know what to look for, how to grade it, and when to call**
Drug interactions	Administered in a controlled clinical environment	**Patient takes with other home medications — interaction risk ongoing**

The Nurse-Led Model

A structured, multidisciplinary surveillance system — not passive patient self-management



Oral SACT Clinic
Dedicated nurse-led clinic model: Educate, template for documentation, script for supportive meds, book F/U apt, blood slips, send scripts etc.

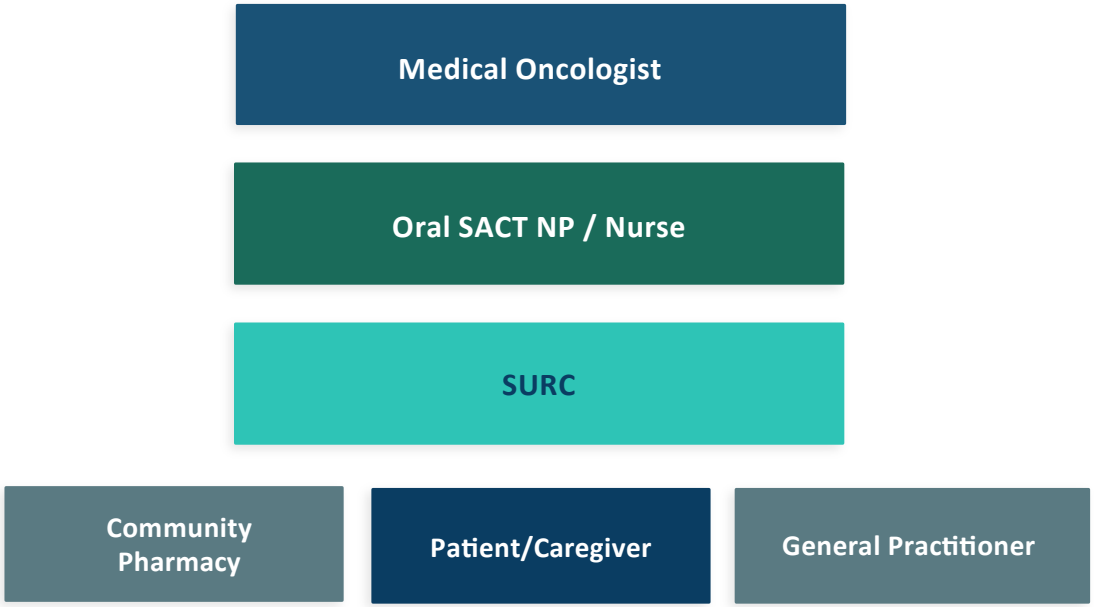
SURC (Symptom Urgent Review Clinic)
Cancer nurse hotline for symptom management. Unwell oral SACT patients escalated to NP. Combined follow-up for IV+oral regimens (CAPOX, Pem/lenva).

Pharmacist Integration
Clinical pharmacist: medication history, interaction checks (including CAM), first-cycle supply coordination, patient counselling on administration and safe handling.

GP & Community Pharmacy
Structured letters to GPs and community pharmacists. Email contact pathway. Continuity beyond the hospital boundary.

Escalation Pathways

Nursing surveillance connected to a complete escalation system



Highest-Risk Moments in Oral SACT

Where nurse surveillance makes the biggest difference to patient safety

Treatment Initiation

Highest incidence of early haematologic toxicity varies .Niraparib: thrombocytopenia any grade 67.1%, grade ≥3 39.7%, grade ≥4 in 26.9%. Weekly blood counts and BP essential. Nausea, fatigue and insomnia peak early — proactive anti-emetic planning at baseline. This varies.

Concurrent Events

Intercurrent illness, infection

Patients on oral SACT who develop intercurrent illness (e.g. dental , URTI, shingles) may need therapy held. Without nursing follow-up, these events go undetected.

Transition to Home

After each clinic visit

The gap between appointments is the highest-risk period. Patients at home self-manage. Without a structured call or check-in schedule, toxicity escalates unseen. The NP follow-up calls and the SURC hotline bridge this gap.

Highest-Risk Moments in Oral SACT

Where nurse surveillance makes the biggest difference to patient safety

Silent Non-Adherence

Ongoing risk

WHO defines adherence as extent behaviors coincide with medical advice. Under-adherence → drug resistance, suboptimal response. Over-adherence → increased severe toxicity, premature cessation. Both lead to earlier disease progression and decreased overall survival.

Dose Adjustments

After hold or reduction

Restarting after a dose hold requires close monitoring. Follow guidelines for dosing delays and dose reductions for individual oral therapies

Polypharmacy & Interactions

Ongoing risk

Oral SACTs interact with common medications and complementary therapies. Pharmacist-led medication history at initiation captures these, but ongoing vigilance is needed as community medications change.

MDTM presentation: treatment recommendation

↓

Medical Oncology OPD consult

Treatment Plan/script (1st dose dispensed PH Pharmacy)

↓

Referral to Oral SACT Clinic (NP/BCN)

↓

Education /Supportive care screening/Assessment for factors effecting adherence/Referrals

Pharmacist Medication reconciliation

↓

Engaging the GP

↓

Engaging community Pharmacist

↓

Telephone RV one week post C1

↓

Clinic RV/Phone RV 2 weeks post C1D1 (drug dependent)

↓

Ongoing clinic/phone review: treatment and/or patient specific. Alternating Med Oncologist

Disease	PWCode
Breast Adjuvant and Neoadjuvant	capecitabine (3503 v4)
Breast Metastatic	vinORELBine (oral) (1545 v5)
Glioma	Temozolomide chemoradiation (part 1) (365 v8)
Glioma	Temozolomide following chemoradiation (part 2) (366 v7)
Breast Metastatic	abemaciclib (3625 v2)
Multiple Myeloma	lenalidomide and dexAMETHASOne (547 v8)
Breast Adjuvant and Neoadjuvant	abemaciclib (4168 v2)
Pancreas - Advanced	Capecitabine chemoradiation (1757 v6)
Breast Metastatic	Palbociclib (3369 v7)
Breast Metastatic	Ribociclib (3379 v5)
Non-Small Cell Lung Cancer (Advanced/Metastatic)	Osimertinib (1996 v4)
Ovarian Advanced/Metastatic	Olaparib (3737 v6)
Renal Advanced/Metastatic	cABOZANtinib (2027 v5)
Melanoma Advanced/Metastatic	daBRAFEnib and tRAMEtinib (1619 v5)
Gastric and Oesophageal Advanced or Metastatic	trifluridine/tipiracil Days 1 to 5 and 8 to 12 every 28 days (3806 v2)
Rectal Locally Advanced	Capecitabine chemoradiation (84 v7)
Pancreas and biliary	Capecitabine adjuvant (3385 v6)
Prostate	Enzalutamide (4305 v2)
Prostate	Apalutamide (4040 v2)
Non-Small Cell Lung Cancer (Advanced/Metastatic)	Alectinib (3409 v5)
Gastrointestinal Stromal Cell Tumours	Imatinib (1222 v7)
Prostate	Darolutamide (4319 v1)
Prostate	Bicalutamide (1476 v4)
Renal Advanced/Metastatic	sUNITinib (322 v7)
Multiple Myeloma	Lenalidomide IFM 2009 (3. Maintenance) (3984 v3)
Pancreas and biliary	Pemigatinib (4387 v1)

Name of Drug: Temozolomide

Cancer: Glioblastoma

STUPP Part 1 Concurrent chemo/RT

Education pack contents

- EviQ printout
- Oral
  https://www.eviq.org.au/patients-and-carers/patient-information-sheets/how-you-have-anticancer-medicine-treatment/3086-oral-anti-cancer-medicine
- Safe handling
  3095-Chemotherapy safety at home | eviQ
- Nausea and Vomiting
  https://www.eviq.org.au/patients-and-carers/patient-information-sheets/managing-side-effects/3100-nausea-and-vomiting-during-cancer-treatment
- Constipation
  3515-PI-Constipation-during-cancer-treatment-v.2.pdf.aspx (eviq.org.au)
- Fatigue
- https://www.eviq.org.au/patients-and-carers/patient-information-sheets/managing-side-effects/3424-feeling-tired-fatigue-oncoduring-cancer-treatme
- SURC magnet and brochure
- Online resources
- Temozolomide Patient Pack

Recommended follow-up (if F2F vs phone F/U

- Blood test FBE weekly intervals for 6 weeks
- RV weekly with Radiation Oncologist
- RV Medical Oncologist 3 weeks

Key toxicities to monitor for

- Nausea and Vomiting
- Neutropenia
- Thrombocytopenia
- Constipation
- Skin Rash

Supports

Brain Tumour Alliance Australia | Front Page (btaa.org.au)

Brain Tumour / Cancer - Brain Foundation

Peninsula Health

Oral SACT Clinic
Frankston Hospital
2 Hastings Road
FRANKSTON VIC 3199

01 September 2025

Rye Family Clinic
Shop 5, 2217 Point Nepean Road
RYE VIC 3941

[redacted]054228

Dear Doctor,

Your [redacted] Perkov, was recently reviewed at the Peninsula Health Oncology Clinic and has commenced oral systemic anti-cancer therapy (SACT). The patient has received comprehensive medication education through the Oral SACT Clinic.

Type of Cancer: Locally advanced rectal cancer	
Oral Systemic Anticancer Agent (Oral SACT) regimen: Capecitabine 1500mg twice a day on days of radiotherapy	
Commencement date: 04/08/2025	**Cycle Length:** Every 7 days

The aim of the Oral SACT in this instance is:
To maximise the change of long term, disease-free survival

Information for health professionals and patients about particular drugs and aspects of cancer can be accessed via:

- **eviQ:** A free resource of evidence-based, consensus driven cancer treatment protocols and information for use at the point of care.
- **eviQ education:** provides tailored online learning modules to enhance your understanding of anticancer treatments. Relevant courses:
  - Oral anti-cancer drugs in community pharmacy
  - Pharmacy anti-cancer drug course
- **Cancer Council Victoria helpline (13 11 20):** is available to answer questions, provide guidance and connect you with further support resources

Please do not hesitate to contact us if you would like more information:

- Email us at: OralSACT@phcn.vic.gov.au (Monday – Friday 8:00 – 4:30pm)
- If you require urgent assistance please contact Symptom Urgent Review Clinic (SURC) 03 9784 8856 or Switchboard 03 9784 7777 and ask for Oncology Advance Trainee.

ABN 52 892 860 159 peninsulahealth.org.au

Patient Education & Adherence

"Adherence is the extent to which a person's behaviors coincide with medical or health advice" — **WHO, 2003**

The Teach-Back Framework

1. Explain information in plain language — no jargon, culturally appropriate
2. Ask the patient to explain back in their own words
3. Re-explain anything misunderstood
4. Repeat steps 2–3 until comprehension is confirmed

What the Education Session Covers

- **Administration —** Dose, timing, food interactions, correct swallowing (whole capsule), dose administration aids, and calendars.
- **Side effects —** Named, graded, described in plain language. Patient given written resource.
- **Self-monitoring —** Temperature, BP, bruising, bleeding, fatigue — what to record and when.
- **Escalation pathway —** When and how to contact SURC. Contact number. What to say. GP communication.
- **Drug interactions —** Complementary medicines, antacids, OTC medications — patient prompted to show all.
- **Tools used —** MASCC teaching resource, eviQ protocol, written patient handout, GP and community pharmacy letter

Outcomes & Impact

What the Peninsula Health oral SACT model has achieved

180

Individual patients supported through Oral SACT Clinic

202

Review appointments shifted to oral SACT clinic model

22

OSACT pathways built in CHARM

>100%

Growth in oral SACT volume — the model is ready to scale

✅ **Adherence —** Patients educated in structured sessions with teach-back confirmation. Dose administration aids and calendars provided. Community pharmacy letter to reinforce dispensing-point education.

🛑 **Toxicity management —** Early detection through serial pathology and proactive calls. Grade 2+ toxicities actioned within the same clinical contact. Dose holds and reductions within NP scope, reducing delays.

🏥 **Hospital avoidance —** SURC provides triage and management without requiring ED presentation. Pharmacist and NP manage most events in ambulatory settings.

🔗 **Escalation quality —** CHARM pathways standardise escalation triggers. SURC escalation to NP removes variation in unwell call management. Patient knows exactly who to contact and when.

📈 **Service capacity —** 202 appointments shifted from medical oncology to nurse-led model. Pharmacist integration Monday/Friday supports sustainable model without increasing physician burden.

Scale & Sustainability

What services must build before oral therapy volumes grow further

👩‍⚕️ Workforce

- NP / nurse practitioner leadership with clear clinical scope.
- Oncology nurses trained in oral SACT pharmacology and toxicity grading.
- Defined SURC nursing scope — including unwell calls and escalation.
- Clinical pharmacist embedded in the team, not just a consulting resource.

🖥️ Digital & Systems

- CHARM (or equivalent) pathways for all oral SACT regimens.
- Virtual oral SACT chair to allocate pathways/protocols to.
- Structured EMR documentation templates/fields —for education, follow-up, toxicity grading.
- Allocated funded clinic with template.
- Email and phone contact phone infrastructure.

📋 Protocols

- Standardized baseline assessment tool for all new oral SACT starts
- Teach-back confirmed education documentation
- Toxicity grading guides aligned to CTCAE
- Escalation decision trees accessible to all team members

🌐 Community Integration

- Structured GP communication letter at commencement and dose changes.
- Community pharmacist letter with regimen and contact details.
- Patient Alert card — regimen, contact number.
- Video/phone consult capacity for patients.

Key Messages

What every oncology service needs to understand about oral SACT

01 Oral therapy is not simpler than IV therapy — it transfers complexity to the patient and caregiver, who require structured, proactive nursing support to manage it safely.

02 A designed surveillance model — not passive self-management — is the only safe approach as oral SACT volumes grow. At Peninsula Health, patient numbers doubled in 4 years.

03 Nurses are best placed to lead oral SACT monitoring: proactive calls, toxicity screening, adherence assessment, education, and escalation within scope — preserving physician capacity for complex decisions.

04 Standardization cuts variation. Teach-back education, CHARM pathways, CTCAE grading, structured escalation triggers, and community letters all reduce the risk of patients being managed differently based on who happens to call.

05 Service development . Workforce capability, digital systems, protocols, and community connections need to be established before volume pressure makes safe care impossible.

Thank You

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