As the world’s leading provider of injectable drugs and infusion technologies, Hospira offers healthcare facilities solutions to improve clinician efficiency and patient safety. We provide a broad range of oncolytics, needle-free compounding and transfer devices and the Plum A+™ Infusion pump for closed system IV administration of hazardous medications – All designed with your safety in mind.
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## Abstracts FRIDAY, 26 JULY

- **Breakfast Session 1: Closed System Infusion: safeguarding your health**  
  - FRIDAY, 26 JULY 20

- **Breakfast Session 2: Supportalk Cancer Council NSW**  
  - Peer Support programs – connecting with others

- **Plenary Session 1 – Who are we, where are we going and how do we get there?**

## CONCURRENT SESSION A: MODELS OF CARE 1

- Implementing an evidence-based model of onco-geriatric care
- Pre and post gynaecological care of women undergoing stem cell transplant
- A pilot project to improve access to chemotherapy/biotherapy for rural patients: The Townsville Tele Nursing Model
- Introducing the nurse practitioner role to regional oncology patients
- Oral chemotherapy nurse: A trial position at Sir Charles Gairdner Hospital (SCGH), Perth, Western Australia (WA)

## CONCURRENT SESSION B: SUPPORTING HEALTH PROFESSIONALS

- The implementation of rotating inpatient medical ward nurses to the cancer care services day unit: Providing and promoting quality care to cancer patients in the ward
- Brain tumour regional support project
- Increasing cancer nurses’ wellbeing: A pilot study to identify potential workplace strategies
- Staff rotation for cancer nurses in a tertiary health organisation: An evaluation
- Bringing cancer care closer to home, Country Health South Australia’s story

## CONCURRENT SESSION C: QUALITY AND SAFETY 1

- ‘It’s time to change’. A facilitator’s experience in implementing a standardised approach to chemotherapy training
- The role of the nurse in patient education and follow up of people receiving oral anti-cancer treatment: An Australian survey
- Practice development and nursing transfer form (NTF) innovation
- Evaluation of an education program to facilitate patient adherence, toxicity monitoring and promote safety in the self-administration of oral chemotherapy in the home setting

## CONCURRENT SESSION D: WORKSHOP: IMPROVING CANCER PAIN OUTCOMES

## CONCURRENT SESSION E: EDUCATION

- 1+1=3? Combined nursing and allied health education: more than the sum of its parts
- Can a novel on-line pain assessment learning module improve specialist palliative care nurse’s pain assessment knowledge?: Results from a pilot spaced education initiative
- Education resources, can standardisation be achieved?
- Development of a cancer education framework for the Grampians region

## CONCURRENT SESSION F: PRACTICE IMPROVEMENT 1

- An education package to support the nursing management of cutaneous toxicities associated with targeted cancer therapies
- Unplanned oncology admissions within 14 days of discharge: A retrospective review
- Professional development needs of prostate cancer specialist nurses
- Cost benefit analysis of Capecitabine vs Infusional SFU in rectal cancer patients at Illawarra Shoalhaven local health district
- Exploring reasons for extended length of stay in older cancer patients

## CONCURRENT SESSION G: IMPROVING THE SYMPTOM EXPERIENCE

- Evaluation of an acupuncture service in a day oncology unit
- Vemurafenib – Treatment and nursing management of side effects
- Evaluating the role of specialist nurses in supporting cancer patients with breathlessness
- Management of fungating wounds in the radiation treatment unit: Is a standardised approach feasible?

## CONCURRENT SESSION H: IMPROVING THE PATIENT & FAMILY EXPERIENCE

- Predictors of distress and unmet needs amongst adolescents and young adults who have a parent with cancer
- Oncology nurses family assessment processes: An investigation of current practices
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Welcome to Brisbane!

On behalf of the Local Organising Committee I would like to thank you for attending our first independent CNSA Winter Congress. We do appreciate the time and effort you have made to be here.

We welcome our two international speakers, Professor Brenda Nevidjon and Beth Faiman (kindly supported by Celgene) along with our national speakers who will set the tone for what we hope is a successful Congress.

We have planned this Congress for you, to keep you up to date with where cancer nursing is currently and what the future may and will hold for us. This Congress has been designed to get you thinking, to stimulate discussion whilst remembering that the patient is at the centre of everything we do. We are hoping that there is enough within the program for those of us who work in a specialised cancer unit, and those of us who work in a more generalist oncology setting be that regional, rural or remote. Make the most of this Congress. Read the abstracts and select those papers you wish to attend and the posters you wish to view. Think about any questions you may wish to ask of the presenters, we want this to be a Congress with a lot of interaction and discussion. If you are feeling a little confused or lost, or this is your first CNSA Winter Congress please visit us on the Information stand and we can assist and direct you. There is also a literature table where you can find information about other aspects of cancer care and conferences which may interest you.

We are very grateful to our industry supporters without whom this Congress would not be possible. Please visit them and see the latest updates in drug support for our patients and product developments. Please also visit our not for profit organisation stands, these organisations provide invaluable information for our patients and support for us as Cancer Nurses.

Queensland is renowned for its openness and hospitality, so please introduce yourself, become involved in the activities from the welcome and farewell drinks and the dinners to just saying hello.

We hope this Congress will be informative, thought provoking, interactive and most of all enjoyable.

Jane Campbell
Local Organising Committee Chair

Cancer Nurses
Society of Australia

23. Helping young people deal with the "scary stuff": An acceptance and commitment therapy program for those impacted by parental cancer

24. Intravascular device management in a tertiary cancer care centre: A point-prevalence study of nursing practice

25. Self-care support for blood cancer patients suffering from oral mucositis due to chemotherapy

26. Development of learning framework for the novice practitioner in lung cancer care coordination

27. Cancer, cultural sensitivity and enhanced patient outcomes

29. CINV Check: An audit of chemotherapy induced nausea and vomiting (CINV) prevention in patients receiving moderately emetogenic chemotherapy (MEC) at Cabrini Malvern day oncology

30. Assessing the potential value of cancer information resources in e-book format

Company Profiles

Notes
WINTER CONGRESS PLANNING AND DEVELOPMENT COMMITTEE
- Maryanne Hargraves – Chair
- Sandy McKiernan – CNSA President
- Megan Nutt – CNSA Treasurer
- Jane Campbell – Local Organising Committee Chair
- Julie Calvert – CNSA Executive Officer

LOCAL ORGANISING COMMITTEE
- Jane Campbell – Local Organising Committee Chair
- Kylie Ash
- Leisa Brown
- Juanita Chaffey
- Ray Chan
- Elisabeth Coyne
- Judy Eddy
- Sandie McCarthy
- Emily Russell
- Pauline Rose

NATIONAL EXECUTIVE COMMITTEE
President – Sandy McKiernan
Past President – Mei Krishnasamy
Secretary, Website and Membership Coordinator – Anne Mellon
Treasurer – Megan Nutt
ISNCC Representative – Tish Lancaster
ACT Representative – Vivienne Van Dissel
QLD Representative – Alexandra McCarthy
NSW Representative – Mary Ryan
VIC Representative – Trevor Saunders
TAS Representative – Laura Pyszkowski
WA Representative – Samantha Gibson
CNSA Executive Officer – Julie Calvert
CNSA Administration Assistant – Amy Ribbons
Ms Beth Faiman

Beth Faiman received a bachelor of science in nursing and registered nurse certification at Ursuline College in Pepper Pike, Ohio, completed in 1996. She received a master of science in nursing and certification as an adult nurse practitioner at Kent State University in Kent, Ohio in 2002.

She holds an advanced oncology nurse certification through ONCC. She is currently employed as an Adult Nurse Practitioner in the department of Hematologic Oncology and Blood Disorders at the Cleveland Clinic in Cleveland, Ohio. She is also a full-time pre-doctoral research fellow and PhD Candidate at the Frances Payne Bolton School of Nursing at Case Western Reserve in Cleveland, Ohio pursuing a PhD in nursing research. She is adjunct faculty at Ursuline College, Case Western Reserve University and Kent State University. She is recipient of the 2012 Oncology Nursing Society Excellence in Medical Oncology Award.

Ms. Faiman is an active author, presenter, and educator on the topic of multiple myeloma, plasma cell dyscrasias, general cancer diagnosis and treatment, as well as management of skeletal and other cancer complications. She is an appointed delegate on the International Myeloma Foundation Nurse Leadership Board. She is Editor-in-Chief of The Oncology Nurse APN/PA. She has authored many book chapters relating to diagnosis and management of multiple myeloma, blood disorders and has written numerous manuscripts relating to the diagnosis and treatment of myeloma, palliation, and cancer symptom management.

Ms Kim Hobbs

Kim Hobbs has a Masters Degree in Social Work, and building upon a solid base of clinical care, is passionate about constantly improving interventions to address supportive care needs for people with cancer throughout all stages of treatment and recovery. Assessing intimacy and sexuality concerns should be an integral component of comprehensive cancer care for all people with cancer and their partners. In addition to a long career in clinical practice (the last several years specialising in gynaecological cancers), she has also been involved in a range of other activities including research, the development of educational resources for both clinicians and consumers, and presentations at conferences and workshops which focus on sexuality.

Mr Dan Mellor

Dan Mellor is the Deputy Director of Pharmacy at the Peter MacCallum Cancer Centre in Melbourne, a post he has held since 2006. Dan completed his Masters Degree in Pharmacy in the UK and worked in both NHS and private hospitals before moving to Australia.
He holds a post-graduate qualification in clinical oncology research from the University of Melbourne and is currently completing a part-time PhD in Cancer Pharmacogenomics at Monash University.

Dan is Chair of the COSA Cancer Pharmacists Group (CPG) and is an active member of the COSA Council. He tutors both undergraduate (clinical cancer pharmacy at RMIT) and postgraduate pharmacists and teaches on CPG and SHPA cancer pharmacy courses. Dan is a pharmacy registration examiner for AHPRA and consults with multiple pharmaceutical companies at an international level. He is frequently invited to speak at national and international conferences. Dan is active in pharmacy research and has authored 15 peer-reviewed publications and 25 conference posters in recent years. Dan’s achievements have been recognized by the SHPA when he became the 2012 recipient of the SHPA William Mercer Young Achiever’s Award recognising an outstanding contribution to hospital pharmacy.

Ms Janine Porter-Steele
Janine undertook her training in the UK as an RN, midwife and health visitor, completed a Bachelor of Nursing at QUT and Masters in Nursing Leadership at ACU, and is now the Manager of the Wesley Hospital Kim Walters Choices Program in Brisbane which offers support and information to women, men and their families who are affected by breast and gynaecological cancers. Janine is a Breast Care and Women’s Health Nurse with special interests in menopause, sexuality and cancer and depression. She is currently undertaking PhD studies in the area of breast cancer and sexuality and is also employed as a research officer at QUT School of Nursing.

Dr Margaret Redelman
Margaret received her medical degree in Sydney and sexuality training in the USA. She then worked in Sexually Transmitted Diseases Clinics, Family Planning Clinics and General Practice for many years. She now works in private practice in Bondi Junction, Sydney, as a medical sex and relationship therapist. Her work covers positive male and female sexuality, sexual dysfunctions and the interpersonal relationships of both heterosexual and homosexual couples. She is a guest lecturer and public speaker on topics of sexuality. She has published articles on sexuality in accredited medical journals and participates in research for the treatment of male and female sexual function.

She is on the executive committee of SAS (Society for Australian Sexologists) and has clinical accreditation from SAS. She was President of ASSERT (Australian Society Sexuality Educators Researchers and Therapists) National from 2004 to 2009. She was President of the 18th World Association for Sexual Health (WAS) Congress held in Sydney in 2007. She is the current president elect on the Asia-Oceania Federation for Sexology (AOFS) and will be President of the 13th AOFS Conference to be held in Brisbane in 2014.

Associate Professor Jane Turner
Jane Turner is Associate Professor in the Discipline of Psychiatry at the University of Queensland. She is responsible for the teaching of Psychiatry in the Medical Programme of UQ, and had worked for over 20 years as a consultation-liaison psychiatrist in oncology. She has been extensively involved in the development and implementation of clinical practice guidelines, and had led a state-wide initiative to develop a sustainable model of communication skills training in oncology. Her research and clinical interests focus on the emotional impact of advanced cancer, especially on families, and the development of innovative models of psychosocial care in oncology. She has recently completed a multi-site RCT of a brief psychosocial intervention for depressed cancer patients delivered by trained front-line health professionals, and has NHMRC funding for a nurse-delivered survivorship intervention for patients who have completed treatment for head and neck cancer.

Professor Ross Young
Executive Dean of the Faculty of Health, QUT, Professor Ross Young, is a clinical psychologist with a research background in integrating genetic and environmental risks for mental illness. He was Executive Director of the Institute of Health and Biomedical Innovation (IHBI) at QUT from 2006 until joining the Faculty of Health in early 2013.

Professor Young has research interests in the psychological and biological factors contributing to substance misuse, and major psychiatric illness, such as schizophrenia. He is part of a team that has identified an important gene in the risk for schizophrenia. He mainrains a Visiting Clinical Appointment at the Princess Alexandra Hospital Alcohol and Drug Assessment Unit (ADAIU) and sits on a variety of health related Boards including Cancer Council Queensland and the Gallipolli Medical Research Foundation. He is Chairman of the Board of Mantle Housing and Patron of the Association of Relatives and Families of the Mentally Ill (ARAFMI) Queensland. He is a past National President of the Australian Association for Cognitive and Behaviour Therapy.

Professor Young has a visiting research appointment at the Alcohol Research Center at the University of California, Los Angeles.

Professor Young has published over 190 refereed journal articles and book chapters.
**Social Program Information**

**PRE-Congress Educational Dinner**

**Date:** Wednesday 24th July 2013  
**Venue:** Brisbane Convention and Exhibition Centre, Plaza Gallery  
**Time:** 7.30pm – 10.00pm  
**Dress:** Smart Casual  
**Cost:** With compliments of Celgene  
*This Pre-Congress Educational Dinner features a presentation by Beth Faiman, The Nurse Practitioner, Multiple Myeloma Program, Cleveland Clinic Foundation, USA*

**Welcome Reception**

**Date:** Thursday 25th July 2013  
**Venue:** Brisbane Convention and Exhibition Centre, Plaza Foyer  
**Time:** 5.00pm – 7.00pm  
**Dress:** Smart Casual  
**Cost:** The Welcome Reception is included in the registration fee for full registrants and includes canapés and drinks.

**Congress Gala Dinner**

**Date:** Friday 26th July 2013  
**Venue:** Rydges South Bank, Level 12  
**Time:** 7.30pm – 11.30pm  
**Dress:** Cocktail  
**Cost:** $100.00 p/person  
This is a ticketed event, should you wish to purchase a ticket or if you have selected to attend but no longer wish to then please contact the Registration Desk immediately.

**Farewell Reception**

**Date:** Saturday 27th July 2013  
**Venue:** Brisbane Convention and Exhibition Centre, Plaza Gallery  
**Time:** 3.30pm – 4.30pm  
**Dress:** Casual  
**Cost:** Join us at the conclusion of the congress for a farewell refreshment and an opportunity to network with your colleagues and peers. The farewell Reception is included in the registration fee for full registrants.  
If you have selected to attend but no longer wish to then please contact the Registration Desk immediately.

**Registration Desk**

The registration desk will be located in the Convenors Office which is on the Plaza Level of the Brisbane Convention and Exhibition Centre. The opening times are as follows:

- Thursday 25 July: 8.00am – 7.00pm  
- Friday 26 July: 7.00am – 5.00pm  
- Saturday 27 July: 7.00am – 4.30pm

**Registration Entitlements**

- Registration for full registrants includes entry into all sessions, the congress satchel, abstract book, attendance certificate (sent out electronically post congress), morning & afternoon teas, lunches on each day of the congress, the Welcome Reception on Thursday 25 July and the Farewell Reception on Saturday 27 July.

- Day registration includes entry into all sessions for that day, the congress abstract book, attendance certificate (sent out electronically post congress), morning and afternoon tea and lunch on the day of registration

**Information Desk**

For delegates who are first timers to CNSA Winter Congress, or for those who may not be familiar with Brisbane, the Local Organising Committee will host an information desk where you can ask questions and find useful literature such as maps of the South Bank area. The information desk will be situated adjacent to the registration desk.

**Catering/Break Times**

Morning, afternoon tea and lunch will be served within the congress exhibition area which is located on the Plaza level in the Plaza Foyer.

**Friday 26 July**

- 10.30am – 11.00am Morning Tea  
- 12.30pm – 1.30pm Lunch  
- 3.00pm – 3.30pm Afternoon Tea

**Saturday 27 July**

- 10.30am – 11.00am Morning Tea  
- 12.30pm – 1.30pm Lunch

**Dietary Requirements**

If you have not already done so, please advise the Congress Managers of any specific dietary requirements and/or food allergies. If you have advised of a special diet request, please make yourself known to banqueting staff in order to collect your special meal. Please note that vegetarians will be catered for as standard.
CONGRESS MESSAGE BOARD
There will be a message board located adjacent to the registration desk for delegates wishing to communicate with colleagues. The Congress Gala Dinner list of attendees will also be displayed on the board.

ATTENDANCE CERTIFICATES
Certificates of attendance will be emailed out to all delegates post congress. For delegates attending a pre-congress workshop, you will receive a separate certificate for the workshop you attended and this will also be emailed to the email address you nominated at registration.

SPEAKER PREPARATION ROOM
All presenters must check-in at the Speakers’ Preparation room (Concord Speakers Lounge) at least 2 hours prior to the start of their session time. Presentations must be brought on either USB memory stick or CD.

POSTER DISPLAY
The poster display will be located within the exhibition area in the Plaza Foyer.

LITERATURE DESK
There will be a literature table situated within the exhibition area where you will find flyers and brochures which may be of interest to you.

BUSINESS SERVICES
The Centre’s Information Desk can provide services such as photocopying, printing, send faxes etc. The Information Desk is located at the Grey Street Entrance to the building.

INTERNET ACCESS
Casual wireless internet is available at no cost to visitors of the centre and is designed for web browsing and checking web based email. There will also be an internet kiosk located within the exhibition area should you wish to use a PC rather than your mobile/personal device.

CLOAKROOM FACILITIES
The Information Desk on Grey Street has cloakroom facilities to assist with storing personal items.

TRANSPORT OPTIONS
A comprehensive network of trains, buses and city cats (ferries) link the Centre with Brisbane city and suburbs. Translink tickets are the best way to visit and travel around the city. The Translink website contains more details: http://www.translink.com.au/

BY TRAIN?
The closest train station is South Brisbane; only a few minutes walk away. A regular Air Train service operates between Brisbane’s international and domestic airports. Travelling time is approximately 25mins. Tickets are available from the Information Desk.

BY BUS?
The Cultural Centre is the main hub for most bus routes, only a few minutes walk away adjacent to the Queensland Performing Arts Centre. A Free Loop downtown bus service circles Brisbane’s Central Business District only.

BY RIVER CAT?
The City Cat terminal is located outside the riverside restaurants on the Clem Jones Promenade. City Cats run daily from 5.30am-10.30pm.

BY TAXI?
A dedicated taxi rank is located at the main entrance of the Centre on the Cnr Merivale and Glenelg Streets. Taxis are also accessible in other locations in the South Bank precinct including the 2 hotels – Rydges and Mantra.
THURSDAY 25 JULY
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P6 & P7
Concurrent Session L  
Plaza Auditorium
Concurrent Session M  
P9
Breast SIG Meeting  
P8
Radiation Oncology SIG Meeting  
P9
Regional Group Chair Meeting  
P10
AJCN Editorial Meeting  
P11
Plenary Session 4  
Plaza Auditorium
Farewell Reception  
Plaza Gallery
A unique urban riverside convention precinct, hub of Brisbane’s thriving arts and cultural activities and brimming with the city’s most sophisticated restaurants and retail outlets, is home to the Brisbane Convention & Exhibition Centre. Within a few minute’s walk, delegates and guests can visit any of the 30 or more cafes, bars and restaurants, capture the culture at Australia’s most celebrated Gallery of Modern Art or stroll along the riverfront promenade and enjoy the warmth and relaxation of Australia’s only inner city sand and swimming beach. Discover more about South Bank by visiting the Congress Information Desk.

FANCY A MORNING STROLL/JOG?

Brisbane has some excellent walking/running tracks close by to the Convention Centre. The registration desk can provide delegates with a map of suitable tracks ranging from 3km – 8km. Why not sign up to a walking group or running group via the Congress Notice board and meet other walkers/joggers outside the entrance to Rydges Hotel at 6am.
**Plaza Level**

The Congress will be held in the Plaza Auditorium, Plaza Foyer, P6 – P11 and the Plaza Gallery (indicated in purple).

The Plaza Level is the connecting link between Brisbane Convention & Exhibition Centre on Grey Street and Brisbane Convention & Exhibition Centre on Merivale Street.

**Concord Level**

The Concord Speakers Lounge is the designated Speaker Preparation Room.
Exhibitor Listing

1. Mayo Healthcare
2. Fresenius Medical Care
3. Care Fusion
4. Clinical Oncological Society of Australia (COSA)
5. BD
6. Palliative Care Nurses Australia
7. Cancer Australia
8. Link Pharma
9. REM Systems
10. Cancer Council Queensland
11. Midmed
12. Baxter Healthcare
13. Ipsen
14. Bristol-Myers Squibb
15. Celgene
16. Roche
17. Elekta
18. Aspen Australia
19. Sanofi
20. Sanofi
21. Hospira
22. Hospira
23. Novartis Oncology
24. Cancer Nurses Society of Australia
25. Sydney Nursing School/The University of Sydney
26. Amgen Oncology
27. Janssen
28. Cancer Institute NSW – eviQ
29. Cook Medical
30. The Cancer Patients Foundation, Look Good…. Feel Better
31. Fresenius Kabi
32. Fresenius Kabi
33. Bard Access Systems
34. MSD
35. QUT
36. Cancer Council NSW
37. Merck Serono
38. Smiths Medical
39. Pierre Fabre Oncology

T1 – Lung Foundation Australia
T2/T3 – Sollo Jewellery
T4 – International Society of Nurses in Cancer Care (ISNCC)
T5 – Breast Cancer Network Australia

Exhibition Opening Hours

**Thursday 25 July**
Welcome Reception 1700 – 1900

**Friday 26 July**
Morning tea 1030 – 1100
Lunch 1230 – 1330
Afternoon tea 1500 – 1530
Closing time 1700

**Saturday 27 July**
Morning tea 1030 – 1100
Lunch 1230 – 1330
Closing Time 1330
### THURSDAY, 25 JULY – Pre-Congress Workshop Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Workshop</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900 – 1700</td>
<td>Workshop 1</td>
<td>Antineoplastic Drug Administration Course (ADAC) – Facilitation Skills Training Workshop (10.00am - 4.45pm)</td>
</tr>
<tr>
<td>0900 – 1700</td>
<td>Workshop 2</td>
<td>Cancer Care Coordination Professional Development day: Updating this Key Role (9.30am - 4.00pm)</td>
</tr>
<tr>
<td>0900 – 1700</td>
<td>Workshop 3</td>
<td>Recent Advances in Cancer Care: a Workshop for Experienced Cancer Nurses (9.00am - 4.30pm)</td>
</tr>
<tr>
<td>0900 – 1700</td>
<td>Workshop 4</td>
<td>Cancer Basics – a workshop for nurses and allied health professionals (9.00am - 4.30pm)</td>
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</table>

### FRIDAY, 26 JULY – Winter Congress Program, Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Chair</th>
<th>Venue</th>
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</thead>
<tbody>
<tr>
<td>0700 – 1715</td>
<td>Registration</td>
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<tr>
<td>0730 – 0830</td>
<td>Breakfast Session 1: Closed System Infusion: safeguarding your health</td>
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<td>Supported by: Hospira</td>
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<td>Room: P6 &amp; P7</td>
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<td>Breakfast served from 0715</td>
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<tr>
<td>0845 – 0900</td>
<td>Welcome to Country Ceremony by Uncle Eddie Ruska</td>
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<td></td>
<td>Welcome Note by Sandy McKiernan, CNSA President and Jane Campbell, LOC Chair</td>
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<tr>
<td>0900 – 0915</td>
<td>Official Opening</td>
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<td></td>
<td>Dr Frances Hughes, Chief Nursing and Midwifery Officer for Queensland Health</td>
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<td></td>
<td>Venue: Plaza Auditorium</td>
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<tr>
<td>0915 – 0950</td>
<td>Plenary Session 1 – Who are we, where are we going and how do we get there?</td>
<td>Sandy McKiernan</td>
<td>Plaza Auditorium</td>
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<tr>
<td></td>
<td>Venue: Plaza Auditorium</td>
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<tr>
<td>0950 – 1030</td>
<td>The Heart of the Matter – The emotional dimensions of cancer nursing</td>
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<td></td>
<td>Associate Professor Jane Turner, Psychiatrist, University of Queensland</td>
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<tr>
<td>1030 – 1100</td>
<td>Morning Tea and Poster Viewing</td>
<td></td>
<td>Plaza Foyer</td>
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<tr>
<td>1045 – 1145</td>
<td>CONCURRENT SESSION A: Models of Care 1</td>
<td>Sandie McCarthy</td>
<td>Plaza Auditorium</td>
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<tr>
<td>1045 – 1145</td>
<td>Chair: Sandie McCarthy</td>
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<tr>
<td>1100 – 1230</td>
<td>implementing an evidenced-based model of oncogeriatric care</td>
<td>Robyn Berry</td>
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<tr>
<td>1115 – 1150</td>
<td>Pre and post gynaecological care of women undergoing stem cell transplant</td>
<td>Jessica Jude</td>
<td></td>
</tr>
<tr>
<td>1130 – 1145</td>
<td>A Pilot Project to Improve Access to Chemotherapy/Biotherapy for Rural Patients: The Townsville Tele Nursing Model</td>
<td>Susan Price</td>
<td></td>
</tr>
<tr>
<td>1145 – 1200</td>
<td>Introducing the Nurse Practitioner Role to Regional Oncology Patients</td>
<td>Anne Rooms</td>
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<tr>
<td>1200 – 1245</td>
<td>Oral chemotherapy nurse: A trial position at Sir Charles Gairdner Hospital (SCGH), Perth, Western Australia (WA)</td>
<td>Katrina Fye</td>
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</tr>
<tr>
<td>1245 – 1300</td>
<td>CNSA AGM</td>
<td></td>
<td>Plaza Auditorium</td>
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</tbody>
</table>

### Notes
- CNSA AGM: If you have any questions, please raise them at the AGM.
- **Pre-Congress Educational Dinner**
  - Welcome to Country Ceremony
  - Official Opening
  - Plenary Sessions
- **CNSA Research Committee**
  - Welcome Note
  - Cancer Pain Guidelines
  - Cancer Basics
  - Oncology Nurses: Leading from the bedside to the board room
- **CNSA Winter Congress Program, Day 1**
  - Registration
  - Morning Tea and Poster Viewing
  - Concurrent Sessions
- **Supporting health professionals**
  - Increasing Cancer Nurses' Wellbeing: A Pilot study to Identify Potential Workplace Strategies
  - Practice Development and Nursing Transformation Form (NTP) Innovation
- **Evaluation of an education program**
  - Facilitate patient adherence, toxicity monitoring and promote safety in the self-administration of oral chemotherapy in the home setting
  - Workshops
  - Improving cancer pain outcomes
  - Improving cancer pain management using patient-centred approaches
- **Participants**
  - Will be provided with an opportunity to shape the dissemination and implementation strategy to promote their uptake at the local and national level.
**FRIDAY, 26 JULY – Winter Congress Program, Day 1 continued …**

<table>
<thead>
<tr>
<th>Time</th>
<th>Concurrent Session E: Education</th>
<th>Concurrent Session F: Practice improvement 1</th>
<th>Concurrent Session G: Improving the symptom experience</th>
<th>Concurrent Session H: Improving the patient &amp; family experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1330 – 1500</td>
<td>1+1=3? Combined Nursing and Allied Health Education: More than the sum of its parts – Leisa Brown</td>
<td>An education package to support the nursing management of cutaneous toxicities associated with targeted cancer therapies – Marie Condon</td>
<td>Evaluation of an Acupuncture Service in a Day Oncology Unit – Chris McKeon</td>
<td>Predictors of Distress and Unmet Needs Amongst Adolescents and Young Adults who have a Parent with Cancer – Fiona McDonald</td>
</tr>
<tr>
<td>1400</td>
<td>Educational resources, can standardisation be achieved? – Heather Pile</td>
<td>Professional Development Needs of Prostate Cancer Specialist Nurses – Julie Sykes</td>
<td>Evaluating the role of specialist nurses in supporting cancer patients with breathlessness – Isabella Zhao</td>
<td>Cancer Council WA: Building Effective Cancer Support Groups Program – Deborah Kruger</td>
</tr>
<tr>
<td>1430</td>
<td>Discussion</td>
<td>Exploring reasons for extended length of stay in older cancer patients – Meenir Krishnasamy</td>
<td>Discussion</td>
<td>A new online support service for young people living with cancer – Pandora Patterson</td>
</tr>
<tr>
<td>1445</td>
<td>Discussion</td>
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<td>Discussion</td>
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<tr>
<td>1500 – 1530</td>
<td>Afternoon Tea and Poster Viewing</td>
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<tr>
<td>1530 – 1700</td>
<td>Plenary Session 2 - DEBATE: Does palliative care have a place in haematology? Chair: Jane Campbell Venue: Plaza Auditorium</td>
<td>Moderator: Professor Ross Young, Executive Dean, Faculty of Health, QUT</td>
<td>This will be a stimulating debate on a subject that is topical and controversial. The debating panel will include a Palliative Care Physician, an ethicist, a nurse practitioner and a haematologist.</td>
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<tr>
<td>1700 – 1800</td>
<td>Gynae Oncology SIG Meeting Room: P8</td>
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<tr>
<td>1930 – 2300</td>
<td>Congress Gala Dinner – Rydges Hotel</td>
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</tbody>
</table>

**Win an iPad mini**

Collect your exhibitor stamps in your ‘mini passport’ then hand into the registration desk at lunchtime on Saturday to be in with a chance to win!
### SATURDAY, 27 JULY – Winter Congress Program, Day 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>0715</td>
<td>CNSA Education Committee breakfast meeting</td>
</tr>
<tr>
<td>0730 – 0830</td>
<td><strong>Breakfast Session 3:</strong> The role and management of EGRF TKIs: The Good, The Bad and the Ugly</td>
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<td>Supported by:</td>
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<tr>
<td></td>
<td>Room: P9</td>
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<tr>
<td></td>
<td>Breakfast served from 0715</td>
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<tr>
<td>0730 – 0830</td>
<td><strong>Breakfast Session 4:</strong> Optimising patient outcomes in advanced prostate cancer: a proactive management approach</td>
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<td>Supported by:</td>
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<tr>
<td></td>
<td>Room: P6 &amp; P7</td>
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<tr>
<td></td>
<td>Breakfast served from 0715</td>
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<tr>
<td></td>
<td>Presenter: Associate Professor Mei Krishnasamy  Venue: Plaza Auditorium</td>
</tr>
<tr>
<td>0900 – 1030</td>
<td><strong>Plenary Session 3 – Future challenges for health professionals surrounding cancer genomics</strong></td>
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<td></td>
<td>Chair: Leanne Monterosso  Venue: Plaza Auditorium  Dr Kim Alexander, Lecturer, QUT and Mr Dan Mellor, Deputy Director of Pharmacy at the Peter MacCallum Cancer Centre</td>
</tr>
<tr>
<td>1030 – 1100</td>
<td>Morning Tea and Poster Viewing  <strong>Venue: Plaza Foyer</strong></td>
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<tr>
<td>1100 – 1230</td>
<td><strong>CONCURRENT SESSION J:</strong> Models of care 2</td>
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<tr>
<td></td>
<td>Chair: Emily Russell  Room: P8</td>
</tr>
<tr>
<td>1115</td>
<td>Evaluation of Nurse Led Telephone Follow Up in Low/Intermediate Risk Prostate Cancer Patients – Mary Leathy</td>
</tr>
<tr>
<td>1130</td>
<td>Wimmera Oncology Nurse Practitioner collaborative model – 2 years on... – Carmel O’Kane</td>
</tr>
<tr>
<td>1145</td>
<td>A clinical audit to re-assess the needs of high grade glioma patients through evaluation of the nurse-led neurosurgical oncology clinic – Anne King</td>
</tr>
<tr>
<td>1200</td>
<td>Discussion</td>
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<tr>
<td>1215</td>
<td>Discussion</td>
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<tr>
<td>1230 – 1330</td>
<td>Lunch  <strong>Venue: Plaza Foyer</strong></td>
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<td></td>
<td>SIG Meetings  Breast SIG  Room: P8</td>
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<tr>
<td></td>
<td>Radiation Onc SIG  Room: P9</td>
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<tr>
<td>1330 – 1400</td>
<td>Awards Presentations (Best Paper, First time presenter award and Best Poster)</td>
</tr>
<tr>
<td>1400 – 1530</td>
<td><strong>Plenary Session 4 – Sex in the afternoon: Afternoon Delight</strong>  Chair: Kylie Ash  Venue: Plaza Auditorium</td>
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<tr>
<td></td>
<td>A panel style discussion session on the topic of sexuality.</td>
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<td>Panel Members:  Dr Margaret Redelman, Medical Sex and Relationship Therapist in Private Practice, Sydney</td>
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<td></td>
<td>Ms Kim Hobbs, Social Worker, Westmead Hospital</td>
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<td>Ms Janine Porter-Steel, Manager of the Wesley Hospital Kim Walters Choices Program in Brisbane</td>
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<td></td>
<td>Welcome to Winter Congress 2014</td>
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<tr>
<td>1530 – 1630</td>
<td>** Farewell Drinks and Close  **  <strong>Venue: Plaza Gallery</strong></td>
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<tr>
<td>Poster No.</td>
<td>Poster Title</td>
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</tr>
<tr>
<td>1</td>
<td>Measuring the quality of current education practice</td>
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<td>2</td>
<td>Evaluating the oncology nurse practitioner role: Success or failure?</td>
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<tr>
<td>3</td>
<td>Bringing it home across the tyranny of distance</td>
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<tr>
<td>4</td>
<td>A 12 day evidence-based practice program for cancer nurses in an Australian</td>
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<td>tertiary cancer centre</td>
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<td>5</td>
<td>A summer clinical research program for an undergraduate student in an</td>
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<td>Australian tertiary cancer centre</td>
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<td>6</td>
<td>Establishing best practice in nursing intervention post bone marrow aspirate</td>
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<td>and trephine</td>
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<td>7</td>
<td>Making the path straight</td>
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<td>8</td>
<td>Art as a diversional and cathartic experience within the acute setting</td>
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<tr>
<td>9</td>
<td>A patient centred approach to the care continuum</td>
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<td>10</td>
<td>Connecting cancer care: Working together to support women and their families</td>
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<td>affected by ovarian cancer</td>
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<td>11</td>
<td>Untangling the lines. Our experience of implementing a closed intravenous</td>
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<td>chemotherapy system</td>
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<td>12</td>
<td>Implementation of a nurse-led transfusion support program in the day oncology</td>
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<td></td>
<td>unit</td>
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<tr>
<td>13</td>
<td>When you look in the mirror and don’t recognise the person looking back at</td>
</tr>
<tr>
<td></td>
<td>you … Where do you turn for help?</td>
</tr>
<tr>
<td>14</td>
<td>So, who needs and adolescent and young adult (AYA) clinical nurse consultant</td>
</tr>
<tr>
<td></td>
<td>anyway? Case study of an 18 year old diagnosed with osteosarcoma.</td>
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<tr>
<td>15</td>
<td>Contraception after breast cancer: Developing evidence based guidelines</td>
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<tr>
<td>16</td>
<td>Queensland Trophoblast Centre (QTC)</td>
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<tr>
<td>17</td>
<td>‘Tissues in our pocket’ – ‘Collecting bits and pieces’ – The impact of</td>
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<td>providing holistic nursing care</td>
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<td>18</td>
<td>Helping young people deal with the &quot;scary stuff&quot;: An acceptance and</td>
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<td>commitment therapy program for thse impacted by parental cancer</td>
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<tr>
<td>19</td>
<td>Intravascular device management in a tertiary cancer care centre: A</td>
</tr>
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<td>point-prevalence study of nursing practice</td>
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<tr>
<td>20</td>
<td>Self-care support for blood cancer patients suffering from oral mucositis</td>
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<td>due to chemotherapy</td>
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<td>21</td>
<td>Development of learning framework for the novice practitioner in lung</td>
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<td>cancer care coordination</td>
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<tr>
<td>22</td>
<td>Cancer, cultural sensitivity and enhanced patient outcomes</td>
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<tr>
<td>23</td>
<td>CINV Check: An audit of CINV prevention in patients receiving moderately</td>
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<td>emetogenic chemotherapy</td>
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<tr>
<td>24</td>
<td>Assessing the potential value of cancer information resources in e-book</td>
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BREAFAST SESSION 1: CLOSED SYSTEM INFUSION: SAFEGUARDING YOUR HEALTH

While most nurses do recognize the growing evidence for the benefits of closed systems for protection against contamination from cytotoxic drugs, in a cash strapped hospital funding environment, it may be difficult to convince hospital management of the necessity of closed systems. The presenter, Mr. David Ford was Director of Pharmacy and Chairman of the Drugs and Therapeutics Committee for Melbourne Health for 10 years, during which time he oversaw the implementation of closed systems throughout the hospital. His primary drivers for implementing a closed system were protecting staff from contamination and patients from infection risk. The presentation is his experience of creating a successful business case.

BREAFAST SESSION 2: SUPPORTALK CANCER COUNCIL NSW PEER SUPPORT PROGRAMS – CONNECTING WITH OTHERS

Cancer can be an overwhelming experience for everyone involved. And sometimes you just want to talk with someone who understands what you’re going through. However, peer support is sometimes misunderstood and not always valued as a powerful tool in addressing unmet supportive care needs.

That’s why Cancer Council created Supportalk – A community of people affected by cancer, which your patients can connect with online, by phone or in person. It means there’s always someone to share experiences with, for as long as they need to talk.

Come along to this session to find out more about Supportalk.

PLENARY SESSION 1 – WHO ARE WE, WHERE ARE WE GOING AND HOW DO WE GET THERE? ONCOLOGY NURSES: LEADING FROM THE BEDSIDE TO THE BOARD ROOM

Professor Brenda Nevidjon
Professor and Faculty Coordinator of the Health Care Systems Instructional Area, Duke University, USA

Every oncology nurse is a leader but may not always recognize that. This presentation will define several models of leadership, including servant and transformational leadership. Participants will learn about fundamental characteristics of leadership. Contrary to the often held belief that leaders are born, every nurse can develop or strengthen leadership skills and style. Using their leadership skills, oncology nurses can influence the workplace, their health of their community, and national policy related to cancer care. As advocates for patients, oncology nurses use skills of leadership daily. This session will identify how oncology nurses can build upon those skills and use them in other settings.

THE HEART OF THE MATTER – THE EMOTIONAL DIMENSIONS OF CANCER NURSING

Associate Professor Jane Turner
Associate Professor in the Discipline of Psychiatry at the University of Queensland

Recent reports indicate that patients diagnosed with cancer in Australia have the best rates of survival of any country in the world. This has been achieved through early detection, prevention, and advances in treatment. However these advances come at a cost – for patients who often endure intensive and toxic treatments, and for the health professionals who care for them.

For oncology nurses in particular, the ongoing pressure to update knowledge and skills to deliver high-quality care is compounded by the “hidden curriculum”. This “hidden curriculum” is the expectation that nurses will deliver compassionate and dedicated care to patients with increasingly complex needs, that they will demonstrate exemplary interpersonal skills, and be in the front line in responding to the raw emotional distress, grief and anger of patients and their families, especially when faced with adverse outcomes. As this curriculum is hidden, there is no systematic access to focused training or support and no acknowledgement of the associated emotional burden of these roles. This presentation discusses some of the unique stressors facing oncology nurses and considers strategies which might assist in a demanding and constantly changing workplace.

CONCURRENT SESSION A: MODELS OF CARE 1

IMPLEMENTING AN EVIDENCE-BASED MODEL OF ONCO-GERIATRIC CARE

Berry, R. 1, McCarthy, A.1,2, Salkield, G. 1, Bedford, M. 1, Stone, L. 1, Walpole, E.1, Thomson, D. 1
1Princess Alexandra Hospital, Brisbane, QLD, Australia
2Queensland University of Technology, Brisbane, QLD, Australia

Introduction

Older cancer patients should undergo a comprehensive assessment to enable accurate treatment decision-making, and to identify risks so that they can be linked to services that enhance their treatment outcomes.

Aims

We tested a model of nurse-led oncogeriatric care incorporating Comprehensive Geriatric Assessment (CGA). The aim of this presentation is to describe the challenges encountered in implementing the model.

Methodology

175 patients >65 years were assessed by a geriatric oncology nurse prior to treatment using the following instruments: Vulnerable Elders Survey-13; Cumulative Illness Rating Scale (Geriatric); Malnutrition Screening Tool; Standardized Mini-mental State Examination; Geriatric Depression Scale; Barthel Index; and Lawton Instrumental Activities of Daily Living Scale.

Results

We identified several issues with this commonly recommended suite of CGA tools. For example, the Cumulative Index Rating Scale (Geriatric) was logistically troublesome for a non-medical person to use and the Geriatric Depression Scale distressed some patients. Our data indicated that social support, falls risk and muscle strength were also predictors of tolerance to treatment and should be included in the CGA. We further identified the need for screening, however limitations with the VES-13 were apparent and in response a modified screener and CGA were developed.

Conclusion

Robust research guided the development of a nurse-led model of oncogeriatric care. Nurses within such a model have the potential to implement holistic, person-centred care.
References

PRE AND POST GYNAECOLOGICAL CARE OF WOMEN UNDERGOING STEM CELL TRANSPLANT
Hickey, M.1, Ayton, R.1, Giasli, A.1, Jude, J.1
1Royal Women’s Hospital, Parkville, VIC, Australia

Women undergoing stem cell transplant [SCT] for the treatment of haematological malignancies will have numerous gynaecological care requirements both before and following transplantation. Considerations prior to treatment may range from; pre transplant screening, menstrual suppression, pregnancy prevention and fertility preservation. Following transplant concerns may include; management of induced menopause, genital tract graft verse host disease, risk management of secondary cancers, bone health and sexuality.

The Menopause Symptoms After Cancer [MSAC] service is staffed by a multidisciplinary team of gynaecologists, endocrinologists, psychiatrist, psychologist, sexual counsellors and specialist nurses. The MSAC service also works with Bone Marrow Transplant Services at the Royal Melbourne Hospital and Reproductive Services at the Women’s.

MSAC provides care to women before and after stem cell transplantation. All women undergoing allograft SCT are referred and all premenopausal women undergoing autologous SCT. The aim of this guideline was to ensure standardise treatment for these women with unique gynaecological needs based on the best available evidence1.

A review of the literature was undertaken and guidelines developed with expert opinion where literature did not exist. As a result the MSAC service has been able to provide woman centred gynaecological care to compliment treatments for their haematological malignancies.

References:

A PILOT PROJECT TO IMPROVE ACCESS TO CHEMOTHERAPY/BIOThERAPY FOR RURAL PATIENTS: THE TOWNSVILLE TELE NURSING MODEL
Price, S1, Roberts, S2, Bloomfield, A1
1Townsville Cancer Centre, Townville, QLD Australia
2Queensland Health, Douglas, QLD Australia

Background
One-third of Australians diagnosed with cancer live outside metropolitan areas in which tertiary cancer centre cares are located. Rural patients face many challenges in accessing care provided by centres utilising traditional models of care. The aim of this project is to build capacity within a rural hospital service to provide local access to low-risk chemotherapy/biotherapy treatments for patients.

References:

Neulasta® PBS Information: Section 100 listed. Authority required.
Refer to PBS Schedule for full Authority listing.

Further information is available on request from Amgen Australia Pty Ltd.
Amgen Australia Pty Ltd. ABN 31 051 057 428. Level 7, 123 Epping Road, North Ryde NSW 2113.
Telephone: 02 9870 1333. Fax: 02 9870 1344. NO-AUS-AMG-268-2013-March-NP. Date prepared April 2013.
INTRODUCING THE NURSE PRACTITIONER ROLE TO REGIONAL ONCOLOGY PATIENTS

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Introduction
For some time in Australia, it has been recognised that the Nurse Practitioner Role offers feasible and cost effective alternatives to the redesign of health care delivery. To improve outcomes for Oncology patients across all health settings, it is paramount for the Oncology Nurse Practitioner (ONP) to have formal collaboration and partnerships with other health care providers.

Objectives/Aims
This study focussed around identified gaps from Oncologists, GPs and supportive care staff perspectives. Collaborative engagement with internal and external partners and other health service providers determined the ONP model and scope of practice within rural/regional Victoria and Southern Regional New South Wales with the primary aim to improve Oncology patient outcomes.

Methods
A mixed methods design – Gap analysis and Literature Review – was employed by the Oncology Nurse Practitioner; to undertake a needs analysis in the development of the ONP Model of Care.

Conclusions
This ONP model reflects a key strategic objective: To provide access to Quality Specialist Supportive Care for Regional Oncology Patients.

ORAL CHEMOTHERAPY NURSE: A TRIAL POSITION AT SIR CHARLES GAIRDNER HOSPITAL (SCGH), PERTH, WESTERN AUSTRALIA (WA)
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2Curtin Health Innovations Research Institute (CHIRI), Curtin University, Perth, WA, Australia
3School of Medicine and Pharmacology, University of Western Australia, WA, Australia

Introduction
Oral chemotherapy is a growing mode of cancer treatment outstripping the development of policy/procedures to support patients worldwide. Internationally, patients have suffered serious harm and death due to oral chemotherapy errors.

Objectives/Aims
To develop a nursing role that identified areas of patient need, developed processes and collected resources to support patient safety and quality care during oral chemotherapy treatment.

Description/Methodology
The position supported patients with brain tumours taking oral chemotherapy. Observation of current processes, two quality improvement exercises (QI’s) including a Quality Use of Medicines audit 3, searches of academic/grey literature and collaboration with other health professionals was used to develop the role.

Results
Development of a system to educate, monitor and follow-up brain cancer patients. QI’s highlighted gaps in policy and procedure to support patients and led to development of a draft oral chemotherapy policy.

Conclusions
Although this position was not made permanent, the process highlighted needs of patients on oral chemotherapy, and opened a dialogue with health professionals committed to improving the safety and quality of care for these patients.

References

CONCURRENT SESSION B: SUPPORTING HEALTH PROFESSIONALS

THE IMPLEMENTATION OF ROTATING INPATIENT MEDICAL WARD NURSES TO THE CANCER CARE SERVICES DAY UNIT: PROVIDING AND PROMOTING QUALITY CARE TO CANCER PATIENTS IN THE WARD.
Lehn-Van, T
Queensland Health – Nambour Hospital, QLD, Australia

Cancer Care Services at Nambour Hospital consist of an outpatient day therapy unit and an inpatient medical ward. Traditionally, the medical wards were a mix of medical patients. Today, we have a specialty oncology/haematology ward. Five years ago a rotation to the day therapy unit was offered to inpatient nurses who had an interest in oncology to provide better care to cancer patients on the ward.

The objective was to provide nurses with the knowledge, skills and education needed to provide quality care to cancer patients on the ward and to mentor the current inpatient nurses on the ward.

In 2008, an expression of interest was put forth to recruit nurses interested in cancer care to rotate to the day cancer care clinic. Each nurse would then do a three-month placement. The placement involved learning about cancer care through specific modules and working with the patients in the clinic. Competencies were required such as chemotherapy administration, accessing central venous access devices, management of side effects, etc.

Preliminary results of a survey conducted have been positive. Better communication and collaboration are stated from the outpatient nurses. Inpatient nurses stated satisfaction in being able to care for cancer patients by having the knowledge and skills provided in the rotation.

The implementation of the rotation continues today with eight nurses rotating on a monthly basis to the day therapy unit. More nurses have expressed interest in the rotation so as of today it will continue.
INCREASING CANCER NURSES’ WELLBEING: A PILOT STUDY TO IDENTIFY POTENTIAL WORKPLACE STRATEGIES

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3Sir Charles Gairdner Hospital, Perth, WA, Australia
4Edith Cowan University & Sir Charles Gairdner Hospital, Perth, WA, Australia

**Introduction**
Cancer nursing is stressful and burnout is common. The nature of cancer nursing together with work overload, lack of resources and staff shortages contributes to this stress. Accumulated stressors experienced by cancer nurses can exceed their capacity to cope, diminishing the quality of patient care and the retention of experienced nurses in the workforce.

**Aims**
This project aimed to identify potential workplace strategies/activities to enhance the wellbeing of nurses who care for cancer patients on a Haematology/Oncology ward of a Western Australian tertiary hospital.

**Methodology**
A pilot project consisting of two phases: a focus group followed by a survey was undertaken using the Quality Improvement method. A questionnaire was developed using data collected through a focus group together with a review of the literature. A sample of 28 nurses participated in the survey (response rate = 64%).

**Results**
116 participants attended the professional day, with 31% travelling from regional Victoria. The majority were of nursing (56%) and allied health backgrounds (23%) and 65% were referred less than 10 people with brain tumours per year. Delegates rated presentations from 1 to 5 with all speakers rating greater than 4.21. Support for future forums was strong with 100% of delegates indicating they would attend a similar forum if offered next year.

Two staff from Goulburn Valley participated in a placement with the ABTSS, and found it very positive. Surveys conducted 8 weeks post placement indicated improved confidence in identifying needs of people with brain tumours, increased ability to provide practical strategies to assist and seek support.

**Conclusions**
Despite the comparatively small number of people diagnosed with brain tumours, this project demonstrated a strong need for ongoing professional development in this challenging area particularly in regional areas. Through collaboration with Cancer Council Victoria, ongoing planned initiatives include an annual brain tumour clinical professional day and a quarterly newsletter for health professionals.

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STAFF ROTATION FOR CANCER NURSES IN A TERTIARY HEALTH ORGANISATION: AN EVALUATION

**Barratt, C.**
1Royal Perth Hospital, Nedlands, WA, Australia

**Introduction**
A tertiary hospital within Perth, Western Australia has risen to the ongoing challenge of increased service demand and staffing cancer services with nurses possessing the necessary skill set to deliver safe, quality care.

**Objectives**
A well implemented staff rotation has potential to assist with workforce planning, promote professional and clinical development and job satisfaction, reduce stress and improve interdepartmental relationships. The objective of this initiative was to create a more versatile workforce, influencing the ability of the organisation to meet demand for service and improve the quality of nursing care delivered to patients with cancer.

**Description/methodology**
Workforce planning issues, encompassing recruitment and retention were addressed to ensure delivery of cancer services was safe and able to meet demand. Methods employed included application of a flexible and dynamic approach to staffing, and a structured support system to facilitate staff development. These were deemed essential to promote and validate the change and improve staff cooperation and motivation. Nurses who participated in the rotation and managers had opportunity to complete a questionnaire to evaluate benefits, difficulties and provide suggestions for improvement.

**Results**
This initiative demonstrated clear benefits to staff and the organisation. Rotation through cancer care services has provided nurses with a broader skill set and an increased scope of understanding of the cancer disease trajectory which they are able to apply to patient care.

**Conclusion**
The presentation will outline the process followed to facilitate the project and provide a summary of the project evaluation.
Aims
To enable safe quality care delivery, staff have commenced the antineoplastic drug administration course (ADAC) developed by the Cancer Institute NSW. The blended program has been well received highly praised by the participants.

It was identified that five staff per site would be required to undertake the education program to ensure continuity of service delivery. The majority of participants are not cancer care nurses and they have been supported to successfully achieve the course requirements through clinical placement at tertiary cancer services. The networks established during clinical placement and workshop continues to provide support to the participants.

To enable the participants the opportunities required to achieve competencies a multifaceted approach with support is required across sites to ensure a positive learning and teaching experience. Rural nurses are inventive and willing to support their community to provide safe quality care so treatment is provided locally.

Conclusion
To date 65 nurses 57 have completed the online component of ADAC. The rural nurses have embraced the blended learning. The changes have been impressive with standardised practices and policies developed including equipment, unit setup and training. Recognising the importance of developing supportive relationships and allocating time for education has contributed to developing a culture of support in the workplace.

CONCURRENT SESSION C: QUALITY AND SAFETY

‘IT’S TIME TO CHANGE’. A FACILITATOR’S EXPERIENCE IN IMPLEMENTING A STANDARDISED APPROACH TO CHEMOTHERAPY TRAINING

Cussans, L., Walsh, A.
The Royal Adelaide Hospital, Adelaide, SA, Australia

Introduction
A diagnosis of cancer is life changing and it is imperative that a patient’s cancer journey is optimised through standardised comprehensive care. The South Australian Cancer Control Plan 2011-2015 discusses ‘...key areas of focus surrounding optimising care, service development, workforce and quality...’ (2011, p 2) The standardisation of chemotherapy training and competence of the cancer nursing workforce across South Australia is vital to successfully achieve this.

Objectives/Aim
The implementation of the State- wide Chemotherapy Education and Assessment Program in a major tertiary teaching hospital. The Antineoplastic Drug Administration Course (ADAC) developed by Cancer Institute of New South Wales (CINSW) was utilised.

Description
The release of a full time Clinical Practice Consultant was pivotal for the facilitation of the program’s blended training, including clinical learning and competency assessment. This was provided to approximately 85 experienced and 40 novice cancer nurses within the Royal Adelaide Hospital. Support to other sites including country was also given.

Results
To date, 60 experienced and 15 novice cancer nurses have completed the program. Whilst initial feedback through evaluations has been positive; barriers influencing the facilitation of clinical learning and competency assessment include staff availability and motivation.

Conclusions
While successfully initiated, this is an ongoing process requiring further consideration to ensure competence is maintained, future training/ support needs identified, the provision for ongoing facilitation to new cancer nursing staff is implemented and ‘quality and safety’ aspects are addressed.

References

THE ROLE OF THE NURSE IN PATIENT EDUCATION AND FOLLOW UP OF PEOPLE RECEIVING ORAL ANTI-CANCER TREATMENT: AN AUSTRALIAN SURVEY

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Introduction
The use of oral anti-cancer treatment (OCT) is increasingly common. Recent clinical incidents highlighted safety challenges the use of OCT pose to both health care workers and patients. These challenges include new toxicity profiles and compliance issues. Whilst not new, these challenges are especially relevant to nurses who are frequently the provider of patient education, toxicity management and follow up.

Objective
A national cross sectional survey was undertaken to assess the nursing role in education and follow up of patients who are taking OCT.

Methodology
A Multinational Association of Supportive Cancer Care (MASCC) survey was reproduced with permission, and 4 questions were included to capture the use of the MASCC Oral Agent Teaching Tool and other patient education materials in use in Australia. The survey was distributed to members of the Cancer Nurses Society of Australia (CNSA) with snowball sampling survey data was downloaded and analysed using descriptive statistics. This study had ethics approval.

Results
A total of 180 responses to the survey. The survey results highlighted variation in processes for providing information about OCT to patients. Historical pathways for establishing contact with patients receiving intravenous chemotherapy are now bypassed by patients receiving OCT alone and nurses are confronted with new side effect and symptom management profiles associated with novel OCT.

Conclusion
Workflow, organisational processes and resources have not kept pace with increasing use of OCT in cancer treatment. This exposes patients to increased risk of harm that the role of nurses may mitigate.

References

PRACTICE DEVELOPMENT AND NURSING TRANSFER FORM (NTF) INNOVATION

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National Safety and Quality Health Service Standards (2013) provide 10 standards to improve healthcare services safety and quality of care. A Nursing Transfer Working Group (NTWG) in an inpatient oncology unit has developed improved clinical handover systems by implementation of a nursing transfer form to improve the transfer of professional and accountability of patient care from one ward to another professional group. Analysis of electronic incident management systems highlighted increased patient risk and adverse events during inter and intra-hospital transfers; due to lack of transfer information.
The NTWG analysed evidence based literature on patient transfer systems to design a standardised form in transferring a patient’s physical and psychological aspects of care. The new format was developed utilising a patient centred care approach based on the Introduction, Situation, Background, Assessment, Recommendation (ISBAR) tool utilised at the Royal Hobart Hospital. Risk assessment information including falls, infection control, allergies, relevant patient history, care goals, family situation and psychological safety transfer means within multidisciplinary fields were reviewed.

The form was trailed in an inpatient oncology ward for four weeks and surveys were emailed to staff requesting comments on efficiency, useability and suggestions. The draft was adjusted accordingly and re-presented to the Quality Improvement Unit for hospital wide distribution.

New standardised processes for patient transfer accountability have resulted in improved safety and quality of patient care transfers to another professional group; of information sets. This has resulted in reduced nursing time, reduced expenditure of medications, wound care dressings, decreased adverse events and increased patient safety.

**EVALUATION OF AN EDUCATION PROGRAM TO FACILITATE PATIENT ADHERENCE, TOXICITY MONITORING AND PROMOTE SAFETY IN THE SELF-ADMINISTRATION OF ORAL CHEMOTHERAPY IN THE HOME SETTING**

**Griffiths, T.1, Pascoe, L.2**

1 Austin Health/Olivia Newton John Cancer & Wellness Centre, Heidelberg, VIC, Australia  
2 LaTrobe University, Bundoora, VIC, Australia

**Introduction**

The use of oral chemotherapy as a cancer treatment is increasing (Hede 2009), with patients expected to self-administer them (Goodin et al. 2007). While self-administration in the home setting offers advantages to patients (Simchowitch et al. 2010), it poses significant challenges for health care professionals, many of which revolve around adherence, toxicity monitoring and safety issues (Halfdanarson & Jotoi 2010). In this study, patients prescribed oral chemotherapy, received education and follow-up support from the Chemotherapy Nurse Coordinator (CNC) at the Olivia Newton-John Cancer and Wellness Centre, Melbourne Victoria.

**Aim**

Evaluate an education program to facilitate patient adherence, toxicity monitoring and promote safety of oral chemotherapy in the home setting.

**Methodology**

Cancer patients (N =15) prescribed oral chemotherapy received education about their treatment using a teaching tool developed by The Multinational Association of Supportive Care in Cancer (MASCC)™. The patient’s supportive care needs were assessed using the Distress Thermometer (DT).

A modified version of the MASCC questionnaire was administered pre and post education to assess the patient’s knowledge about their oral chemotherapy, safe storage and handling, and associated toxicity issues. A follow up phone call to the patient one week later addressed issues relating to the education program. The patient also completed the DT.

**Results**

Analysis of findings is yet to be performed. The intention is to identify associations between patient self-management of oral chemotherapy and well-being. Limitations are small sample size.

**Conclusion**

Tailored education programs may facilitate medication adherence, toxicity management and enhance patient’s well-being.

**CONCURRENT SESSION D: WORKSHOP: IMPROVING CANCER PAIN OUTCOMES**

**Lovell, M.1, Agar, M.1, Phillips, J.L.2, Luckett, T.3, Boyle, P.4, Green, A.4, Davidson, P.M.5, Stubbs, J.6**

1 HammondCare, Sydney NSW, Australia  
2 The University of Notre Dame, Australia and The Cunningham Centre for Palliative Care, Sydney, NSW, Australia  
3 Improving Palliative Care through Clinical Trials: ImPacCt, Sydney  
4 The Patricia Ritchie Centre for Cancer Care and Research, Mater Hospital, Sydney, Australia  
5 University of Technology Sydney, Australia  
6 CanSpeak: Cancer Consumer Group, Australia

This 90 minute interactive workshop will provide cancer nurses with an opportunity to explore the needs of people living with cancer and their families in addressing the burden of cancer related pain. It will assist with identify barriers and facilitators to cancer pain management at the local level from the patient, provider and health care system perspectives. A review of current evidence based recommendations for cancer pain management, both pharmacological and non-pharmacological will be provided, along with key recommendations for improving cancer pain management using patient-centred approaches. Participants will be introduced to the recently released Australian Cancer Pain Guidelines and be provided with an opportunity to shape the dissemination and implementation strategy to promote their uptake at the local and national level.

**CONCURRENT SESSION E: EDUCATION**

1+1=3? COMBINED NURSING AND ALLIED HEALTH EDUCATION: MORE THAN THE SUM OF ITS PARTS

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1 Central Integrated Regional Cancer Service, QLD Health, Brisbane, QLD, Australia

**Background**

Central Integrated Regional Cancer Service (CIRCS) aims to improve access to integrated, quality, safe care for people affected by cancer with patient centred care as the guiding principle. CIRCS catchment spans 561, 824 Sq Km and 1.6 million people (2008), 52% of whom live in regional or rural locations. The introduction of regional cancer centres throughout Australia has identified the need for widespread and equitable access to innovative education programs for both nursing and Allied Health Professionals (AHP’s) regardless of geographical location.

**Objective**

The CIRCS Nurse Educator and Allied Health Workforce Development Officer collaborated to identify how a suite of cancer education resources could be adapted and jointly delivered to enhance professional development opportunities for both professional groups.

**Outcomes**

- Development and delivery of cancer care workshops and information sessions for nurses and AHP’s at metropolitan, regional and rural facilities
- Commitment to regional and rural facility site visits to provide a specialty resource
- Broad workshop content, discussion and learning outcomes reflecting the audience diversity
- Shared learning experiences, acknowledgement and appreciation of each other’s roles and contribution to care for people affected by cancer.

**Conclusion**

This collaboration demonstrates the collective benefits of an inter-professional partnership and has embedded a culture of patient and family focused care from the classroom to the clinical context. The evolution of this partnership has challenged the rigidity of professional demarcations that limits role innovation and scope of practice.
CAN A NOVEL ON-LINE PAIN ASSESSMENT LEARNING MODULE IMPROVE SPECIALIST PALLIATIVE CARE NURSE’S PAIN ASSESSMENT KNOWLEDGE?: RESULTS FROM A PILOT SPACED EDUCATION INITIATIVE

**Phillips, J.L.¹, Heneka, N.² Hickman, L.D.³, Lam, L.⁴, Shaw, T.⁵**

¹The University of Notre Dame, Australia and The Cunningham Centre for Palliative Care, Sydney, NSW, Australia
²The Cunningham Centre for Palliative Care, Sydney, NSW, Australia
³University of Technology Sydney, NSW, Australia
⁴The Hong Kong Institute of Education, Hong Kong SAR, CHINA
⁵Sydney University, Sydney, NSW

**Background**
Managing complex pain is core business for specialist palliative care services and nurses play a key role in this process. Despite, guidelines recommending routine pain screening, assessment and reassessment practices, there is often sub-optimal evidence of this occurring, which impact on pain management.

**Aim**
To test the impact of a novel on-line learning pain assessment module on specialist palliative care nurses pain assessment knowledge, attitudes and practices.

**Methods**
Survey and chart audit data was collected at four time points: baseline (T1), immediately post intervention (T2), eight weeks (T3), and sixteen weeks (T4)*. The survey assessed changes in pain assessment knowledge and attitudes, while the chart audit appraised the quality of pain assessment documentation.

**Results**
Participants (n=74), predominately registered nurses (82%) working in two specialist palliative care services enrolled to complete the pain assessment module.

Overall pain assessment knowledge increased post intervention: [T1] (x̄ 7.23, SD±1.49); [T2] (x̄ 8.07, SD±0.94); and [T3] (x̄ 8.22, SD±0.94). Pain assessment confidence increased from T1 to T2 (x̄ 7.38 vs. 8.74). This improvement was reflected in the chart audit data, where pain assessment documentation increased from T1 to T2 (x̄ 2.48 vs. 4.20 per admission), with the majority (87%) of pain assessments undertaken by intervention participants at T3.

**Conclusion**
This pilot study suggests that Spaced Education is a potentially effective format for delivering specialised clinical content that may translate into practice change. A larger adequately powered study is required to confirm these observations.

* T4 data collection in progress

EDUCATIONAL RESOURCES, CAN STANDARDISATION BE ACHIEVED?

**Pile, H.M**
Royal Adelaide Hospital, Adelaide, SA, Australia

**Introduction**
In response to the South Australia Health directive the State-wide Framework – Chemotherapy Education and Assessment program was established. The Cancer Institute NSW eviqEd Anti-neoplastic Drug Administration Course (ADAC) was implemented across SA utilising four different Learning Management System (LMS), endorsement of the project by the Nursing and Midwifery Office SA facilitated nurse leader engagement.

**Objectives**
Engagement with nursing leaders ensured participants were released from clinical areas to undertake the online learning activities, workshop and clinical competencies, this has been essential in the success of the project.

**Description**
Access to dedicated Cancer Nurse Educators is not available in the majority of instances; therefore it was essential to enlist nurses with a passion for education and willingness to learn the facilitator
role Identifying areas for improved cancer nurse learning and establishing potential clinical nurses with a portfolio of education, to act as facilitators willing to provide support to the program encouraged ownership of the education being provided and utilisation of facilities protocols, forms and experiences.

Results
To date approximately 280 nurses have completed the online component of the course with 96 having completed all elements of the program. Workshops have been evaluated and consistently demonstrate positive feedback. Both experienced chemotherapy and novice nurses have reported a high level of satisfaction with the course and most conclude a higher level of confidence in the handling and administration of chemotherapy.

Conclusions
Collaborative work between the project manager and the facilitators has enabled the workshops to be run in a standardised format. Support and timely assessment of staff ensures the project achieves key deliverables.

DEVELOPMENT OF A CANCER EDUCATION FRAMEWORK FOR THE GRAMPIANS REGION
McIntyre, R.
‘Grampians Integrated Cancer Service, Ballarat, VIC, Australia

Introduction
A strategic goal of the Grampians Integrated Cancer Service (GICS) is to implement a regional approach to workforce planning including recruitment, retention and basic training.

Aim
Develop a cancer education framework in the Grampians region for health care professionals to access basic training in cancer care.

Method
A project officer from GICS was engaged to research and prepare a cancer education framework for health care professionals in the Grampians region.

The project included the following methodology:
- A review of the literature in adult education and education methodology
- Consultation with peak cancer bodies to establish best practice in cancer care and available learning resources
- Consultation with local health education services to establish existing infrastructure in the Grampians region
- Distribution of a learning needs survey to health care professionals

Results
A cancer education framework has been proposed and accepted for development by the project steering committee based on evidence obtained through a review of the literature, stakeholder consultation and results of the learning needs of 164 respondents.

The framework will be incorporated into existing educational infrastructure with the integration of online education through the regional e-learning platform, the development of a post graduate certificate in clinical oncology nursing in collaboration with Aquinas Catholic University and the future employment of a cancer nurse educator to support clinical education across the Grampians region.

Conclusion
The cancer education framework for the Grampians region will help to reduce unwanted variation in clinical practice, promote consistency in cancer care and improve clinician access to basic education.

CONCURRENT SESSION F: PRACTICE IMPROVEMENT 1
AN EDUCATION PACKAGE TO SUPPORT THE NURSING MANAGEMENT OF CUTANEOUS TOXICITIES ASSOCIATED WITH TARGETED CANCER THERAPIES.
Condon, M.
St John Of God Hospital Murdoch, Karawara, WA, Australia

Introduction
The use of newer targeted cancer therapies, including tyrosine kinase inhibitors (TKI) and epidermal growth factor receptor inhibitors (EGFRI) in the solid tumour groups, is bringing a complex suite of cutaneous side effects. Whilst not systemically as toxic as some traditional chemotherapy agents, their cutaneous side effect profiles may have a considerable impact on the patient and their health-related quality of life.

Aims
A literature review was conducted in order to establish evidence based guide for the nursing management and associated patient education for those who are experiencing cutaneous toxicities as a result of this treatment with TKI and EGFRI agents. The tumours that have been reviewed include breast, colorectal, pancreas, lung, head and neck and renal cell, which over express the receptors that will be targeted by these agents.

Conclusion
This evidence was collated into a learning package for nurses to assist in improving their knowledge and in turn may impact on the patient through knowledge of ways to achieve a reduction of symptoms and assistance with self-management. This may be associated with an improved quality of life related to the reduction of symptoms.

UNPLANNED ONCOLOGY ADMISSIONS WITHIN 14 DAYS OF DISCHARGE: A RETROSPECTIVE REVIEW
Gibson, S.
St John Of God Hospital Subiaco, Perth, WA, Australia

Aims
To identify the incidence, causes, risk factors and interventions for cancer patients requiring unplanned admissions within 14 days of discharge at a large metropolitan private hospital without a co-located emergency department.

Methods
Retrospective data were collected regarding cancer patients who had an unplanned admission within 14 days of discharge during the period December 1, 2011 and May 31, 2012. Data were collected from the Inpatient Bed Administration (IBA) database and medical record review. Variables collected included demographics, cancer diagnosis, reasons for admission, interventions, admission pathways and length of stay.

Results
133 oncology patients required 206 unplanned admissions. The most common cancer diagnoses associated with unplanned readmission were upper gastrointestinal (25.4%), colorectal (19.6%), gynaecological (18.8%) and breast (13.8%) cancers. The symptoms most commonly associated with unplanned readmission were pain (16%), infection not associated with neutropaenia (15.5%), fever and febrile neutropaenia (14.6%), nausea, vomiting and dehydration (13.6%), dyspnoea (8.3%) and altered neurological status (7.8%). The median length of stay was 6 days.

Conclusion
Cancer patients are at a significant risk of requiring unscheduled care and admission. Strategies and services to limit the burden on patients and the health care system should be reviewed to minimise the need for unplanned admission.
**Key Words**
Cancer · Oncology · Chemotherapy · Unplanned admissions · Toxicities · Emergencies

**PROFESSIONAL DEVELOPMENT NEEDS OF PROSTATE CANCER SPECIALIST NURSES**

**Sykes, J.1, Langbecker, D.2, Waters, L.1, Carnew, L.2, Yates, P.2**

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2Institute of Health and Biomedical Innovation, Queensland University of Technology, QLD

**Introduction**
The role of Prostate Cancer Specialist Nurse (PCSN) is relatively new in Australia. A 3-year program established by the Prostate Cancer Foundation of Australia to implement the role will measure its impact on the patient and the Australian healthcare system.

**Objectives/Aims**
This research phase aimed to identify the priority areas for continuing professional development of thirteen nurses newly recruited into the PCSN role.

**Description/Methodology**
At baseline, nurses responded to an online questionnaire to determine the scope of their previous experience and gauge levels of self-assessed professional competencies.

**Results**
All nurses working in the role completed the questionnaire. Most (n=8) had previously worked as a specialist nurse; approximately half completing further education in the field of urology (n=6) or cancer care (n=7). Nurses rated their level of competency on a five-point scale (novice; advanced beginner; competent; proficient; expert) in four areas: provision and coordination of care; collaborative and therapeutic practice; professional practice; critical thinking and analysis. For most criteria, nurses rated their current level of expertise as ‘competent’ or ‘proficient’. The three areas nurses most frequently nominated as having lower levels of competency (novice or advanced beginner) were: understanding the implications of participation in cancer clinical trials; knowledge of risk factors, genetics and prevention strategies; contribution to prostate cancer nursing research.

**Conclusions**
The appraisal of self-assessed professional competencies highlights several areas where nurses feel there is scope for improvement in their knowledge or skills. One priority area for continuing professional development is enhancement of understanding and application of evidence-based research.

**COST BENEFIT ANALYSIS OF CAPECITABINE VS INFUSIONAL SFU IN RECTAL CANCER PATIENTS AT ILLAWARRA SHOALHAVEN LOCAL HEALTH DISTRICT**

**Bell, G.1**

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Rectal cancer is a common cancer in New South Wales. Preoperative chemoradiotherapy has been established as the standard treatment in locally advanced rectal cancer.

Recent literature has shown that Capecitabine is non-inferior to 5-fluorouracil/leucovorin (SFU/LV) in rectal regimes. Despite these reports, due to the higher unit cost of Capecitabine, infusional SFU combined with radiotherapy has continued to be the standard care for locally advanced rectal cancer at our facility.

A review of the literature highlighted that the majority of patients, if given the choice, would prefer oral over infusional chemotherapy. Furthermore, significant cost savings to health services have also been exhibited with the preferential use of capecitabine over infusional SFU/LV. Additionally, the central lines required for infusional treatment have been associated with significant complications and morbidity.

Our centre decided to conduct a retrospective study identifying all locally advanced rectal cancer patients treated concurrently with SFU/RT for evidence of central line complications. An average cost per patient of complication was then added to the predicted costs involved for infusional SFU. A cost benefit analysis was then attended on the difference between this total and that of the cost if patient had commenced on Capecitabine.

The cost differential between Capecitabine and SFU CIV via PICC was projected to be $583.22 per patient. The cost differential between SFU CIV via portacath was projected to be $1733.46 per patient. The combined projected cost savings due to a change in practice would provide the Local Health District with a saving of approximately $12,333 per year.

**EXPLORING REASONS FOR EXTENDED LENGTH OF STAY IN OLDER CANCER PATIENTS**

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2Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Victoria, Australia.

**Introduction**
Cancer and its treatment can have significant negative impact on the functional and cognitive capacity of older people.

**Aim**
To identify reasons for extended length of stay (ELOS) in older cancer patients (aged over 70 years).

**Methodology**
Following ethical approval, a retrospective, medical case note review was undertaken for patients treated as inpatients at a Victorian cancer centre between January 2010 and January 2012. ELOS was defined as an admission lasting longer than the state mandated high boundary for the Australian Refined Diagnostic Related Group (AR-DRG). Medical case note data retrieved included: age, diagnosis, treatment intent, co-morbidities, reasons for ELOS, supportive care needs, social support, next of kin, place of residence and outcome post admission.

**Results**
During 2010-2012, 2267 new patients aged 70 years were admitted for treatment. Length of stay ranged from 1 to 162 days (≥70 years) and 47 patients (2.07%) had a LOS over the high boundary for their AR-DRG. The mean number of co-morbidities was 6 (range: 1-14). The top three reasons for ELOS in the ≥70 year age group included nutritional and electrolyte imbalance (n=25); complexity of discharge planning (n=19) and treatment and co-morbidity related complications (n=18). Comparative data for 18-69 year old cancer patients (aged over 70 years).

**Conclusion**
The introduction of a standardised approach to comprehensive geriatric assessment at point of referral has potential to reduce ELOS for elderly patients, with particular reference to enabling comprehensive discharge planning.

**CONCURRENT SESSION G: IMPROVING THE SYMPTOM EXPERIENCE**

**EVALUATION OF AN ACUPUNCTURE SERVICE IN A DAY ONCOLOGY UNIT**

**McKeon, C.1,2, Hardy, J.1, Smith, C.2, Chang, E.2**

1Mater Adults Hospital, South Brisbane, QLD, Australia  
2University of Western Sydney, Campbelltown, NSW, Australia

**Introduction**
Research has shown acupuncture to be beneficial for symptoms and side effects of cancer and its treatment.
Objectives/Aims
Evaluate benefit and safety of acupuncture service for patients in day oncology unit.

Description/Methodology
The evaluation of the service consists of a questionnaire completed after 4 to 6 treatments, covering symptom/s treated, benefits, adverse events, should the service continue, use of other complementary medicine and qualitative data and the use of MYCaW (Measure Your Concerns and Wellbeing)2 a validated tool designed for evaluating complementary therapies in cancer support care using a patient centred approach. 112 patients consented to participate in the evaluation. Patients were approached when they first requested the acupuncture service.

Results
A total of 1286 treatments were performed in 12 months. The most three common diagnoses were breast (41%), ovary/cervix/uterus (33%) and colorectal (11%), female (88%) and male (12%). MYCaW results showed mean change in concern1 of 1.795 (95% CI 1.405 – 2.185, p=0.000) and concern2 of 1.514 (95% CI 1.103 – 1.926, p=0.000), which was clinically and statistically significant, wellbeing, not significant.

Conclusions
Nearly all patients received some benefit and wanted the service to continue. Overall the service was well accepted with minimal minor adverse events.

References

VEMURAFENIB – TREATMENT AND NURSING MANAGEMENT OF SIDE EFFECTS
Burrell, H.1 Milne, D.1, Davidson, J.1, Heart, R.1, Russel, C1
1Peter MacCallum Cancer Centre, East Melbourne, VIC, Australia

Background
Melanoma is the 3rd most common cancer in Australia; 50% of this population has a BRAF genetic mutation. Vemurafenib is a BRAF inhibitor and is proven to extend life in stage 4 disease. Vemurafenib is generally well tolerated however has specific side effects that need prompt intervention. These side effects include photosensitivity, skin rash, fatigue uveitis, and secondary non-melanoma skin cancers. Novel therapies such as Vemurafenib present many patient management issues in which nurses play a vital role.

Purpose
The treatment of cancer continues to evolve. Traditionally, cancer is treated with chemotherapy. Today’s first line treatment includes targeted therapies, like Vemurafenib. The treatment and management of these novel targeted treatments is an opportunity for nurses to become involved in patient care and advance their scope of practice.

Methods
Nursing management of patients receiving targeted therapies include implementing treatment specific interventions to prevent, minimise and manage treatment side effects. These interventions begin with a baseline assessment of patient needs and their understanding of the treatment and it’s side effects followed by education. Specific intervention depends on side effect present e.g. full skin examination for non-melanoma skin cancers. It is also in the area of side effects management that nurses can expand scope of practice e.g. Skin biopsy if non-melanoma skin cancers.

Discussion
Treatment of patients with cancer takes a team. Nurses are a vital resource in the safe management of patients having novel treatments with complex side effects.

EVALUATING THE ROLE OF SPECIALIST NURSES IN SUPPORTING CANCER PATIENTS WITH BREATHLESSNESS
Zhao, I1 Yates, P1
1Queensland University of Technology, Brisbane, QLD, Australia

Introduction
Breathlessness is one of the most common symptoms experienced by cancer patients, which has an impact physically, emotionally, psychologically, and socially. Despite growing evidence about the benefits of nurse-delivered non-pharmacological interventions in managing this symptom, patient experience of breathlessness is not well managed.

Aim
To evaluate the practices of specialist cancer nurses and their self-ratings of competencies in breathlessness management.

Methodology
Online survey was conducted with members from the Australia and New Zealand Lung Cancer Nurses Forum.

Results
Twenty-six cancer nurses responded to the survey. Twenty nurses (80%) have had formal qualifications in cancer nursing, and seven (28%) have had specialist training in lung cancer. Nearly all respondents identified that they provided care to patients beyond the initial treatment phase.

Fifteen nurses indicated they provided education on breathlessness management for cancer patients in the past 12 months. Only 40% of these nurses indicated they conducted detailed assessment of dyspnoea once or more times weekly/monthly, and less than one third of these nurses taught patients about behavioral interventions to manage dyspnoea (relaxation, visualization, lower chest breathing, altering breathing rhythm) once or more times weekly/dayly. Over half of the respondents rated their competency levels in teaching relaxation techniques, lower chest breathing and altering breathing rhythm to be less than “competent”.

Conclusions
Responses showed large variation in symptom management practices. These findings highlight the potential benefits of new models of care and professional development programs which support implementation of evidence based interventions.

MANAGEMENT OF FUNGATING WOUNDS IN THE RADIATION TREATMENT UNIT: IS A STANDARDISED APPROACH FEASIBLE?
Mann, J.1, Blades, R.1, Campbell, J.1
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Introduction
Effective management of fungating wounds present complex challenges for clinicians and patients. These wounds have devastating impacts on multiple dimensions of the patient’s life. Care of these wounds can be ad hoc, ineffective, too complex for self-management and costly.

Aims
The aim of these case studies was to trial a standardised wound care protocol for fungating wound management in a radiation treatment unit. Underpinning this was quality of life improvement for patients with life limiting diagnosis, whilst utilising evidence based wound care principals.

Description
A wound care protocol utilising products containing betaine and polyhexamethylene biguanide, use of a hydrophobic gauze to bind pathogens, combined with a highly absorbent outer dressing
CONCURRENT SESSION H: IMPROVING THE PATIENT & FAMILY EXPERIENCE

PREDICTORS OF DISTRESS AND UNMET NEEDS AMONGST ADOLESCNETS AND YOUNG ADULTS WHO HAVE A PARENT WITH CANCER

McDonald, F. E. J., 1 Patterson, P. 1 White, K. J., 2 Butow, P. 3,4, Bell, M. L. 3

1CanTeen Australia, Sydney, NSW, Australia
2Cancer Nursing Research Unit, Sydney Nursing School, The University of Sydney, NSW, Australia
3Psycho-Oncology Co-operative Research Group (POCoG), The University of Sydney, NSW, Australia
4Centre for Medical Psychology and Evidence-based Medicine (CeMPED), The University of Sydney, NSW, Australia

Introduction
Young people who have a parent with cancer experience disproportionate levels of psychological distress and unmet needs.

Objectives/Aims
In this study we examined the role of demographics, cancer variables, and family functioning in predicting the levels of distress and unmet needs amongst young people who have a parent diagnosed with cancer.

Description/Methodology
Young people aged 12 – 24 who have a parent with cancer (n=256) completed the Offspring Cancer Needs Instrument (OCNI) to measure needs, the Kessler-10 (K10) to measure distress, and the Family Relationship Index (FRI) to measure family functioning. The level of communication between the parents and children was also measured, along with demographics and cancer variables. Predictors of distress and unmet needs were assessed using multiple linear regression and by fitting three models (demographics, cancer variables, and family functioning). Age and gender of the young person were included in all models.

Results
Being female and older increased distress but had no impact on levels of unmet needs. Amongst demographic variables, having a father with cancer increased both unmet needs and distress. Amongst cancer variables, a shorter time since diagnosis and occurrence of relapse increased both unmet needs and distress. Amongst family functioning variables, poor family functioning increased unmet needs and a moderate level of communication from parents decreased distress.

Conclusions
Identifying factors which increase the risk of distress and unmet needs assists in identifying at risk young people and also tailoring support to reduce these risks where possible.

ONCOLOGY NURSES FAMILY ASSESSMENT PROCESSES: AN INVESTIGATION OF CURRENT PRACTICES.

Coyne E, Grafton E, Reid A, Marshall A
Griffith University, QLD, Australia

Introduction
The aim of this study was to investigate the oncology nurse’s use of a family framework in the provision of family support. Family is the main source of support when an adult is diagnosed with cancer, although family members are often left out of the patient assessment process. The oncology nurse is the key point of contact for the patient and the family but may not have the time or expertise to conduct family assessments to inform adequate and appropriate support and guidance for family members.

Method
A descriptive study was used to examine oncology nurses practices in relation to family assessment. Focus groups [N=20] were conducted with the different levels of oncology nurses [N=50] across the three Queensland metropolitan hospitals. The focus group size depended on the constraints of the clinical areas. A thematic analysis was undertaken to identify common themes in the data.

Results
Family assessment was completed informally across the treatment period, often occurring when family rapport was established. Experience and time required to complete family assessment were highlighted as issues which influenced nurses’ ability to engage the family in the assessment process. Nurses felt their responsibility was to identify concerns and refer to allied health practitioners for follow-up.

Conclusion
Whilst family are included in discussions and general assessment by oncology nurses, this is often completed informally with little structure and documentation. The development of opening phrases and a structure for assessment could assist oncology nurses in the promotion of appropriate family support.

CANCER COUNCIL WA: BUILDING EFFECTIVE CANCER SUPPORT GROUPS PROGRAM

Kruger, D1, Good, L1, Watts, K2
1Cancer Council WA, Perth, WA, Australia
2Cancer Council WA, Perth, WA, Australia; University of New South Wales, Sydney, NSW, Australia

Introduction
Cancer Council Western Australia’s (CCWA) Regional Cancer Support Coordinators (CSCs), most of whom have a nursing background, connect people and facilitate cancer support groups (CSGs).

Objectives
CSGs conducted according to best practice are associated with improved quality of life and psychosocial adjustment (Herron, 2005). CCWA reports three strategies designed to ensure appropriately run CSGs: (1) clear policies for the conduct of CSGs; (2) formal training for CSG facilitators; and (3) monitoring CSGs by collecting client data.
Connecting Cancer Care

A NEW ONLINE SUPPORT SERVICE FOR YOUNG PEOPLE LIVING WITH CANCER

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1CanTeen Australia, Sydney, NSW, Australia

Introduction

Young people who are impacted by cancer, either directly or due to the diagnosis of a family member, have significant psychosocial unmet needs. They are at heightened risk of developing serious and sustained mental health difficulties, as well as having a reduced capacity to seek support. There is currently a major gap in the provision of early intervention, prevention and support services for these young people.

Objectives/Aims

This paper describes the need for, and development of, an online one-stop shop for young people living with cancer (yplwcc) - the YPLWC E-Mental Health Service.

Description/Methodology

This model of care comprises of an innovative and comprehensive online platform providing information, peer support, a range of online interventions and access to counselling. The development of referral pathways will be a priority.

Results

The YPLWC E-Mental Health Service will contribute to Australia’s National Research Priority of Promoting and Maintaining Good Health and addresses three of the eight priority areas identified in the Australian Government’s 2010 National Strategy for Young Australians, namely; improving the health and wellbeing of young people, supporting young Australians within their families, and strengthening early intervention with young Australians to help prevent problems getting worse and to help young people get their lives back on track.

Conclusions

It is anticipated that young people who take part in the YPLWC E-Mental Health Service will be better equipped to manage their psychosocial wellbeing in relation to their own or their family member’s cancer and other difficult life circumstances.

PLENARY SESSION 2 - DEBATE: DOES PALLIATIVE CARE HAVE A PLACE IN HAEMATOLOGY?

Moderator: Professor Ross Young, Executive Dean, Faculty of Health, QUT

This will be a stimulating debate on a subject that is topical and controversial. The debating panel will include a Palliative Care Physician, an ethicist, a nurse practitioner and a haematologist.
**Abstracts**

**SATURDAY, 27 JULY**


Supported by:

EGFR TKIs are now used routinely in NSCLC patients whose tumour has a mutation in the epidermal growth factor receptor. Whilst these oral agents have altered the prognosis for these lung cancer patients profoundly, we all understand that they can also cause a multiplicity of side effects. Mary Duffy will discuss these problems, and give us some strategies and tips to help your patients manage them. You may have some thoughts which you can share as well...

**BREAKFAST SESSION 4: OPTIMISING PATIENT OUTCOMES IN ADVANCED PROSTATE CANCER: A PROACTIVE MANAGEMENT APPROACH**

Supported by:

Nurses play a pivotal role in educating advanced prostate cancer patients about the physical and psycho-ontological issues related to their cancer and its treatment. In particular, early education of patients and their carers regarding identification and management of treatment-related side effects may improve their preparedness to contend with these should they occur. Informed patients and carers are better positioned to deal with short- and longer-term side effects. Furthermore, these patients may be more likely to make effective treatment decisions at any subsequent treatment phases and be less inhibited by any negative psycho-ontological impact of their previous treatment regimens.

Join a faculty of leading Australian cancer nurses at this interactive symposium to consider effective education and side effect management strategies for advanced prostate cancer patients. Share your experience about how the psychological impact of prostate cancer treatment side effects may be minimised by proactive identification and management. This symposium presents an exciting opportunity to discuss how cancer nurses can work alongside all healthcare professionals to strive for a connected, multi-disciplinary approach to cancer care and better outcomes for patients.

**PLENARY SESSION 3: FUTURE CHALLENGES FOR HEALTH PROFESSIONALS SURROUNDING CANCER GENOMICS**

**Dr Kim Alexander**, Lecturer, QUT

**Mr Dan Mellor**, Deputy Director of Pharmacy, Peter MacCallum Cancer Centre

Biomarkers are currently used in the detection, diagnosis and treatment of cancer. There is also a growing body of evidence and progress in genomic research that will see an emergence of biomarkers to assist in the identification of patients at risk of poor outcomes following cancer treatment, and in the evaluation of symptom management interventions. Nurses will play a critical role in educating patients about their risk for poor outcomes and specific symptoms based on an evaluation of a number of biomarkers. In addition, they will be involved in using biomarker data to guide decisions about symptom management. This session will provide an overview of recent advances in genomic research in the treatment of cancer; discuss the role of genetics in symptom experience and other patient reported outcomes associated with cancer and its treatment, and explore the future implications of biomarkers in the provision of personalised nursing care.

**CONCURRENT SESSION J: MODELS OF CARE 2**

**LETS YARN WITH THE ABORIGINAL COMMUNITY OF ALBURY/WODONGA ABOUT CANCER PREVENTION, EARLY DIAGNOSIS AND BETTER OUTCOMES.**

**Sharan, R.**

**Callaghan, K.**

**Murray, V.**

**Fraser, P.**

1 Hume Regional Integrated Cancer Service, Wodonga, VIC, Australia
2 Lung Foundation Australia, Brisbane QLD, Australia

Cancer is the third largest cause of death of Indigenous Australians. Evidence indicates this population experience poorer outcomes as Indigenous people are often diagnosed later (Cause of Death 2010 and Lung Cancer in Australia report, November 2011).

This project led by Lung Foundation Australia in collaboration with Hume Regional Integrated Cancer Service (RICS) aims to raise awareness and understanding of cancer in the Albury/Wodonga Indigenous community. This will be achieved by providing education to the Aboriginal Health Workers and the wider community about cancer, treatments and support services.

The Aboriginal Health Service Nurse assisted with introductions to key Aboriginal Health Workers and a Steering Group was established to advise on the project. This group consists of 50% Aboriginal membership from several Indigenous organisations. An Aboriginal Project Officer was appointed to engage with the local health workers and community, with successful education sessions being conducted. Aboriginal Health Workers have visited radiation, chemotherapy and palliative care units. These visits provided an understanding of treatment options, referral pathways and supportive care services available, with further sessions being planned. The development of resources is underway with the release of a DVD featuring a local Aboriginal woman diagnosed with lung cancer and plans are progressing to work with Cancer Council Victoria to provide support group facilitator training and pilot an Aboriginal support group.

Evaluations and feedback to date indicate Aboriginal Health Workers are now more confident in contacting cancer services to seek advice for their clients and the Indigenous community are now accessing cancer services earlier.

**EVALUATION OF NURSE LED TELEPHONE FOLLOW UP IN LOW/INTERMEDIATE RISK PROSTATE CANCER PATIENTS**

**Leahy, M, Krishnasamy, M, Herschtal, A, Bressel, M, Dryden, T, Hun Tai, K, Foroudi, F.**

Peter MacCallum Cancer Centre Melbourne Australia.

**Introduction**

As the number of men living with prostate cancer is increasing worldwide the requirement for follow up care also increases. This study was undertaken to evaluate nurse led telephone follow up for men with low to intermediate risk prostate cancer treated with radical radiotherapy when compared with medical follow up.

**Aim**

To assess patient satisfaction and levels of distress with nurse led telephone follow-up (NLFF) for low to intermediate risk prostate cancer patients, and compare to patient satisfaction and distress with conventional medical follow-up.
Methods
A non-randomized, two phase comparative study, where men remained in the study for 24 months. Participants were recruited from outpatient clinics at Peter MacCallum Cancer. 169 patients altogether for both phases, 83 men were recruited to phase 1 to establish baseline data on self report levels of distress, physical symptoms and satisfaction with follow up prior to introduction of the NLC. 86 men were recruited to cohort 2 to provide comparative self report data following introduction of the NLC main outcome measures.

Results
There was no statistically significant difference in patient satisfaction on any of the study measures between the nurse led and standard medical follow up at six months following treatment completion. However there was a trend towards significance (p=0.051) it favored the nurse led follow up regimen.

Conclusions
Nurse Led Telephone consultation provides an acceptable model of follow up for men diagnosed with low to intermediate risk prostate cancer. Multi-centre randomised controlled trials are needed to support the efficacy of nurse-led telephone follow up services.

WIMMERA ONCOLOGY NURSE PRACTITIONER COLLABORATIVE MODEL – 2 YEARS ON...
O’Kane, C.
1 WHCG; SRH; EGHS, Horsham, VIC Australia
In 2010 a collaborative Oncology Nurse Practitioner (ONP) project was generated between the Wimmera Health Care Group (WHCG), East Grampians Health Service (EGHS) and Stawell Regional Health (SRH) with the support of the Grampians Integrated Cancer Service (GICS). Each of the three participating health services are situated on the Western highway in Victoria.
The project team identified service gaps and anticipated that a highway model of care using an Oncology Nurse Practitioner could:
• Link the existing Oncology services and provide liaison with the visiting Medical Oncologist
• Provide local clinical expertise in cancer care to the existing multidisciplinary team
• Provide consumers with timely access to information and co-ordination of care
• Provide advanced skills and extended scope of practice to the nursing divisions
• Co-ordinate and provide education and clinical support to local health professionals.
From this innovative body of work, a position to enhance existing services and develop a sustainable model of care across rural Oncology Services in the region, was developed and implemented. Now 2 years on from this project, an endorsed Nurse Practitioner (NP) works full time in this pioneering role. This presentation will discuss the challenges that the incumbent NP has faced in introducing the role which include understanding rural healthcare; navigating the endorsement process of APHRA; negotiating credentialing at each of the collaborating health services; negotiating support from the visiting Private Oncology team and the collaborating public health services; understanding the relationships and dynamics between each key stakeholder in the region.

A CLINICAL AUDIT OF HIGH GRADE GLIOMA PATIENTS TO ASSESS IMPROVEMENT IN NEEDS AND DISTRESS, BY INTRODUCTION OF A NURSE LED NEUROSURGICAL ONCOLOGY CLINIC
King, A
Cancer & Palliative Care Network, East Perth, Western Australia.
Introduction
High grade gliomas (HGGs) are debilitating, with rapid progression and a poor prognosis. A previous audit identified a gap in care between patients discharged from hospital and input from the neurology cancer nurse coordinator (NCNC). An early post discharge nurse led neurosurgical oncology clinic (NLC) was developed to address this gap.

Aim
To evaluate the NLC by establishing if early NCNC assessment of HGG patients improved gaps in care and patient distress.

Methodology
A retrospective audit was performed on 25 randomly selected patients over a six month period after introduction of the NLC. Data was collected from the NLC and the first medical oncology outpatient appointment, including patient needs identified by distress thermometer, value of information given and referrals to allied health.

Results
The NLC allowed 60% of patients to be seen at diagnosis. Patients expressed unmet needs in social (76%), emotional (72%), family (52%) and physical domains (40%) soon after diagnosis. Distress and unmet needs recorded at the medical oncology appointment were reduced in fifteen patients previously seen in the NLC. Ten patients assessed in medical oncology without an initial NLC appointment had distress levels similar to the initial NLC patient scores. Information packages were found valuable in 60% of patients.

Conclusion
The nurse led neurosurgical-oncology clinic has improved service delivery and patient outcomes through earlier access to the NCNC for holistic assessment, support and information and to facilitate direct referral to allied health.
HAEMATOLOGY IS IN OUR BLOOD

Celgene is committed to improving the lives of patients worldwide.
MAKING MOUTH CARE MATTER

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Mucositis is one of the most dose limiting toxicities related to anticancer therapies such as chemotherapy or radiation therapy. Mucositis is a source of infection and pain and impairs a patients’ ability to obtain adequate nutrition during their treatment phase and beyond. A small exploratory study conducted by a student allied health professional at the Princess Alexandra Hospital in Brisbane, Australia found that patients’ mouths were not routinely being assessed by nursing staff. They also discovered that there were no clear guidelines for standard mouth care interventions across the division of cancer. In 2010 a group of senior oncology nurses from inpatient, outpatient and radiation oncology departments along with a pharmacist formed a group to develop a procedure to standardize mouth care across all departments in cancer services. To compliment this they also developed a form using the WHO grading tool, and matching interventions to assist nursing staff care for patients’ mouths safely. This form and procedure were introduced with extensive education sessions. Early evaluation has shown mixed results of compliance, but that when used, mouths are being graded correctly. Further evaluations are required to link grading, interventions and decreased complications related to mucositis.

MANAGEMENT OF VULVAR SURGICAL EXCISION WOUNDS WITH NEGATIVE PRESSURE WOUND THERAPY: A UNIQUE APPROACH

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¹Queensland Centre for Gynaecologic Cancer – Royal Brisbane and Women’s Hospital, Brisbane, Australia.
²Royal Brisbane and Women’s Hospital, Brisbane, Australia.

Introduction

Vulvar cancer is rare accounting for 6% of gynaecologic malignancies. Primary management is Radical Wide Local Excision with Flaps. Post-surgical wound complication rates have been reported as high as 45%. Complications include wound dehiscence, infection, pain, increased length of stay and delayed adjuvant treatment. There is scant evidence for the use of negative pressure wound therapy (NPWT) in this patient group yet these wounds fulfills criteria for using this therapy.

Aim

The aim of the case studies was to determine if the use of negative pressure wound therapy (NPWT) on post-operative vulvar surgical wounds would be feasible and improve wound healing.

Description

NPWT was applied to the incision site of 3 patients following radical wide local excision with flaps. Patients 1 & 2 had NPWT applied 8-9 days respectively following wound dehiscence. Patient 3 had NPWT applied in the operating theatre over a clean closed surgical incision in an effort to prophylactically prevent complex wound failure.

Results

Significant wound closure was achieved in patients 1 and 2, at 10 and 35 days respectively. Patient 2 was discharged with NPWT and progressed to almost complete healing. Patient 3 had NPWT in situ for six days post operatively, with complete wound union on removal of the dressing. Patients reported that the wound felt splinted and supported with the NPWT in place.

Conclusions

Based on preliminary experience with this small group, there are grounds for developing this technique, particularly for prophylactic use. Post-surgical wound management in this group requires further research.
Results
Both patients and nurses perceived that the nurses supported patient individuality in all Centres. The patients acknowledged individuality between both components of the ICS (p=.000), PersonalControl (p=.000) and DecisionalControl (p=.000) subscales. The nurses perceived they provided individualised care on the ICS scales (p=.000), the ClinicalCare (p=.002) and the PersonalControl (p=.000) subscales. Lowest mean scores for both patients and nurses were on the PersonalControl subscale.

Conclusion
Both patients and nurses perceived that the nurses supported patient individuality in the care received or provided, despite the large numbers of patients treated in the outpatient radiotherapy setting on a daily basis, but with areas for improvement.

References


**EVALUATION OF EDUCATION AND ASSESSMENT PROJECT TO INTRODUCE BEST PRACTICE FOR PSYCHOSOCIAL CARE OF WOMEN WITH GYNAECOLOGIC MALIGNANCIES**

**Tanner, P.1, O’Connor, M.2, Duffield, V.3, Williams, N.3, Miller, L.4**

1WA Cancer and Palliative Care Network, East Perth, WA, Australia
2King Edward Memorial Hospital, Subiaco, Perth, WA, Australia.
3Sir Charles Gairdner Hospital, Nedlands, Perth, WA, Australia.

**Introduction**
The prevalence rates of psychological distress in cancer patients ranges from 35-49% 1 However, this may be higher due to under detection 2. Characteristics of those at risk3 include female, young, school aged children or carer for others.

Whilst research recommends routine screening for distress, this had not been implemented or evaluated in a clinical setting in WA

**Objectives/Aims**
1. To establish the education required to support the use of routing screening
2. To establish the prevalence, level and cause of distress identified by target population
3. To assess the practical implications and impact on existing services

**Description/Methodology**
Education of nurses on psychosocial distress, screening tool and referral pathway

Target – cross sectional study of women with gynaecological malignancies (N=60)

After consent women complete the distress thermometer and problem list at two time lines

Time 1 Preadmission
Time 2 Prior to discharge

Oncology nurses use completed screening tools to assess unmet needs and refer to appropriate service.

**Results**
The outcome of this study will be presented at CNSA Winter Congress 2013

**References**


**CONCURRENT SESSION L: PRACTICE IMPROVEMENT 2**

**RADIOTherAPy NURsING Car PLAN (RNCP)– BRIDGING THE GAP BETWEEN PRACTICE SETTINGS.**

**Hjorth, M**
Epworth Healthcare, Melbourne, VIC, Australia

**Introduction**
Radiotherapy patients experience specific toxicities and require supportive, shared care. Although treatment is predominantly delivered on an outpatient basis, up to 20% of these patients may require inpatient care. Having practiced across both rural and regional settings there was a common identified need for a simple, practical tool to communicate to health professionals outside the department specific patient needs, expected toxicities and symptom management.

**Objective**
To develop a simple tool to communicate with health professionals across practice settings.

To ensure coordinated care and improved patient experience and outcomes.

**Method**
Developed a simple, practical tool that informs radiotherapy dose/ site/finish date/potential side effects/symptom management/ pre-meds/dressing requirements. The tool also has a picture of the treatment site.

Implemented into our department KPI’s.

• 100% inpatients will have a RNCP completed within 48hours of admission and added to the inpatient file.

• 100% patients completing treatment will be given a RNCP in the event of needing supportive services post treatment.

**Results**
A simple survey of nursing staff suggests the RNCP communicates patient information relevant to enhancing continuity of care and improving the patient’s experience.

One of the inadvertent outcomes has been feedback from both health professionals and patients suggest this tool is also an effective education tool.

**Conclusion**
This tool has been a change agent as it provided the opportunity to reflect on nursing practice, bridge the gap between practice settings, improve patient experience and ultimately influence positive patient outcomes and staff satisfaction.
DEVELOPING AN AUDIOVISUAL TOOL FOR PRE-CHEMOTHERAPY EDUCATION

Jaenke, S1, Elliott, H1

1 St John of God Hospital, Subiaco, Western Australia, Australia

This abstract describes a quality improvement project undertaken in a private hospital oncology outpatient department. An audiovisual education tool for new chemotherapy patients was developed in response to feedback regarding patient education delivered in the department.

The project aimed to improve patient outcomes and their overall experience of pre-chemotherapy education by providing consistent structured information. The previous method of patient education consisted of a one-on-one nurse-led session using a checklist to guide provision of verbal and written information.

The project was undertaken by the nurse manager, a clinical nurse and registered nurse. The nurse manager obtained feedback from oncologists and a patient satisfaction survey. A literature review of chemotherapy patient education demonstrated significant evidence that addition of a video to the current education format was appropriate. This was developed using information supported by current best practice standards and short video interviews with patient volunteers. The video has been developed for use in conjunction with the current face to face education format and for unrestricted patient viewing after their education session.

The video is complete and it is awaiting final approval for use. Once it is in use an evaluation will be undertaken to assess outcomes for both patients and nurses.

As oncology nurses we have the opportunity to provide patients with knowledge to assist them in safely completing their treatment and managing toxicities. We hope that with the provision of concise, consistent information the use of this audiovisual education tool will improve the overall experience of chemotherapy patients.

A STRATEGY TO REDUCE THE INCIDENCE OF FALLS IN THE CANCER SETTING

Seletto, K., Gomez, Y., Woolmer, C.

Cabrini, Malvern, VIC, Australia

Introduction

Approximately 1500 people per day fall in Victorian hospitals, adding $406 million a year to the annual health budget and causing significant distress for patients and their families (World Health Organisation, 2012). A cancer diagnosis increases the risk for falls; however, few hospital studies have examined patients with cancer at risk of falling: A review of the evidence. Journal of Palliative medicine.vo14 pp.,221-230


MEDICATION INCIDENT REDUCTION AT ILLAWARRA CANCER CARE CENTRE

Bell, G1

1 Illawarra Shoalhaven Local Health District, NSW, Australia

Background


Available at www.cancernetwork.com Accessed 02.04.13 World Health Organisation (2012)


Methods

In 2009, the Illawarra Cancer Care Centre (ICCC) reviewed its systems for prescription and administration of chemotherapy. The review targeted improved patient safety in the prescription and administration of chemotherapy, developing processes to support the changes.

It was identified, that the use of an Oncology Information System (OIS) providing electronic prescribing, administration and comprehensive clinical decision support could assist in the reduction of medication errors within our service.

Additionally, use of current evidence based, best practice cancer treatment protocols, such as the Cancer Institute NSW’s eviQ chemotherapy protocols, would standardise the prescription process, as they provide predictability, support accuracy, reduce errors, and enhance workflow by decreasing ambiguity. (Shulman et al 2008)

With these foundation principles, ICCC embarked on a new, complete OIS in December 2010.

Results

In January 2011, the use of eviQ chemotherapy protocols in an oncology information system was launched. This has resulted in a dramatic 63% reduction in reported adverse medication incidents. Additionally, significant cost savings were directly associated with decreased use of anti-emetic drugs.
Conclusion
The use of standardised, best practice cancer treatment protocols combined with an introduction of an Oncology Information System with comprehensive clinical decision support and thorough planning, has resulted in significant gains for patient safety.

MEDICATION SELF-MANAGEMENT: IMPLICATIONS FOR NURSING PRACTICE
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Medication self-management (MSM) and adherence are interesting concepts in oncology as numerous medications are available for oral administration which can be taken independently by the patient. For many reasons, home or self-administration of oncology related medications is a welcome benefit, yet successful self-management of medications requires that the patient take the appropriate medication at the correct dose and schedule for optimal efficacy. Patient and provider related factors interfere with appropriate self-management and adherence. One cannot assume that patients will adhere to the correct medication dose and schedules simply because a person is facing a potentially life-threatening illness. Oncology patients often have multiple co-morbidities which may prove taxing to individuals having to manage their own health on a day-to-day basis. The presentation aims to: 1) Educate nurses in oncology about the concept of self-management as it relates to medication adherence, 2) discuss barriers to self-management that may lead to adherence problems and negative health outcomes, and 3) review self-management intervention strategies for oncology professionals.

CONCURRENT SESSION M: IMPROVING CANCER SERVICES
WHAT IS A ‘CULTURALLY SAFE CANCER SERVICE’ FOR ABORIGINAL AND TORRES STRAIT ISLANDERS AND HOW DOES IT HAPPEN?
THE EXPERIENCES OF ONE MAJOR TERTIARY TEACHING HOSPITAL IN SOUTH AUSTRALIA
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¹ Central Adelaide Local Health Network, Adelaide, SA, Australia
Introduction
To promote and develop a greater awareness of cultural safety for patients the Aboriginal and Torres Strait Islander Cancer Care Coordinators introduced the use of ‘Interactive Ochre’ a contemporary e-Learning resource that brings an Indigenous perspective to cultural awareness training (developed by TAFE SA) in response to a Training Needs Analysis undertaken in 2012.

Objectives/Aims
To integrate culturally sensitive practice into every day routine care for Aboriginal and Torres Strait Islander patients through increasing the level of understanding of nurses and allied staff of specific issues that can impact Aboriginal and Torres Strait Islander peoples access to and completion of cancer treatments.

Description/Methodology
Five one hour workshops were designed and introduced in the Cancer Centre, to enable staff to attend during double handover time in an effort to maximise attendance and minimise the impact on direct patient care.
One staff member from each of the four key service areas has received additional training and up skilling to become a key advocate to support Aboriginal and Torres Strait Islander patients who access cancer services.

RESULTS
Preliminary feedback from key advocates indicates that these roles have increased their knowledge and understanding of key issues. Staff feedback on the length and content of the workshop will be presented from the evaluation surveys.

Conclusions
This presentation will outline the processes and outcomes of initiatives that have been introduced to increase the Cultural Awareness of Cancer Services staff.

NURSE PRACTITIONER IMPLEMENTATION IN REGIONAL VICTORIA
Kendall, R¹
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Purpose
The Grampians region covers 48,000 square km’s and has a population base of 225,000 people. We undertook a model development project to define the role and responsibilities of a Palliative Care Nurse Practitioner (NP) within the Grampians region. This project included establishing systems to support the development and implementation of a NP Service within the Grampians Regional Palliative Care Team (GRPCT). It was thought that the introduction of NP’s would increase palliative provision to increase support for patients wishing to die in the place of their choice. The Grampians region did not have any NP’s in any field working in the region until this role, therefore approaching the introduction was fraught with hurdles and barriers.

Four areas that the project addressed were:
1. Understanding local demand and opportunities
2. Shaping the service model for NP’s
3. Priming the organization for NP’s
4. Preparing the Nursing Workforce

Key Outcomes
As a result of this project, A Palliative Care NP has been implemented within the GRPCT in August 2011. The role, whilst new, has been widely accepted within the acute and community care settings and provides greater responsiveness and accessibility to palliative care services within the region. The implementation of the first Nurse Practitioner position in the Grampians region has now engaged key stakeholders and begun conversations around model development and implementation of NP’s into other specialties of nursing in the region. Lessons learnt will be invaluable as we develop advanced practice models that focus on improved patient outcomes.

ESTABLISH, ENGAGE, EDUCATE, EXCITE, EMPOWER, EVALUATE AND EVOLVE!
Moore, L¹, Matthews, K¹, Drake, J¹, Hesketh, E²
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² John Hunter Children’s Hospital, Newcastle, NSW, Australia
Adolescent and young adults (AYA) aged 15-25years with a cancer diagnosis are considered a cohort of vulnerable patients with distinct physical, social and psychological needs. AYA’s require an expert age appropriate multidisciplinary team delivering a tailored service delivery model to optimise access to support, advocacy and strategies at diagnosis.

To establish a sustainable multidisciplinary AYA team embedded in the referral process of newly diagnosed AYA’s from all cancer streams at the beginning of the cancer treatment pathway.
The Hunter and Northern NSW Youth Cancer Service have proactively engaged and built strong relationships with all cancer streams within adult, paediatric, urban, rural and remote cancer facilities. Co-location of the AYA team (clinical nurse consultant, social worker and clinical psychologist) based in the adult hospital and adolescent oncologist at the paediatric hospital has enhanced
communication and collaboration amongst cancer services. The AYA team provide a comprehensive service delivery model maximising staff availability to patients/families as an inpatient/outpatient and by utilising tele-health facilities. Links have been established with other youth cancer services nationally and education has been provided to health professionals about unique AYA needs.

There is greater awareness of the AYA service and referrals (n=56 in 2012) are being made by a range of medical staff at commencement of AYA cancer treatment.

Continuation of the AYA care model will provide invaluable support for AYA's and their families into survivorship or end of life.

Australian Government Cancer Australia, Canteen. National Service Delivery for Adolescents and Young Adults with Cancer 2007.

IMPROVING THE PATIENT EXPERIENCE IN THEIR CANCER JOURNEY

McGinness, C¹, Wallace, M¹
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Introduction
No one but the patient experiences the health system journey and yet health services and processes are built primarily on health professionals' views of what is needed, rather than the customer's experience and knowledge of system requirements.

Objectives
1. To understand the Cancer system from the patients view point.
2. To develop an improvement plan in collaboration with patients

Description
Phase 1
There were five components of the analysis phase:
1. Big picture mapping of patients experiences
2. Demand profiling of patients accessing the service
3. Literature review
4. Value stream mapping of the key processes
5. Patient focus groups

Phase 2
Implementation of collaborative patient and interdisciplinary improvement plans to improve the patient’s experience with system improvements.

Results
• 20% increase in satisfaction levels (Press Ganey)
• 50% improvements in waiting times
• January 2012 patient waiting > 5 minutes - 30% (n=420)
• December 2012 patient waiting > 5 minutes - 15% (n=210)
• Increase in capacity, flow and chair utilisation in the day oncology unit.
• Improved match of appointment times to actual times.
• 25% of appointments on time – January 2012
• 35% of appointments on time – June 2012
• Rostering patterns match patient schedule resulting in 4% reduction of sick leave and no overtime hours.

There are multiple system issues. Working with one issue at a time in a disciplined way is an important factor to achieve goals of excellence.
1. MEASURING THE QUALITY OF CURRENT EDUCATION PRACTICE
Blanchard, G.¹, Cox Y.³
¹Calvary Mater, Newcastle, NSW, Australia

The way in which the individual may learn and what we perceive it to be may be very different indeed. In times of stress the ability to remember important information is hampered. In clinical practice it seems that patients have difficulty remembering what is told to them about their chemotherapy treatment plan during their education and for this reason we were trying to establish if the way in which we provide the information to them needs to be improved.

At the Calvary Mater Newcastle standard practice is to provide patients with a separate outpatient education appointment on a day other than their first treatment.

A quality survey was sent to 80 patients who had commenced intravenous chemotherapy in the preceding 6 months. The aim was to assess if patients received and understood information given during education.

The survey contained 19 questions and understanding was measured using a likert scale. Additional information was also asked to identify if patients were treated as inpatients or outpatients, to identify wait times between education and commencement of treatment and also if they attended education alone.

Of the surveys sent there was a 49% response rate and of these responders 70% either agreed or strongly agreed that the education appointment was beneficial.

From the small sample size it could be hypothesised then that the majority of patients received both written and verbal information on chemotherapy treatments and side effects and had a high level of understanding of the chemotherapy education received.

2. EVALUATING THE ONCOLOGY NURSE PRACTITIONER ROLE: SUCCESS OR FAILURE?
Booms, A.
Albury Wodonga Health, Albury, NSW, Australia

Introduction
Since the implementation of the Oncology Nurse Practitioner (ONP) role over a year ago, the integration of the ONP into the health care system has been challenging. The ONP explored the acceptance of the role and the experiences of oncology patients and health care providers in their collaboration with the Oncology Nurse Practitioner.

Objectives/Aims
The aim of this study was to evaluate client’s and health professionals satisfaction of the ONP role in relation to education received, quality of care, understanding and acceptance of the role.

Methods
A health care staff and patient survey was conducted. The staff survey focussed on role implementation, acceptance of the role and future role development. The patient survey focussed on quality of care, information delivery and understanding of the ONP role.

Conclusion
This study revealed high satisfaction from patients accessing specialist care from the Oncology Nurse Practitioner and a good understanding of the ONP role. Health Care staff surveys highlighted the need for ongoing education delivery by the ONP and high satisfaction in using the ONP as resource person within the health care setting.

4. BRINGING IT HOME ACROSS THE TYRANNY OF DISTANCE
Brown, L., Bransdon, M.
Central Integrated Regional Cancer Service (CIRCS), Queensland Health, Brisbane, QLD, Australia

Background
The impact of distance is important to acknowledge for patients in rural areas as they experience greater difficulty accessing services. Central Integrated Regional Cancer Service is committed to overcoming the challenges posed by the vast distances across its catchment which spans 561, 824 Sq Km through collaboration with communities to identify their capability to safely deliver specialist services.

Objective
Over the past decade, safe quality care closer to home has been a philosophy espoused. This poster demonstrates the practicalities of achieving such a philosophy. Central Venous Access Device management is often foreign in rural and regional areas; however an increasing number of patients require staff to be confident and competent. Through the use of Telehealth, simulated bedside teaching, provision of a 24 hour resource and appropriate equipment, “Bill” returned home, 1400kms from Brisbane.

Outcomes
Our celebrations were watching a “flashback” occur through the TV screen, problem solving anchoring issues through improvising with what consumables were available and the gratitude of the staff and Bill for navigating these “uncharted waters”.

Making it happen requires dedicated specialist staff to initially travel and provide theoretical workshops and ongoing support. This enables increased access and confidence to ask the questions and challenge the perceptions of availability and quality of knowledge, skills and attitudes to deliver expanded services.

Conclusion
Dedication to the process saw Bill returning home and avoiding 6 weeks in Brisbane with increased costs, loss of income and isolation from loved ones. Bill often states “you saved me, you brought me home”.

5. A 12 DAY EVIDENCE-BASED PRACTICE PROGRAM FOR CANCER NURSES IN AN AUSTRALIAN TERTIARY CANCER CENTRE
Chan, R.
Royal Brisbane and Women’s Hospital, Herston, QLD, Australia

Introduction
Nurses are expected to be evidence-based practitioners. For cancer nurses, the ever increasing demand of cancer care further stresses the importance of evidence-based practice (EBP). However, nurses often find that they lack research training, understanding of critical appraisal and statistical analysis, and time to access research.

Objectives
This paper aims to describe the design and outcomes of a 12 day EBP program for cancer nurses.

Description
This 12 day program (1 day/week) aims to develop the participant’s knowledge and skills in locating, appraising and integrating relevant evidence into clinical practice/decision making. This program is conducted as a 96 hour classroom workshop facilitated
by a Cancer Care Nurse Researcher. The facilitator is a Cochrane author of five Cochrane reviews. The 96 hour classroom workshop time is off-line time sponsored in-kind by the Nursing Director of Cancer Care Services. Each participant answers a clinical question through conducting a systematic review. If appropriate, the participants are encouraged to apply their EBP skills gained in this workshop directly to their clinical work unit.

Results
To date, 13 participants have successfully completed the program. All participants participated in or completed a small scale systematic review using the Cochrane Collaboration methodology. Some led to practice change/conference presentations and peer-reviewed publications. Participants who completed this workshop can seek advanced standing for a post-graduate subject as part of a post-graduate course from University of Queensland, Queensland University of Technology and Griffith University.

Conclusions
The 12 week EBP program is feasible and effective in leading to tangible outcomes.

6. A SUMMER CLINICAL RESEARCH PROGRAM FOR AN UNDERGRADUATE STUDENT IN AN AUSTRALIAN TERTIARY CANCER CENTRE
Mann J, Wickremaratne K1,2, Chan R.1,2
1Cancer Care Services, Royal Brisbane and Women’s Hospital, Herston, QLD, Australia
2School of Nursing and Midwifery, University of Queensland, Brisbane, QLD, Australia

Introduction
According to the ANMC National Competency Standards, Registered Nurses are required to practice within an evidence-based framework. Amongst undergraduate nursing programs in Australia, there is a wide variation in how students are prepared to be competent evidence-based practitioners. In addition to the academic programs, some universities offer short-term research programs to allow participating students to gain hands-on research and evidence-based practice (EBP) experience.

Objectives
This case report aims to describe a summer research program in an Australian tertiary cancer centre and the learning outcomes perceived by the research mentors and the undergraduate student.
Description
This research program, offered by the University of Queensland, provided the student with an opportunity to work alongside two nurse researchers on a research project over 10 weeks. The student received a scholarship of $1,000 for participating in this program. The research project was a double-blind randomised controlled trial investigating the effects of two creams for managing radiodermatitis in patients with cancer.

Results
The learning outcomes perceived by the mentors and the student included increased knowledge, confidence and skills in a number of areas related to (1) research and EBP and (2) cancer care nursing practice. These outcomes correspond to a number of ANMC National Competency Standards for Registered Nurses.

Conclusions
This program is a positive experience for the student as well as the mentors. The perceived learning outcomes reported in this paper can potentially inform the development of a learning plan to maximise the benefits of such programs.

7. ESTABLISHING BEST PRACTICE IN NURSING INTERVENTIONS POST BONE MARROW ASPIRATE AND TREPHEINE
Matthews, R.; Russell, E.; Downs, B.
1Cancer Care Services, Royal Brisbane and Women’s Hospital, Herston, QLD, Australia

Introduction
The Oncology Procedure Unit at the Royal Brisbane and Women’s Hospital performs approximately 1800 Bone Marrow Aspirate and Trephines (BMAT) per annum

Objectives/Aims
Investigations were undertaken to establish best practice of nursing management for patients who undergo this procedure. Benchmarking was conducted in private and public hospitals and independent collection centres throughout Australia. A literature search of available studies was undertaken searching the Cochrane Database of Systematic Reviews, The Cochrane Library Issue 6, 2012; Ovid MEDLINE 2002 to June Week 1 2012. Nationally recognised guidelines were reviewed.

Results
One review of UK data documented 15 adverse events among 20223 procedures. The main complication recorded was haemorrhage. Based on these results the BMAT procedure is considered a low risk procedure. The procedural risk increases when conscious sedation is administered. Benchmarking revealed that the monitoring of vital signs varies in frequency and extent for patients receiving conscious sedation for BMAT.

Conclusion
This review has identified critical areas for improvement of nursing management for patients undergoing BMAT. To effectively manage these patients, the Oncology Procedure Unit has introduced an interdisciplinary clinical pathway. A presentation has been implemented to educate nurses within the unit.

Reference

8. MAKING THE PATH STRAIGHT
Finselbach, R.; Faranda, C.
1Hollywood Hospital Ramsay Health, Perth, WA, Australia

Patients undergoing treatment for cancer encounter many professionals with varying levels of training, experience and competency. This can lead to variance in the care and advice they receive. The aim of this clinical project was to improve and standardise assessment, education and care of patients receiving chemotherapy and to have accurate documentation by introducing a clinical pathway. As a secondary aim the pathway was utilised to support novice practitioners (RN’s and EN’s) in their learning and care of cancer patients.

The setting of the project was a 30 bed Oncology/Haematology Day Unit within a private hospital in Perth. The pathway was developed by a multidisciplinary team facilitated by Connie Faranda (Clinical Pathways Coordinator) and Richelle Finselbach (Clinical Nurse Day Suite).

Current practice in the unit was evaluated, including a review of the documentation of assessment and education of patients. Guidelines for assessment of patients receiving chemotherapy were examined and a literature search for clinical pathways was undertaken. The pathway was then designed in conjunction with input from the staff of the unit and the oncologists/haematologists. An audit and evaluation of the pathway was completed 8 months following implementation in the day unit and focused on structure and compliance. As a result the pathway was modified to guide practice and improve efficiencies.

The benefits of introducing the pathway for chemotherapy administration are to reduce error and variance in practice and education. Quality of care is maintained and assessment of the cancer patient has increased in its accuracy and documentation.

9. ART AS A DIVERSIONAL AND CATHARTIC EXPERIENCE WITHIN THE ACUTE SETTING
Gleave, L.; Duff, C.
1Barwon Health, Geelong, VIC, Australia

Introduction
Extended hospital admissions place patients at risk of feeling anxious, bored and frustrated. The Art Activities Project is a cathartic activity for patients, a positive distraction from the clinical aspect of their hospital admission providing some pleasure and insightfulness into their cancer experience.

Aim
The aim of this project is to provide a pleasant distraction from the clinical aspect of care, to alleviate anxiety, boredom and frustration of patients in the acute setting. Participation will improve the overall experience of the hospital admission.

Description
The facilitator of the Project identifies suitable patients based on their expected length of stay, social or emotional circumstances. Art materials are provided for structured and unstructured activities, patients are encouraged to experiment with various art mediums and techniques to encourage creative expression. Activities are offered on an individual or group basis depending on personal preference, providing a safe environment in which to create.

Results
Participants complete the Distress Thermometer and Outcome Star before and after to assess effects on anxiety, fear, sadness, boredom and frustration. Results have indicated a positive outcome demonstrated in this statement “We spent the happiest hour painting. It was a happy, fun time in which we were totally absorbed, thus forgetting our troubles and woes”.

Conclusions
Art activities prove to be a pleasant distraction within the clinical experience of a hospital admission enhancing an individual’s quality of life, even if only for a short period.
10. A PATIENT CENTRED APPROACH TO THE CARE CONTINUUM

Woolmer, C., ¹ Gomez, Y., ¹ Seletto, K., ¹
¹ Cabrini Hospital, Melbourne, VIC, Australia.

Introduction
Each Cancer patient experience is subjective, yet as health care professionals, we provide care based on what we consider to be needed rather than what is “patient centred”. In March 2012, a multi-disciplinary team and a patient, attended a 2 day forum to develop a quality improvement plan focusing on a patient centred approach.

Objectives/Aims
Standardise work to optimise individual patient and family well being for physical, mental and spiritual care in the cancer patients journey.

Description/Methodology
To assess current capability, assessment via data collection occurred to develop a baseline “from” picture, thus allowing a clear non-biased identification of gaps. Via identification and application of Lean thinking, the “new model of care” is being trialled (and PCDA - Plan, Do, Check, Act )
Our method of measurement included;
• Real time date from staff and patients
• PET ( Patient experience Tracker )

Results
In March 2012 a collective agreement acknowledged the plan of care for a patient is not known by the patient.
Post implementation of the “new model of care”, survey results for February 2013, revealed a dramatic increase, 66% of patients reporting to know their plan of care..

Conclusion
It is important for us to understand the patient experience and how this translates to all healthcare professionals and their practice. This is a process that we continue to trial and evaluate in order to provide “patient centred care.

11. CONNECTING CANCER CARE: WORKING TOGETHER TO SUPPORT WOMEN AND THEIR FAMILIES AFFECTED BY OVARIAN CANCER.

Gooden, H.,¹ Kirk, R.,²
¹ Ovarian Cancer Australia, Melbourne, VIC, Australia. University of Sydney, Camperdown, NSW, Australia
² Ovarian Cancer Australia, Melbourne, VIC, Australia

Introduction
Ovarian cancer has the poorest outcomes of all gynaecological cancers. No screening and late-diagnoses contribute to ovarian cancer being the seventh highest cause of cancer-related female deaths in Australia. (AIHW & NBOCC 2010). The landscape of cancer care in the twenty-first century is rapidly changing with the onset of the biomedical revolution. Targeted treatments mean the gap between those offered curative or palliative treatment will widen. Psychosocial support will become even more critical to ensure best quality of life.

Objectives
Ovarian Cancer Australia (OCA) seeks to work with gynaecology-oncology nurses across Australia to ensure women are aware of psychosocial support services when diagnosed with ovarian cancer. Recognising people’s different information and support seeking behaviours, OCA offers comprehensive support services to build resilience; print, online, social media, apps, telephone and face-to-face.

Description
Online evaluation survey of three psychosocial support services (Telephone1 Community2 and Resilience Kit3) utilising SurveyMonkey©. Women who utilise our services were invited to participate (N=151; Average Completion rate= 34.9%).

Results
Evaluations highlighted the importance of psychosocial support and nurse referrals. Top 5 reasons for seeking support: connecting with women; information; practical support; inspiration; emotional support. Top 5 ways services found3: hospital resource; cancer helpline; nurse/gynaecology-oncologist; GP; and online. 100% nominated they would prefer nurse/clinician referral or endorsement at time point- 'close to diagnosis'.

Conclusion
Connecting together with cancer nurses will enable OCA to reach all women affected by ovarian cancer. This will ensure women and families are empowered with information to decide the timing and mode of services that best fit their needs.

12. UNTANGLING THE LINES: OUR EXPERIENCE OF IMPLEMENTING A CLOSED INTRAVENOUS CHEMOTHERAPY SYSTEM

Campbell, T.,¹ Griffiths, M.,¹
¹ Sydney Adventist Hospital, Sydney, NSW, Australia

Introduction
Choosing a suitable closed system for intravenous chemotherapy administration can present a tangled web of confusing options especially when chemotherapy is supplied by an external compounding. Our trial of changing practice from spiking chemotherapy at the bedside to having it arrived “pre-spiked” as part of a closed system has been beneficial despite the challenges in implementation.

Objectives/Aims
To identify specific features of a closed system to meet best practice and implement and evaluate the product in association with the external compounder.

Description/Methodology
A literature search and review of our local policies was undertaken to identify specific features of a closed system to meet best practice and implement and evaluate the product in association with the external compounding.

Results
There have been no incidents of exposure and infections related to product use. There have been no incidents of exposure and infections related to product use. There have been no incidents of exposure and infections related to product use.

References
Furlow, B. (2010), How to improve the safety of chemotherapy administration. Oncology Nurse Advisor, June, pp.21-25.
13. THE IMPLEMENTATION OF A NURSE-LED TRANSFUSION SUPPORT PROGRAM IN THE DAY ONCOLOGY UNIT.

Gwynne, M.¹, Hayes, L.¹, Probst, K.¹
¹Northern Health, Cancer Services, Epping, VIC, Australia

Introduction
As the haematology service at Northern Health expands, so has the demand on haematology supportive therapy for non malignant and malignant haematological conditions. Frequent blood transfusion coordination can be complicated and at times confusing for patients. The implementation of a structured program was required to enable the patient to become involved in their transfusion needs.

Objectives/Aims
To effectively manage the increasing volume of patients requiring transfusion support at Northern Health, through the use of CHARM.

Description/Methodology
Data collection was performed over a three year period of the number of blood transfusions administered in Day Oncology over 2 campuses. (TNH & CHS)

Literature review was conducted and current practices from external sources were explored.

Results
The data collection revealed a 45% increase in blood transfusion administration from 2010 – 2012.

CHARM was utilized by the haematologist to create a transfusion pathway with indicated parameters for transfusion. This allowed nursing staff to monitor transfusion frequency and organize blood tests, transport and assess supportive care needs in advance. A database was created to maintain a record of patient’s requirements.

A Transfusion Support Program Nursing Assessment Tool was developed to record information in scanned medical records.

Conclusions
Implementation of a Transfusion Support program has enabled effective management of patient’s care improving quality of life and decreased hospital overnight admissions. Further evaluations will be performed as the program expands. Currently 15 patients are monitored through the program for their transfusion needs.

14. WHEN YOU LOOK IN THE MIRROR AND DON’T RECOGNISE THE PERSON LOOKING BACK AT YOU... WHERE DO YOU TURN FOR HELP?

Harrold, S.¹, Hotchkin, T²
¹ Cancer Patients Foundation Ltd, Redcliffe, QLD, Australia
² Cancer Patients Foundation Ltd, Sydney, NSW, Australia

Introduction
Look Good...Feel Better is a free community service that helps to improve the confidence and wellbeing of people undergoing treatment for cancer. This is achieved by helping patients to manage the appearance-related side-effects of their treatment. The program operates in 26 countries and was brought to Australia in 1990. Workshops are held in 185 locations, predominantly in hospitals or cancer treatment centres, with separate sessions for women, men and teens. More than 105,000 patients have attended to date.

ACTIV1STs for a brighter future

Our product 1STs have opened up many new and significant therapeutic directions in oncology and haematology. But our 1ST priority will always be to actively continue to innovate, in support of your efforts to improve outcomes for patients.

For more information visit rocheinteract.com.au
Objectives
Look Good...Feel Better offers patients a brief respite from their diagnosis while spending time with others on the same journey. Most participants are either referred by an oncology nurse or social worker, or they self-refer.

Description
Over two hours, in a small-group format, patients learn how to use cosmetics, wigs and headwear to minimise the visible side effects of their treatment. Workshops are delivered by 1600 trained beauty industry volunteers, with all products donated by the cosmetic industry.

Look Good...Feel Better is run by a registered charity, the Cancer Patients Foundation, which is funded predominantly by the cosmetic industry and community supporters. The program is strictly non-medical and non-commercial.

Results
While Look Good...Feel Better has not been independently evaluated, extensive feedback from participants and cancer nurses indicates that the majority of attendees report a positive impact on their wellbeing.

Conclusions
Our goal is for Look Good...Feel Better to become an integral part of cancer care by 2015, and to help 15,000 patients a year to face cancer with confidence.

15. SO, WHO NEEDS AN ADOLESCENT AND YOUNG ADULT (AYA) CLINICAL NURSE CONSULTANT ANYWAY? CASE STUDY. SEAN: AN 18 YEAR OLD DIAGNOSED WITH OSTEOSARCOMA.
Henderson, F.
Princess Alexandra Hospital, Brisbane, QLD, Australia

Introduction
Adolescents and young adults with cancer aged between 15 and 25 years have unique needs that affect physical health, psychological health, quality of life, social engagement, education and employment. In 2007, the AYA National Cancer Reference Group developed the National Service Delivery Framework for Adolescents and Young Adults with Cancer to maximise survival and quality of life outcomes for young people affected by cancer and to enhance supportive care services for the young person and their family. In 2009 and in keeping with the recommended NSDF, an AYA Cancer Service including a Clinical Nurse Consultant was introduced at the Princess Alexandra Hospital. An osteosarcoma diagnosis requires a 12 month treatment pathway including chemotherapy and surgery. This treatment pathway impacted upon all aspects of a Sean’s life.

Objectives/Aims
The aim of this presentation is to examine the treatment journey of a young person diagnosed with cancer. This will show the value of the role of the AYA CNC within the AYA Cancer Service in meeting the unique needs of the young person with osteosarcoma.

Description/Methodology
Information was collected retrospectively through chart review and by accessing the QOOL database to examine the AYA Psychosocial Multidisciplinary Meeting minutes.

Results/Conclusions
Information showed independent CNC assessment, intervention and interdisciplinary collaboration ensuring Sean’s timely access to medical treatment and AYA allied health services.

References
Common Terminology Criteria for Adverse Events (CTCAE) V4 June 2010
National Service Delivery Framework for Adolescents and Young Adults with Cancer

16. CONTRACEPTION AFTER BREAST CANCER: DEVELOPING EVIDENCE BASED GUIDELINES
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1Royal Women's Hospital, Parkville, VIC, Australia

Approximately 25% of breast cancers in Australia are diagnosed in women of reproductive age. Chemotherapy for breast cancer commonly impairs fertility, but some will not require chemotherapy and others will remain fertile after chemotherapy1.

Hormonal contraception is avoided following breast cancer, even in oestrogen-receptor negative disease. Women using hormonal contraception are advised to stop, however oncologists differ in recommending removal of the levonorgestrel intrauterine system [LNG IUS] which has low systemic levels of progestogen. If contraception is discontinued and women remain fertile, they may be at risk of unintended pregnancy. We aimed to develop evidence-based guidelines to address this gap.

A review of the literature was undertaken and guidelines developed using with the World Health Organisation classification of contraception.

The current evidence suggests;
- Systemic hormonal contraceptives are not recommended and should be avoided regardless of receptor status
- Copper T intrauterine device is recommended as safe contraception
- Safety of LNG IUS after breast cancer is not known and there is no level I data available1.
- Tamoxifen is not contraceptive and may be teratogenic.
- Emergency contraception may be used after unprotected intercourse but there is limited evidence for safety1.
- Barrier and natural methods can be used however the efficacy is strongly linked to education and correct usage.

Comprehensive guidelines have been established for health professionals caring for women undergoing breast cancer treatment. This work has been undertaken with the collaboration of the interdisciplinary team.


19. THE ROLE OF A NEUROENDOCRINE TUMOUR NURSE SPECIALIST
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Background
Neuroendocrine tumours (NET) are relatively rare tumours originating in hormone producing cells mainly throughout the gastrointestinal tract, but can occur in other site of the body. The management of NET patients can be complex necessitating the role of a NET nurse specialist to optimise outcomes through effective care coordination.

Aim
The aim of this clinical paper is to describe the role and the potential benefits of the NET nurse specialist in a tertiary cancer care centre in Queensland, Australia.

Description
The nurse specialist is a Clinical Nurse with 21 years oncology experience. She works within a multidisciplinary team and under the supervision of the Director of Medical Oncology. The nurse specialist role involves optimising the coordination of care of NET patients referred to a statewide service offering Lutate treatment. Specifically, the nurse specialist is responsible for patient education, organising for specialised scans/other clinical investigations, identifying problems with pathology reporting and retrieval of records from referring hospitals.
Results
It is feasible to implement the NET nurse specialist role in a tertiary cancer care centre. Anecdotally, patients and members of the MDT reported positive feedbacks. The potential benefits of the role include increased patient satisfaction, reduced unnecessary hospital appointments and increased efficiency of the MDT meetings.

Conclusion
The implementation of the NET nurse specialist role has been successful with potential benefits identified. Future research or quality improvement activities are required to formally evaluate the outcomes of this role.

20. E-HEALTH: ENHANCING MULTIDISCIPLINARY PRACTICE AND EDUCATION FOR RURAL HEALTH CARE PROVIDERS
McIntyre, R
Grampians Integrated Cancer Service, Ballarat, VIC, Australia

Introduction
MDMs bring together health care professionals involved in the care of people affected by cancer to plan treatment approaches on a case by case basis. The local context and client circumstance are taken into account enhancing patient centered care.

Aim
To develop a service model to improve multidisciplinary care coordination.

Method
The Grampians Integrated Cancer Service (GICS) facilitate a monthly general MDM, aptly named the Wimmera MDM, at Wimmera Health Care Group, Horsham Campus. The use of information technology, such as the online WebEx secure meeting system combined with teleconferencing; enables a full quorum of cancer specialists some of whom would otherwise be unable to contribute, to draw upon their collective multidisciplinary knowledge and experience to provide fuller treatment recommendations for patients.

Results
The Wimmera MDM has enhanced communication between all meeting participants with broader consensus of client treatment plans. The model has also had the unexpected benefit of providing education in ‘case study’ format, which enhances participation of GPs, specialist oncology nursing staff, interns and medical students attending the meeting.

Conclusion
Participants have continued to show strong commitment to ensure this models continued success. A recent review of the effectiveness of the Horsham MDM amongst attendees and against its Terms of Reference showed strong satisfaction from lead clinicians that contribute to this MDM. Future planning 2013 will include an upgrade of IT equipment and a promotional plan to further engage Primary Care Providers in the region to participate in the Wimmera MDM.

21. QUEENSLAND TROPHOBLAST CENTRE (QTC)
Morrison, S.J.1, 2, Eddy, M.J. 1, 2, Sanday, K.L.1, Garrett, A.J.1, 2
1 The Queen Elizabeth Hospital, Adelaide, SA, Australia 2 Queensland Centre for Gynaecological Cancer (QCGC) Brisbane, QLD, Australia

Introduction
Queensland has been running a Gestational Trophoblastic Disease Registry since 1976. In 2012 we updated and expanded the service. A database was developed to aid in the management and tracking of patients diagnosed with Gestational Trophoblastic Disease (GTD) in Queensland.

Aim
QTC provides a state-wide service for the registration and monitoring of patients diagnosed with GTD. It also provides a consultative service for patients and clinicians. With improved record keeping and resources we are able to ensure capture of and appropriate management of patients with GTD across Queensland, in line with international standards and guidelines.

We are also able to undertake research to a high ethical standard in order to improve patient outcomes.

Description
From July 2010, clinician lead meetings were held regarding the expansion / improvement of the existing GTD service. Through these multidisciplinary meetings a plan was formulated to progress the project and a small project team followed through with the development of the QTC service which included staffing, records management, treatment protocols and administrative and clinical guidelines.

Conclusion
The QTC is now established and work continues to ensure clinicians in Queensland are aware of the service thus enabling patient with GTD to receive appropriate management and care in line with international best practice.

References

22. ‘TISSUES IN OUR POCKET’ - ‘COLLECTING BITS AND PIECES’ – THE IMPACT OF PROVIDING HOLISTIC NURSING CARE
Norman, R. 1, O’Dell, K.1
1 The Queen Elizabeth Hospital, Adelaide, SA, Australia

Introduction
Nurses collect ‘bits and pieces’ of their patients’ journey when providing care.

A closer examination of stress within the nursing profession highlights the complexity of this issue and also alludes to the origin of stress from a number of different sources. With the evolution of more complex, aggressive and invasive treatments within the Haematology/Oncology specialty and, as organisations, from necessity, move to a more business management focus, the pressures on our nursing population increase

Objectives/Aims
This investigation seeks to identify the multidimensional facets of stress in Haematology/Oncology nurses in an acute care hospital setting in South Australia, with the aim of making recommendations for practice management, self-care and, further research.

Description/Methodology
A survey of haematology/oncology nurses working on an inpatient unit was undertaken. Nursing staff were asked a series of questions encompassing the sources of stress that were identified.

Results
35 registered and enrolled nurses were surveyed with experience ranging between newly graduated and 20 plus years. The survey responses confirmed that stress is multidimensional, with organisational stress consistently identified. The results of the survey are presented, along with nursing staff perceptions of the type of stress they are experiencing.

Conclusions
It is obvious that providing quality, holistic care to Haematology/Oncology patients comes at the cost of compromising the health of nurses. Responsibility for the management of stress within nursing must lie with both management and the nurses themselves if a healthy, optimal functioning workforce is to be maintained.

Introduction
The Lancet 2010

Description
It is obvious that providing quality, holistic care to Haematology/Oncology patients comes at the cost of compromising the health of nurses. Responsibility for the management of stress within nursing must lie with both management and the nurses themselves if a healthy, optimal functioning workforce is to be maintained.

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23. HELPING YOUNG PEOPLE DEAL WITH THE "SCARY STUFF": AN ACCEPTANCE AND COMMITMENT THERAPY PROGRAM FOR THOSE IMPACTED BY PARENTAL CANCER

Patterson, P.1, McDonald, F. E. J. 1, Ciarrochi, J. 2, Hayes, L.3, Tracey, D.2
1CanTeen Australia, 2University of Western Sydney, 3University of Melbourne

Introduction
For adolescents and young adults, having a parent diagnosed with cancer can lead to elevated levels of psychological distress, uncertainty and disruption of family functioning, and also challenge the development of their coping skills. To address these issues, a manualised 7-week face-to-face group program called Truce was developed for young people aged 14 to 22 years.

Objectives/Aims
To describe the Truce program and report on the evaluation protocol and initial results.

Description/Methodology
Using Acceptance and Commitment Therapy, the program teaches mindfulness, values-based living, and dealing with difficult thoughts and feelings, within the context of coping with having a parent with cancer. The program is also informed by family systems theory, with parents attending one of the sessions and working through a ‘parent booklet’.

Results
Preliminary results related to program fidelity and participant satisfaction for one group (N=6 young people, N=5 parents) are reported. Fidelity was ensured through training and support for facilitators, measuring facilitator program adherence, and participant exposure and engagement. Like fidelity, satisfaction was high, and both young people and parents agreed they would recommend the program. Young people felt better able to handle difficult thoughts and feelings, and parents reported positive changes in their children’s behaviour and family interactions.

Conclusions
These preliminary results suggest that Truce has the potential to enrich the lives of young people impacted by parental cancer. Truce provides health professionals the opportunity to help their patients’ family members by referring them to the program.

24. INTRAVASCULAR DEVICE MANAGEMENT IN A TERTIARY CANCER CARE CENTRE: A POINT-PREVALENCE STUDY OF NURSING PRACTICE

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1Cancer Care Services, Royal Brisbane and Women’s Hospital, Herston 2Centre for Clinical Nursing, Royal Brisbane and Women’s Hospital, Herston

Introduction
The prevention and control of adverse events related to intravascular devices (IVDs) are increasingly recognised as a nurse sensitive indicator. The majority of cancer nurses manage IVDs on a daily basis, thus placing them in a unique position to improve patient outcomes. Optimal nursing management should include the utilisation of best available evidence in IVD assessment, management and documentation.

Aim
To observe nursing IVD mangement, assessment and documentation in a haemato-oncology setting.

Methodology
A prospective cross-sectional point-prevalence study was conducted in two inpatient units of the largest tertiary cancer centre in Queensland. Four cancer nurses conducted site inspections and documentation review, using a standardised audit tool.

Results
One hundred percent of inpatients with haemato-oncological malignancies (n=58) in the cancer care centre participated in this study. Of the 58 participants, 48 had an IVD in situ (14 with a peripheral cannula and 34 with a Central Venous Access Device). Of the 48 IVDs, approximately 80% of the dressings were clean, dry and intact. Site complications such as oedema, oozing and redness were observed in 27%. Additional securement was observed in the majority of devices (75%).

Conclusion
Suboptimal outcomes concerning dressing integrity, site complications and nursing documentation were identified, indicating the need for further improvement. The high usage of additional securement indicates that the primary dressing might not be sufficient. The results can inform nursing education and future research.

25. SELF-CARE SUPPORT FOR BLOOD CANCER PATIENTS SUFFERING FROM ORAL MUCOSITIS DUE TO CHEMOTHERAPY

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1Kurume University Graduate School of Medicine, Kurume, Fukuoka, Japan 2Kurume University School of Nursing, Kurume, Fukuoka, Japan

Introduction
It is said that symptoms such as inflammation or pain of oral mucositis (OM) by chemotherapy are relaxed by the patient’s habitual cleanliness and self-care. Larson proposed an “Integrated Approach to Symptom Management” (IASM) to be used by nurses to promote patient self-care symptom-management abilities.

Objectives/Aims
The purpose is to consider whether implementing IASM, which identifies “symptom” with “OM” for blood cancer patients who experienced chemotherapy, is effective.

Description/Methodology
The object was five patients (male/female= two/three). I listened to the experience of the patients and performed orientation with a pamphlet which included outbreak mechanism and measures method of OM and intervened along IASM.

On the completion day of the pharmaceutical treatment, I evaluated a) Symptom: Common Terminology Criteria for Adverse Events ver.4.0 (CTCAE), Oral Assessment Guide (OAG) ; b) Function: the Eastern Cooperative Oncology Group Performance Status (PS) ; c) Quality of Life(QOL) ; d) Self-care: intraoral observation technology, entering the oral care number of times, the progress of the symptom.

This study was undertaken with the approval of the Kurume University Ethics Committee, and all patients provided written informed consent.

Results
Two of five people appeared in OM. a1) CTCAE didn’t change. a2) As for OAG, one turned worse. b), c), d) As for PS (one), QOL (three), the self-care (all), a level improved.

Conclusions
Intervention by IASM for OM was effective. Ability for self-care improved.

The nurse must have a preventive viewpoint in future.

References
26. DEVELOPMENT OF LEARNING FRAMEWORK FOR THE NOVICE PRACTITIONER IN LUNG CANCER CARE COORDINATION

**Statham, E.**
QLD Health – Nambour General Hospital, Glenview, QLD, Australia

As a novice practitioner in Cancer Care Coordination allocated a portfolio in lung cancer, it was necessary to develop competency in this specific area of cancer nursing. Current evidence based practice was researched and the systems and processes relevant in the local setting were identified. The findings were documented to establish a thorough understanding of the journey for the patient diagnosed with lung cancer.

The aim of the project was to construct a patient-focused learning framework to guide the novice practitioner in lung cancer care coordination towards competency by documenting the unique pathway from diagnosis, through staging, MDT management, through treatment to survivorship or palliation.

The activity relied on a critical reflection of individual practice, demonstrated a commitment to professional development, encouraged leadership qualities, addressed contemporary issues of health literacy, applied the principles of adult learning, addressed the challenge of retaining new knowledge for an aging workforce and contributed to practice development.

The learning framework included an examination of lung anatomy and physiology, the pathophysiology of cancer, the contributory factors for lung cancer, diagnostic investigations, staging criteria and an explanation of treatment options, including surgery, radiation therapy and chemotherapy, in the curative and palliative setting. Key stakeholders were identified, contact details summarised and the unique responsibilities of the cancer care coordinator within the multidisciplinary team outlined.

This undertaking served as a valuable experience in developing confidence and competency in lung cancer care coordination and the framework has since been adopted as a reference for new staff to the unit.

27. CANCER, CULTURAL SENSITIVITY AND ENHANCED PATIENT OUTCOMES.

**Tapsall, D, Hickling, M, McKenzie, D, Murphy, J, Rudling, M, Williams, R.**
Logan Hospital, QLD, Australia

**Background**
Logan City has a multicultural population requiring a culturally sensitive approach to cancer care. They also need multidisciplinary input to successfully address their socio-cultural needs. Currently there are over 1000 Aboriginal and Torres Strait Islander people living in Logan City (Australian Bureau Statistics, 2011). This accounts for 2.8% of the total population. Evidence has shown that this population hesitates to access mainstream health care, including palliative care.

**Aim**
This poster presentation examines the case of an Aboriginal gentleman with chronic myelomonocytic leukaemia. This poster presentation format will illustrate how two separate Cancer Services modalities (Haematology and Palliation), coupled with attention to the precepts of cultural diversity, was utilised at the Day Therapy Unit at the Logan Hospital to enhance patient outcomes.

**Description**
Mr N needs focused on his ability to remain in control of his cultural heritage as well as receiving appropriate multidisciplinary care. On initial assessment Mr. N expressed his fears of dying short of breath and in pain. This presentation will illustrate how a secondary outreach ambulatory centre addressed the needs of the patient and his significant others to assist them in transitioning from active treatment for his malignancy to end-of-life care, whilst maintaining control over his choices.

**Conclusion**
Partnership with multidisciplinary culturally aware team, patients and significant others leads to positive patient outcomes.

29. CINV CHECK: AN AUDIT OF CHEMOTHERAPY INDUCED NAUSEA AND VOMITING (CINV) PREVENTION IN PATIENTS RECEIVING MODERATELY EMETOGENIC CHEMOTHERAPY (MEC) AT CABRINI MALVERN DAY ONCOLOGY

**Wiley, G, Proposch A**
Cabrini Hospital Malvern, Melbourne, Victoria, Australia

**Introduction**
CINV Check is an audit program developed to support nurses in their goal of improving the management of chemotherapy-induced nausea and vomiting. This poster looks at the audit undertaken at Cabrini Malvern Day Oncology.

**Objectives/Aims**
- Encourage greater communication about CINV between patients, nurses and oncologists
- Promote evidence-based practice in assessing and responding to CINV risk in MEC
- Patients and improve patient quality of life during chemotherapy

**Description/Methodology**
- Patients receiving MEC irrespective of protocol or cycle number
- Patients with colorectal, ovarian or lung cancer
- Patients Day 1 of their chemotherapy cycle

**Results**
- **Standard 1:** 95% risk assessed appropriately
  77% risk identified
- **Standard 2:** 59% reported in diary and to nurse
  41% in diary only
  100% patients did not have their treatment further optimised
- **Standard 3:** 73% reported CINV
  93% reported nausea only

**Conclusions**
- **Standard 1:** Nursing Staff require further education in identifying risk factors
- CINV risk factors must be incorporated into patient education sessions as standard screening
- **Standard 2:** Patient symptom diary may enable more accurate review of patients
- A review of current practice of escalation of antiemetic therapy may be beneficial
- **Standard 3:** More work is required to achieve absence of CINV in patients.

**References**
Program developed in collaboration with Professor Kate White, Professor Ian Olver, Professor Michael Green, Dr Devinder Gill, Vivacity Health and MSD
30. ASSESSING THE POTENTIAL VALUE OF CANCER INFORMATION RESOURCES IN E-BOOK FORMAT

**Wuellner, L., Smith, S., Mitchell, P.**
Cancer Council NSW, Woolloomooloo, NSW, Australia

**Introduction**
Cancer Council’s *Understanding Cancer* series comprises more than 50 printed titles with information for people affected by cancer. Booklets are distributed by health professionals and through Cancer Council information centres and distribution channels. They are also available online in PDF format.

**Objectives/Aims**
Current statistics indicate approximately 20% of Australians read electronic books (e-books). Cancer Council is exploring whether publishing e-books will improve consumer access to information.

**Description/Methodology**
An informal survey was developed to evaluate carers’ and patients’ usage of e-books, and determine perceived benefits and barriers to adoption. Callers to the Cancer Information and Support Line (13 11 20) received a survey and it was available on cancercouncil.com.au.

**Results**
Of 53 respondents, 47.2% had read e-books and 77.4% own an e-reader. About 60% of people would ‘definitely’ or ‘probably’ read *Understanding Cancer* e-books.

The highest perceived barrier is lack of adoption by family and friends. Respondents identified the most compelling potential benefits as accessibility and cost effectiveness.

**Conclusions**
Trends forecasting an increased uptake in e-book usage are reflected in our survey results. It is recommended that further investigation is undertaken to identify best practice for health information in e-book format, as well as demographic profiling of target audiences. This will enable us to prioritise information produced and disseminated as e-books.

**References**
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More information about Roche in Australia is available through www.roche-australia.com or Roche Medical Information on 1800 233 950.
YERVOY (ipilimumab) Approved Product Information. 16 May 2013.

**INDICATION:**
YERVOY (ipilimumab), as monotherapy, is indicated for the treatment of patients with unresectable or metastatic melanoma who have failed or are intolerant to prior therapy.

**STUDY DESIGN:**
A Phase 3 randomised double-blind study of patients with unresectable or metastatic melanoma (N=676 patients) who had failed or were intolerant to at least one prior therapy. Patients were randomised 3:1:1 to receive YERVOY 3 mg/kg in combination with an investigational gp100 peptide vaccine (gp100) (n=403), YERVOY 3 mg/kg monotherapy (n=137), or gp100 alone (n=136). The primary endpoint was overall survival in the YERVOY + gp100 arm vs. the gp100 alone arm.

**REFERENCES:**
In Metastatic Hormone Refractory Prostate Cancer

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*15.1 months median overall survival with JEVTA® (cabazitaxel) vs 12.7 months with mitoxantrone (HR=0.70 [95% CI 0.59 - 0.83], p<0.0001)¹

Introducing JEVTA®, in combination with prednisone or prednisolone, for the treatment of mHRPC† previously treated with a docetaxel-containing regimen²

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INDICATIONS: Jevtana in combination with prednisone or prednisolone is indicated for the treatment of patients with hormone refractory metastatic prostate cancer previously treated with a docetaxel containing regimen.

CONTRAINDICATIONS: Contraindicated in patients with a history of severe hypersensitivity reactions to cabazitaxel, any of the excipients of cabazitaxel or other drugs formulated with polysorbate 80, a baseline neutrophil count ≤1,500/mm³, hepatic impairment, those who are pregnant (pregnancy category D) or breast-feeding, or those who will have a concomitant yellow fever vaccine.

PRECAUTIONS: Neutropenia has been reported (especially elderly patients ≥65 years of age), therefore monitoring of complete blood count is essential on a weekly basis during cycle 1 and before each treatment cycle thereafter so that the dose can be adjusted, if needed. The use of G-CSF has been shown to limit the incidence and severity of neutropenia (see full PI). Patients should be pre-medicated prior to each Jevtana administration to minimise hypersensitivity reactions. If severe reactions occur such as generalised rash/erythema, hypotension and bronchospasm, Jevtana should be discontinued immediately. Severe nausea, vomiting or diarrhoea may occur; monitor for dehydration and treat appropriately. Cases of peripheral neuropathy, renal disorders have been reported. Anaemia and cardiac arrhythmias have been reported and should be monitored for. Effective contraception should used throughout treatment and are recommended to continue this for up to 6 months after the last dose of Jevtana.

INTERACTIONS: Co-administration with potent CYP3A inhibitors should be avoided. Caution should be exercised with concomitant use of moderate CYP3A inhibitors. Co-administration with CYP3A inducers should be avoided. In addition, patients should also refrain from taking St. John’s Wort. Vaccination with a live attenuated vaccine should be avoided in patients receiving cabazitaxel.

ADVERSE EFFECTS: The most commonly occurring adverse reactions in the Jevtana group were neutropenia (81.7%), febrile neutropenia (7.5%), diarrhoea (6.2%), leukopenia (68.2%) and anaemia (10.5%). See full PI.

DOSAGE AND ADMINISTRATION: The recommended dose of Jevtana is 25 mg/m² administered as a 1-hour intravenous infusion every 3 weeks in combination with oral prednisone (or prednisolone). 10 mg administered daily throughout Jevtana treatment. Dose modifications may be necessary should a patient experience adverse reactions such as prolonged grade ≥3 neutropenia, febrile neutropenia or neutropenic infection, Grade ≥3 diarrhoea or persisting diarrhoea, Grade ≥2 peripheral neuropathy. Preparation for the intravenous administration: Refer to PI for detailed instructions for preparing Jevtana for administration.


DATE OF PREPARATION: 08 January 2013, Version 02.
