CNSA 17th Winter Congress

To download the app, go to your app store and search for “ShowGizmo”. Once downloaded find CNSA and tap our event to join!

Mobile web app: showgizmo.mobi
Welcome

Supporters & Partners

Committees

Speaker Profiles

Getting Social

Congress Information

Room Allocations

Floor Plans

Exhibition and exhibition opening hours

Program

Poster Listing

Breakfast Session 1: The Chris O'Brien Lifehouse Implementation Experience

Breakfast Session 2: Optimising supportive care in immuno-oncology: The VOYCE nurses network

Plenary Session 1

Leading in a time of change: Improving cancer services using experienced based co-design methodology

The metamorphosis of melanoma from forgotten disease to poster child

Concurrent Session A: Models of Care (a)

Epworth Healthcare Leadership Programs: Developing nurse leaders

The New Zealand Cancer Nurse Coordinator initiative: Establishing a new model of nursing care

Finding the key to the lock: Development of the access co-ordinator role in a cancer imaging department

The development of the cancer nurse practitioner role in Australia: A qualitative study

Measuring what matters: Quantifying the activity of radiotherapy nurses in a patient centred model of care

Concurrent Session B: Education for Nurses (a)

An evaluation of registered nurses’ oral cryotherapy knowledge and confidence in the acute haematology/oncology setting: A pre-test/post-test pilot study

ADAC – Standardising skills for all clinical staff

Leading in a time of change – Preparing nurses for the future of the deadly dust

Intrathecal pain management: Development of a self-directed learning package

A quasi experimental randomised controlled trial utilising a translational research intervention to improve cancer nurses adherence with recommended pain screening and assessment practices

Concurrent Session C: Evidence Based Practice

A natural oil-based emulsion containing allantoin versus aqueous cream for managing radiodermatitis in patients with cancer: A phase III double-blind randomised controlled trial

Central venous access device flushing: Practices and attitudes amongst Australian cancer nurses

Acute transfusion reaction knowledge and management – How well are we doing?

Speeding to zero: A nurse led project to reduce central line associated blood stream infections in haematology/oncology inpatients

Randomised controlled trials of an energy conservation and management intervention for cancer-related fatigue in men treated for prostate cancer

Concurrent Session D: Supportive Care (Breast)

Men get breast cancer too: An information resource for men with breast cancer

A Melbourne based nursing perspective on advanced breast cancer (ABC) supportive care: Is ABC as easy as 1, 2, 3?

The role of the Australian breast care nurse: A self-report online survey

Enhanced surveillance of gestational breast cancer

‘I wish I could fix it’: Supporting your partner through breast cancer: An information resource for partners of women with breast cancer

Concurrent Session E: Education for Nurses (b)

Eliciting key clinical information – What to ask and why in Radiotherapy

EVIQ education – Supporting best practice through patient focused evidenced based radiation oncology modules

The effect of language on cancer nursing practice

EVIQ Bridging the Gap – Real-time evidence retrieval using a bibliometrics solution

Queensland’s extension of EDCAN to Queensland-Cancer Education Program (Q-CEP)

Concurrent Session F: Survivorship

Nurse-lead survivorship clinic in practice

Women’s experience of breast care nurses in a survivorship clinic

Helping indigenous people with cancer to better navigate towards optimal care: A pilot study

Developing a rehabilitation framework for cancer survivorship

Breaking down the barriers: Examination of the barriers to psychological screening and referral of men with chronic illness displaying signs of distress
Plenary Session 2
Dressing and securement options for central venous access devices: Do they work, or are they just more work?!  
Facing an uncertain future: Cancer care in the era of antimicrobial resistance

Plenary Session 3
Improving the patient journey through better mental health care: Core business for all nurses  
Cancer Care in Indigenous communities, with advances in personalised medicine are we closing the gap in health outcomes?

Concurrent Session G: Education for Patients
“RESILIENCE” support group model: A tailored information and peer support program for women newly diagnosed with ovarian cancer and their carers  
Cancer Council Helpline – How many people use this information and support service and why not?  
Using web-enabled technology to support men with prostate cancer  
The development and evaluation of resources for friends of young people living with cancer  
A shift in paradigm – Central Integrated Regional Cancer Service (CIRCS) Cancer Education Program

Concurrent Session H: Supportive Care
The role of team leader in promoting supportive care screening among cancer nurses  
Distress screening and supportive care needs of cancer patients and carers in regional western Australia  
Digital information service and cancer supportive care: A Victorian perspective  
Same same but different: Comparison of oncology nurses family practices in Australia and Denmark  
The implications of the withdrawal of the Liverpool Care Pathway in the UK for Australia: A discussion paper  
Evaluation of the gynaecology basic sexual health assessment questions included in the supportive needs screening tool

Concurrent Session I: Models of Care (b)
Western Health Oncology Hospital in the home: Issues for patients, caregivers and the health system specific to home-based cancer treatment  
Innovative nursing workforce strategy.... Incorporating an endorsed enrolled nurse into a chemotherapy day unit  
Improving cancer symptom and chemotherapy toxicity management for patients undergoing chemotherapy at Western Health  
Expanding the scope of practice of the enrolled nurses to include administration of antineoplastic agents: Key issues and recommendations of the CNSA education committee  
“Let’s talk about sex” – The implementation of a nurse practitioner (NP) led sexual health and erectile dysfunction (SHED) clinic at Peter MacCallum Cancer Centre (Peter Mac)  
How do prostate cancer specialist nurses’ professional development needs change over time?

Plenary Session 4
Developing community pathways for people living with and beyond cancer

Poster Abstracts
1. A severe docetaxel skin reaction: A case report  
2. Co-ordination of supportive care needs in metastatic breast cancer  
3. Promoting awareness in quality radiotherapy nursing  
4. My journey as a novice researcher: A journey worth taking!  
5. Peripherally inserted central catheter (PICC) cushioning material: A pilot study comparing gauze with silicone foam for chemotherapy patients  
6. Crowning Glory – Is that the whole story? Implementing scalp cooling in an Australian setting  
7. Psychosocial nursing interventions for patients with cancer  
8. Who are today’s leaders?  
9. Piccs, ports and peripheral cannulas – The patients’ perspective  
10. Prostate cancer specialist nurses – Influencing care beyond the bedside  
11. Extending the scope of practice of an endorsed enrolled nurse in a chemotherapy day unit ... What can they do?  
12. Dabrafenib, a new era – Targeted therapies and side-effects  
13. Online patient-held resources for improving cancer pain management  
14. Nurse care guides – A communication, education and documentation tool  
15. The establishment of chemo@home – An integrated model of patient centred service delivery for chemotherapy patients  
16. Development and implementation of Australian consensus guidelines for the safe handling and administration of monoclonal antibodies for cancer treatment by healthcare personnel  
17. Urgent care of the oncology patient – Analysis from a cross sectional study of the clinical characteristics of oncology patients presenting to one Sydney tertiary referral emergency department
On behalf of the Local Organising Committee I would like to welcome you to the 17th Annual CNSA Winter Congress. This year’s congress will be a time to learn, discuss, debate and reflect on where we have come from, what we have achieved and what the future holds for Cancer Nursing. The foci for 2014 will incorporate the evolution in nursing leadership, evidence based treatments and patient centred care, including change, challenge, co-morbidities, collaboration, conflict and cost.

This year we welcome Dr Theresa Wiseman from The Royal Marsden NHS Foundation Trust, UK as our international speaker, who along with our renowned national speakers will set the tone for a fantastic congress.

We have planned this congress so there are relevant sessions for all delegates attending. Make sure you make the most of this program so that you can select the concurrent sessions that are right for you.

Please also make sure you leave yourself enough time to look at the great display of posters.

We are very grateful to our industry supporters, without them this congress would not be possible. Please visit them and see the latest products and resources they have to offer. This year we also have a number of not for profit organisation stands, these organisations continue to provide invaluable information for our patients and support for us as Cancer Nurses.

Melbourne is a city filled with fabulous food, coffee, culture and shopping! If you want to get out and explore the city a member of the Local Organising Committee will be more than happy to point you in the right direction.

We hope that this congress will be informative and thought provoking and that you will gain valuable information that you can put into practice.

Jac Mathieson
PRE-Congress Workshop Supporters

Australian Cancer Survivorship Centre

SUPPORTERS & PARTNERS

National Executive Committee
President: Sandy McKiernan
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CNSA Administration Assistant: Amy Ribbons

Winter Congress Committee
- Samantha Gibson – Winter Congress Committee Chair
- Jac Mathieson – Local Organising Committee Chair
- Sandy McKiernan – CNSA President
- Raymond Chan – CNSA President Elect
- Julie Calvert – CNSA Executive Officer
- Kate Ryall – Professional Conference Organiser

Local Organising Committee
- Jac Mathieson – Local Organising Committee Chair
- Judy Forsyth
- Tina Griffiths
- Nicole Kinnane
- Mei Krishnasamy
- Donna Milne
- Cathie Pigott
- Georgina Wiley
Dr Theresa Wiseman is Lead for Health Service Research, Nursing, Rehabilitation and Quality, at The Royal Marsden NHS Foundation Trust, London UK. Dr Wiseman was a lead investigator on the internationally acclaimed work on Evidence Based Co-Design, an innovative and uniquely patient-centred approach to improving UK health services provision. She has recently completed an analysis of the UK Patient Experience Survey and has experience and expertise in developing interventions and care pathways to respond to patient experience. Dr Wiseman has an impressive conference presentation and publication profile and was responsible for developing the 10 Top Tips as part of the Macmillan National Cancer Survivorship Initiative funded Consequences of Cancer and Treatment Collaborative, which is distributed widely throughout the UK.

Associate Professor Gail Garvey, a Kamilaroi woman from New South Wales and Senior Research Fellow at Menzies School of Health Research has 25 years experience working in Indigenous education and health research. She plays a leadership role in Indigenous cancer research, advocates involving Indigenous stakeholders and clinicians to achieve maximum impact from research and has an impressive record in research capacity-building.

A/Prof Garvey leads two national grants: DISCOVER-1TT, a Centre of Research Excellence in Indigenous Cancer and a Cancer Council NSW Strategic Research Partnership Grant. These programs investigate system approaches to service delivery and interventions to improve cancer outcomes for Aboriginal and Torres Strait Islander people.

A/Prof Garvey helped establish the National Indigenous Cancer Network (NInCaN) in partnership with Australian Indigenous HealthInfoNet, Cancer Council Australia and The Lowitja Institute. NInCaN aims to encourage and support collaboration around research and services for Indigenous people with cancer, their carers and families.

Professor Grant McArthur is a Fellow of the Royal Australasian College of Physicians and holds a PhD in Medical Biology. In 2004 he was awarded the Translational Research Award of the Fondation Nelia et Amadeo Barletta and presented a plenary paper at the EORTC-NCI-ACCR Symposium on Molecular Targets and Cancer Therapeutics. In 2005 he was awarded the Sir Edward Dunlop Clinical Cancer Research Fellowship of the Cancer Council of Victoria. He is national and international study co-chair of a number of clinical trials of targeted therapies. Research Interests include clinical trials of targeted therapeutics, molecular haematology, melanoma, cell cycle control, differentiation, and functional imaging. He is an associate editor for melanoma at Annals of Oncology and sits on the editorial board of Anti Cancer Drugs, Journal of Clinical Oncology, The Open Clinical Cancer Journal, Therapeutic Advances in Medical Oncology and the Journal of Personalized Medicine. His publications include senior or first author publications in the following journals: EMBO J, Blood, New England Journal of Medicine, Molecular and Cellular Biology, Journal of Clinical Oncology and Nature Cell Biology.

Professor Claire Rickard is from the NHMRC Centre for Research Excellence in Nursing at the Griffith Health Institute, Griffith University. She believes a randomised controlled trial is a thing of beauty and its joys last forever. Rickard attempts to apply that beauty and joy to improve the care of the 70-90% of all hospital patients who need an intravascular access device for treatment. Rickard is Director of the Australian Vascular Access Teaching and Research (AVATAR) Group, a group of more than 100 clinical and academic researchers working towards making intravascular device complications history. The National Health and Medical Research Council have funded her work with more than $6 million. With over 100 published papers, including in The Lancet, her work has significantly advanced global recommendations including the safety of removing peripheral intravenous catheters based on clinically-based rather than time-based criteria. Prof Rickard was inducted into the prestigious STTI International Nurse Researcher Hall of Fame in 2012 in Prague.
Adjunct Associate Professor Kim Ryan
Adjunct Associate Professor Kim Ryan, Credentialed Mental Health Nurse and CEO, Australian College of Mental Health Nurses

Adjunct Associate Professor Ryan was the first salaried Chief Executive Officer of the Australian College of Mental Health Nurses, commencing in the position in 2004. The ACMHN is the peak professional mental health nursing organisation and the recognised Credentialing body for mental health nurses in Australia. She is passionate about mental health and mental health nursing holding a more prominent position on health agendas at local, state, national and international levels and believes this can only be achieved with a strong, united, professional voice.

She is a Board member of the Mental Health Professionals Network (MHPN), a member of the governing council of the Coalition of National Nursing Organisations. She was awarded the position of Adjunct Associate Professor by Sydney University in 2009 in recognition of her contribution to the nursing profession.

Associate Professor Karin Thursky
Associate Professor Karin Thursky is an Infectious Diseases physician with appointments at Royal Melbourne Hospital and Peter MacCallum Cancer Centre and is an honorary fellow with the University of Melbourne Medical School. She is actively involved in the area of quality and safety and has a national profile in antimicrobial stewardship, and development and implementation of consensus guidelines for the prevention and treatment of infections in the cancer patient. Her research area is broad with interests such as clinical epidemiology of infections in the immunocompromised host, health economics, computerised decision support, natural language processing and surveillance.
If you have a Twitter or Facebook account, you can join in on the conversation at this year’s Winter Congress. During the conference, The official CNSA Twitter page @ CNSA_ORG and Facebook page Facebook/CNSA.org will be talking about session highlights and speaker topics, as well as getting interactive and responding to your tweets and questions.

SHOW ME THE HASHTAG …
Join the conversation and share your thoughts instantly by including our dedicated hashtag #cnsa2014 in your tweets and your Facebook posts. Using the hashtag will help the organising committee, speakers and other delegates easily find your conversations, debates and questions.

MORE THAN WORDS …
But it doesn’t just have to be about words, we would love to see your photos of the experience you are having at the Winter Congress. Share your photos on Facebook using #cnsa2014 – the best ones will be added to the official CNSA Winter Congress page.

SHARE THE LOVE …
It’s also good to share – so if you see a tweet or a Facebook post from CNSA that you agree with or like then click the share button or the re-tweet button and let all everyone know that you’re involved with the 2014 Winter Congress.

NEED HELP?
Chilli Fox’s friendly staff members are available throughout the congress to help you get social with CNSA Winter Congress on Twitter and Facebook. Visit them at the registration desk for anything “social media” related.
SOCIAL PROGRAM INFORMATION

**Welcome Reception**
Thursday 24 July 2014, 5.00pm – 6.30pm

**Pullman Albert Park – Exhibition Area**
The Welcome Reception is included in the registration fee for full registrants and includes canapés and drinks.

**Dress:** Smart Casual

**Congress Gala Dinner**
Friday 25 July 2014, 7.30pm – 11.00pm

**The Ballroom, Pullman Albert Park**

**Dress:** Dress to impress!

**Ticket price:** $100.00 p/person which includes canapés, live cooking stations, drinks and entertainment.

*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.*

REGISTRATION DESK

The registration desk will be located on level one of the hotel, within the exhibition area. The opening times are as follows:

- **Thursday 24 July:** 3.00pm – 6.30pm
- **Friday 25 July:** 7.00am – 5.00pm
- **Saturday 26 July:** 8.00am – 4.00pm

**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 and the Welcome Reception on Thursday 24 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

CATERING/BREAK TIMES

Morning, afternoon tea and lunch will be served within the congress exhibition area which is located on level one of the hotel.

- **Friday 25 July**
  - 10.20am – 10.50am: Morning Tea
  - 12.30pm – 1.30pm: Lunch
  - 3.10pm – 3.40pm: Afternoon Tea

- **Saturday 26 July**
  - 10.40am – 11.20am: Morning Tea
  - 1.20pm – 2.20pm: 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 (Room M8) 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 on level one of the hotel.

Don’t forget to vote for your favourite poster. You will find your score card located in your name badge pocket. Please hand this in to the registration desk no later than lunch time on Saturday.

BUSINESS CENTRE

Business services, such as photocopying, printing and faxing is available from “Conference Concierge” which is located on level one of the hotel.

INTERNET ACCESS

Wireless internet is available to congress delegates and is designed for web browsing and checking web based email. Please see the registration desk to obtain the wi-fi access code. Computer terminals are also available on the ground floor, opposite the hotel reception should you wish to use a PC rather than your mobile/personal device.

GETTING AROUND

- **Trams:** Trams travel down St Kilda Rd (numbers 3, 5, 6, 16, 64 and 67). Tram stop 27 is the closest to The Pullman Albert Park and is a short walk down Lorne Street to the hotel.
- **Trains:** The closest train stations to the hotel are Prahran (located on the corner of Greville Street and Porter Street), and Flinders Street.
- **Buses:** The closest bus stop to the hotel is located at the corner of Greville Street and Punt Road, Prahran. The stop ID number is 1115.


- **Taxis:** The hotel is able to order you a taxi upon request, however you can also catch a taxi from designated taxi ranks.
**THURSDAY 24 JULY**

Pre-Congress Workshop 1  
Lake Rooms 1 & 2

Pre-Congress Workshop 2  
Lake Rooms 3 & 4

Pre-Congress Workshop 3  
Element Room

Pre-Congress Workshop 4  
Park Room

Welcome Reception  
Exhibition Area – Grand Ballroom

**FRIDAY 25 JULY**

Breakfast Session 1 – Hospira  
Lake Room

Breakfast Session 2 – BMS  
Element Room

Plenary Session 1  
Grand Ballroom 1 – 4

Concurrent Session A  
Grand Ballroom 1 & 2

Concurrent Session B  
Grand Ballroom 3

Concurrent Session C  
Grand Ballroom 4

Breast SIG Meeting  
Grand Ballroom 1 & 2

Gynae-Oncology SIG Meeting  
Grand Ballroom 3

Radiation Oncology SIG Meeting  
Grand Ballroom 4

Concurrent Session D  
Grand Ballroom 1 & 2

Concurrent Session E  
Grand Ballroom 3

Concurrent Session F  
Grand Ballroom 4

Plenary Session 2  
Grand Ballroom 1 – 4

Gala Dinner  
Grand Ballroom 1 & 2

**SATURDAY 26 JULY**

CNSA Education Committee Breakfast Meeting  
M10

Breakfast Meeting  
M10

Plenary Session 3  
Grand Ballroom 1 – 4

CNSA AGM  
Grand Ballroom 1 – 4

Concurrent Session G  
Grand Ballroom 1 & 2

Concurrent Session H  
Grand Ballroom 3

Concurrent Session I  
Grand Ballroom 4

AJCN Editorial Meeting  
M10

Plenary Session 4  
Grand Ballroom 1 – 4
EXHIBITION AND EXHIBITION OPENING HOURS

THURSDAY 24 JULY
1700 – 1830  Welcome Reception

FRIDAY 25 JULY
1020 – 1050  Morning tea
1230 – 1330  Lunch
1510 – 1540  Afternoon tea

SATURDAY 26 JULY
1040 – 1120  Morning tea
1320 – 1420  Lunch
1420    Exhibition closes

EXHIBITOR LISTING

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Table 1 – Breast Cancer Network Australia
Table 2 – Look Good…Feel Better

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!
We have all your education needs covered

ACN’s postgraduate courses are delivered via distance education with online components, with ongoing support from experienced course coordinators and subject tutors.

Nurses working with cancer patients can choose from the following courses in July 2014:
- Graduate Certificate in Cancer Nursing
- Graduate Certificate in Breast Cancer Nursing

Not ready to commit to a full postgraduate course? ACN offers over 20 subjects related to cancer nursing:

- Blood and marrow transplantation;
- Breast cancers; Haematology nursing
- and many more. July intake is now open.

Need to improve your clinical skills?

Breast Care Nurse Practicum is a five day clinical program developed in collaboration with The Westmead Breast Cancer Institute and McGrath Foundation to support registered nurses in gaining postgraduate and clinical knowledge of breast cancer diagnosis and management. Next course starts: 8 September 2014.
THURSDAY, 24 JULY: Pre-Congress Workshop Program

1000 – 1645

**Workshop 1:** eviQ Education Antineoplastic Drug Administration Course (ADAC) – Facilitation Skills Training  
(1000 – 1645) Room: Lake 1 & 2

**Workshop 2:** Optimising Outcomes with Vascular Access Devices in the Cancer Care Setting. (1000 – 1600)  
Room: Lake 3 & 4

**Workshop 3:** Delivering Innovative Cancer Survivorship Care (1000 – 1645) Room: Element

**Workshop 4:** COSA Geriatric Oncology Workshop (1000 – 1600) Room: Park

1700 – 1830 Welcome Reception and Networking Opportunity held within the Exhibition Area – Grand Ballroom

FRIDAY, 25 JULY: Winter Congress Program, Day One

0700 Registration

0715 – 0815

**Breakfast Session 1:** The Chris O’Brien Lifehouse Implementation Experience  
Room: Lake  
Supported by: Hospira

**Breakfast Session 2:** Optimising supportive care in immunology: The VOYCE nurses network  
Room: Element  
Supported by: Brisbane Myers Squibb

0830 – 0910 Welcome to Country Ceremony  
Congress Opening Address Professor Jim Bishop AO  
Welcome Note Sandy McKiernan, CNSA President, and Jac Mathieson, Local Organising Committee Chair

0910 – 1020 PLENARY SESSION 1  
Chair: Jac Mathieson  
Venue: Grand Ballroom 1 – 4

Leading in a time of change: Improving cancer services using experienced based co-design methodology  
Dr Theresa Wiseman

The metamorphosis of melanoma from forgotten disease to poster child  
Professor Grant A McArthur

1020 – 1050 Morning Tea, Poster Viewing and Exhibition Networking

1050 – 1230

**CONCURRENT SESSION A** Models of Care (a)  
Chair: Nicole Loft  
Venue: Grand Ballroom 1 & 2

Epworth Healthcare Leadership Programs: Developing Nurse Leaders  
Esther Yeoman

An evaluation of registered nurses’ oral cryotherapy knowledge and confidence in the acute haematology/oncology setting: a pre-test/post-test pilot study  
Polly Duffton

The New Zealand Cancer Nurse Coordinator Initiative: Establishing a new model of nursing care  
Natalie James

ADAC – Standardising skills for all clinical staff  
Leisa Brown

Finding the key to the lock: Development of the Access Co-ordinator role in a cancer imaging department  
Jac Mathieson

Leading in a Time of Change – Preparing Nurses for the Future of the Deadly Dust  
Judy Rafferty

Intrathecal pain management: development of a self-directed learning package  
Fleur Holland

Central Venous Access Device Flushing: Practices and Attitudes Amongst Australian Cancer Nurses  
Renee McMullen

Speeding to zero: A nurse led project to reduce central line associated blood stream infections in haematology/oncology inpatients  
Peter Haywood

Measuring What Matters: Quantifying the Activity of Radiotherapy Nurses in a Patient Centred Model of Care  
Esther Yeoman

Acute transfusion reaction knowledge and management - how well are we doing?  
Linley Bielby

1210 Measuring What Matters: Quantifying the Activity of Radiotherapy Nurses in a Patient Centred Model of Care  
Esther Yeoman

A quasi experimental randomised controlled trial utilising a translational research intervention to improve cancer nurses adherence with recommended pain screening and assessment practices  
Jane Phillips

Rad-Onc Special Interest Group Meeting  
Venue: Grand Ballroom 4

1230 – 1330 Breast Special Interest Group Meeting  
Venue: Grand Ballroom 1 & 2

Gynae-Onc Special Interest Group Meeting  
Venue: Grand Ballroom 3

Lunch
### 1330 – 1510

**CONCURRENT SESSION D**  
**Supportive Care (Breast)**  
**Chair:** Elisabeth Black  
**Venue:** Grand Ballroom 1 & 2

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<thead>
<tr>
<th>Time</th>
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<th>Speaker(s)</th>
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<tbody>
<tr>
<td>1330</td>
<td>Men get breast cancer too: An information resource for men with breast cancer</td>
<td>Annie Gayed</td>
<td>Grand Ballroom 1 &amp; 2</td>
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<tr>
<td>1350</td>
<td>A Melbourne based nursing perspective on Advanced Breast Cancer (ABC) supportive care: Is ABC as easy as 1, 2, 3?</td>
<td>Melanie Fisher</td>
<td>Grand Ballroom 1 &amp; 2</td>
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<tr>
<td>1410</td>
<td>The role of the Australian Breast Care Nurse: a self-report online survey</td>
<td>Tracey Ahern</td>
<td>Grand Ballroom 1 &amp; 2</td>
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<td>1430</td>
<td>Enhanced Surveillance of Gestational Breast Cancer</td>
<td>Nasrin Javid</td>
<td>Grand Ballroom 1 &amp; 2</td>
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<td>1450</td>
<td>‘I wish I could fix it’: Supporting your partner through breast cancer: An information resource for partners of women with breast cancer</td>
<td>Annie Gayed</td>
<td>Grand Ballroom 1 &amp; 2</td>
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**CONCURRENT SESSION E**  
**Education for Nurses (b)**  
**Chair:** Margaret Rankin  
**Venue:** Grand Ballroom 3

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<tr>
<td>1330</td>
<td>Eliciting Key Clinical Information – What to ask and why in Radiotherapy</td>
<td>Margaret Hjorth</td>
<td>Grand Ballroom 3</td>
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<tr>
<td>1350</td>
<td>eviQ Education - Supporting best practice through patient focused evidenced based radiation oncology modules</td>
<td>Kim Faulkner</td>
<td>Grand Ballroom 3</td>
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<tr>
<td>1410</td>
<td>The effect of language on cancer nursing practice</td>
<td>Olayinka Akinsanmi</td>
<td>Grand Ballroom 3</td>
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<td>1430</td>
<td>eviQ Bridging the gap – real-time evidence retrieval using a bibliometrics solution</td>
<td>Catherine Johnson</td>
<td>Grand Ballroom 3</td>
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<td>1450</td>
<td>Queensland’s Extension of EdCaN to Queensland-Cancer Education Program (Q-CEP)</td>
<td>Leisa Brown</td>
<td>Grand Ballroom 3</td>
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**CONCURRENT SESSION F**  
**Survivorship**  
**Chair:** Maryanne Hargraves  
**Venue:** Grand Ballroom 4

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<tbody>
<tr>
<td>1330</td>
<td>Nurse-led survivorship clinic in practice</td>
<td>Kerry Shanahan</td>
<td>Grand Ballroom 4</td>
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<tr>
<td>1350</td>
<td>Women’s experience of Breast Care Nurses in a Survivorship Clinic</td>
<td>Lee Kennedy</td>
<td>Grand Ballroom 4</td>
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<td>1410</td>
<td>Helping Indigenous people with cancer to better navigate towards optimal care: a pilot study</td>
<td>Christina Bernardes</td>
<td>Grand Ballroom 4</td>
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<td>1430</td>
<td>Developing a Rehabilitation Framework For Cancer Survivorship</td>
<td>Trish Calder</td>
<td>Grand Ballroom 4</td>
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<td>1450</td>
<td>Breaking down the Barriers: Examination of the Barriers to Psychological Screening and Referral of Men with Chronic Illness Displaying Signs of Distress</td>
<td>Georgina Wiley</td>
<td>Grand Ballroom 4</td>
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1510 – 1540 **Afternoon Tea**

1540 – 1650 **PLENARY SESSION 2**  
**Chair:** Donna Milne  
**Venue:** Grand Ballroom 1 – 4

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<th>Time</th>
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<tr>
<td>1540</td>
<td>Dressing and securement options for central venous access devices: Do they work, or are they just more work?!</td>
<td>Professor Claire Rickard</td>
<td>Grand Ballroom 1 – 4</td>
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<td>1540</td>
<td>Facing an uncertain future: Cancer care in the era of antimicrobial resistance</td>
<td>Associate Professor Karin Thursky</td>
<td>Grand Ballroom 1 – 4</td>
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1930 – 2300 **Congress Gala Dinner – Pullman Albert Park**  
**Venue:** Grand Ballroom 1 & 2

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**14 – 16 June 2015**

Perth Convention and Exhibition Centre  
www.cnsawintercongress.com.au
SATURDAY, 26 JULY: Winter Congress Program, Day Two

**0800**  
Registration

**0715 – 0815**  
Education Committee Meeting  
*Room: M10*

**0830 – 0940**  
**Plenary Session 3**  
*Chair: Sandy McKiernan*  
*Venue: Grand Ballroom 1 – 4*

Improving the patient journey through better mental health care: Core business for all nurses  
Adjunct Associate Professor Kim Ryan

Cancer Care in Indigenous communities, with advances in personalised medicine are we closing the gap in health outcomes?  
Associate Professor Gail Garvey

**0940 – 1040**  
**CNSA AGM**  
*Venue: Grand Ballroom 1 – 4*

**1040 – 1120**  
Morning Tea, Poster Viewing and Exhibition Networking

**1120 – 1320**  
**CONCURRENT SESSION G**  
Education for Patients  
*Chair: Keith Cox*  
*Venue: Grand Ballroom 1 & 2*

- **1120**  
  Resilience Support Group Model: A tailored information and peer support program for women newly diagnosed with ovarian cancer and their carers  
  Tarnya Hotchkin

- **1140**  
  Cancer Council Helpline – how many people use this information and support service and why not?  
  Monica Byrnes

- **1200**  
  Using web-enabled technology to support men with prostate cancer  
  David Blashki

**CONCURRENT SESSION H**  
Supportive Care  
*Chair: Tish Lancaster*  
*Venue: Grand Ballroom 3*

- **1120**  
  The role of team leader in promoting supportive care screening among cancer nurses.  
  Catherine Johnston

**CONCURRENT SESSION I**  
Models of Care (b)  
*Chair: Trevor Saunders*  
*Venue: Grand Ballroom 4*

- **1120**  
  Western Health Oncology Hospital in the Home: issues for patients, caregivers and the health system specific to home-based cancer treatment  
  Andy Robinson

- **1140**  
  Distress Screening and Supportive Care Needs of Cancer Patients and Carers in Regional Western Australia  
  Allison Fosbery

- **1200**  
  Using web-enabled technology to support men with prostate cancer  
  David Blashki

**1220**  
Digital information service and Cancer Supportive Care: A Victorian Perspective  
*Chan Cheah*

**1240**  
The development and evaluation of resources for friends of young people living with cancer  
*Elizabeth Kelly-Dalgety*

**1240**  
Same same but different: comparison of oncology nurses family practices in Australia and Denmark  
*Elisabeth Coyne*

**1300**  
**1320 – 1420**  
Lunch  
*Venue: M10*

**1420 – 1440**  
Awards Presentations

**1440 – 1550**  
**PLENARY SESSION 4**  
*Chair: Raymond Chan*  
*Venue: Grand Ballroom 1 – 4*

Developing community pathways for people living with and beyond cancer  
*Dr Theresa Wiseman*

Panel Discussion – New and Innovative Models of Care  
With new and developing treatments, complex patient profiles and a changing nursing workforce – how can we adjust our models of care to continue to provide best practice care to our patients?  
Dr Theresa Wiseman, Associate Professor Gail Garvey and Adjunct Associate Professor Kim Ryan discuss their thoughts.  
This session will be facilitated by Dr Raymond Chan.

**1550 – 1600**  
**Welcome to Congress 2015 Ruth McConigley, WA LOC Chair**

**Closing Address**  
*CNSA President, Sandy McKiernan*
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<tr>
<th>POSTER NO.</th>
<th>POSTER TITLE</th>
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<tbody>
<tr>
<td>1</td>
<td>A severe Docetaxel skin reaction: A case report</td>
<td>Gillian Blanchard</td>
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<td>2</td>
<td>Co-ordination of supportive care needs in metastatic breast cancer</td>
<td>Melissa Warren</td>
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<td>3</td>
<td>Promoting awareness in quality radiotherapy nursing</td>
<td>Kathryn Watty</td>
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<td>4</td>
<td>My journey as a novice researcher: A journey worth taking!</td>
<td>Rachel Pitt</td>
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<td>5</td>
<td>Peripherally inserted central catheter (PICC) cushioning material: A pilot study comparing gauze with silicone foam for chemotherapy patients</td>
<td>Kerrie Curtis</td>
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<td>6</td>
<td>Crowning glory – is that the whole story? Implementing scalp cooling in an Australian setting</td>
<td>Kerrie Andrews</td>
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<td>7</td>
<td>Psychosocial nursing interventions for patients with cancer</td>
<td>Giselle Ciavarella</td>
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<tr>
<td>8</td>
<td>Who are today’s leaders?</td>
<td>Karen O’Dell</td>
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<td>9</td>
<td>PICCs, ports and peripheral cannulas – the patients’ perspective</td>
<td>Alison Szewajcer</td>
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<td>10</td>
<td>Prostate cancer specialist nurses – influencing care beyond the bedside</td>
<td>Julie Sykes</td>
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<td>11</td>
<td>Extending the scope of practice of an endorsed enrolled nurse in a chemotherapy day unit.... What can they do?</td>
<td>Jade Roether</td>
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<td>12</td>
<td>Dabrafenib, a new era – targeted therapies and side-effects</td>
<td>Theresa Nielsen</td>
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<td>13</td>
<td>Online patient-held resources for improving cancer pain management</td>
<td>Jane Phillips</td>
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<tr>
<td>14</td>
<td>Nurse care guides – a communication, education and documentation tool</td>
<td>Linda McGinn</td>
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<tr>
<td>15</td>
<td>The establishment of Chemo@home – an integrated model of patient centred service delivery for chemotherapy patients</td>
<td>Lorna Rogers</td>
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<td>16</td>
<td>Development and implementation of Australian consensus guidelines for the safe handling and administration of monoclonal antibodies for cancer treatment by healthcare personnel</td>
<td>Trevor Saunders</td>
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<tr>
<td>17</td>
<td>Urgent care of the oncology patient – analysis from a cross sectional study of the clinical characteristics of oncology patients presenting to one Sydney tertiary referral emergency department</td>
<td>Meredith Oatley</td>
</tr>
<tr>
<td>18</td>
<td>Professional challenges and support mechanisms for breast care nurses in rural and remote Queensland</td>
<td>Pammie Ellem</td>
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<tr>
<td>19</td>
<td>A tablet a day? Introducing a mobile electronic device into home based cancer care</td>
<td>Robyn Wilson</td>
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<tr>
<td>20</td>
<td>Ipilimumab: The importance of nursing education and patient</td>
<td>Theresa Nielsen</td>
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**BREAKFAST SESSION 1**

The Chris O’Brien Lifehouse Implementation Experience

**Supported by:**

**Presenter:** Kate Baychek

*Clinical Nurse Educator, Chris O’Brien Lifehouse*

**Description**

Kate Baychek is a Clinical Nurse Educator in Day Therapy at the Chris O’Brien Lifehouse centre in Sydney NSW. Lifehouse is a new purpose-built, comprehensive cancer care centre, the first of its kind in NSW and recently opened in November 2013. The vision of Lifehouse is to provide uncompromising care to patients, housing all of the cancer services under one roof. The first phase included the Day Therapy Centre, Clinics, Radiation Oncology and Medical Imaging departments. The second phase to be opened by the end of 2014 will include theatres, wards and an Intensive Care Unit. In the pledge to provide uncompromising care to patients, the care of staff is a high priority as is the utilisation of evidence-based practice. In choosing the equipment for use in the Day Therapy Centre, implementing a closed system was a priority for the protection of staff and to comply with the NSW WorkCover guidelines. The Nurse Unit Manager chose the Hospira CLAVE™ Oncology needlefree closed system for the nursing staff to use in the delivery of antineoplastic agents. Kate Baychek will share with you the Lifehouse experience of implementing the Hospira CLAVE Oncology closed system.

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**BREAKFAST SESSION 2**

Optimising supportive care in immuno-oncology: The VOYCE nurses network

**Supported by:**

**Presenters:** Donna Milne, RN PhD

Lydia Visintin, RN

**Description**

YERVOY® (ipilimumab) is an immuno-oncology agent that harnesses the body’s own immune system to fight cancer. It is the first therapy to show durable long-term survival benefit in some patients with advanced melanoma; however, treatment can be associated with immune-related adverse reactions (irARs). 1,2 Cancer nurses play an important supporting role in managing patients treated with YERVOY (ipilimumab). Nurse VOYCE (yerVOY Clinical nEtwork) is designed to aid cancer nurses in supporting patients on YERVOY. The Nurse VOYCE breakfast meeting will feature a panel discussion and case studies from nurses who have extensive experience in managing patients with advanced melanoma on YERVOY treatment. Attendees will have the opportunity to participate in case study discussion and make new connections for the soon to be launched Nurse VOYCE!

**References**


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**PLENARY SESSION 1**

**LEADING IN A TIME OF CHANGE: IMPROVING CANCER SERVICES USING EXPERIENCED BASED CO-DESIGN METHODOLOGY**

**Dr Theresa Wiseman**

*The Royal Marsden NHS Foundation Trust, London, UK*

**Background and aims**

This project sought to design better experiences for patients and health care staff from the breast and lung cancer services within two large teaching hospitals in England. Experience based co-design (EBCD) was the chosen action research approach (Bate and Robert 2007). EBCD is a new and innovative methodology combining (1) a user-centred orientation (by adopting a narrative storytelling approach) and (2) a participatory, collaborative change process, allowing staff to ‘see the person in the patient’ and placing patient and staff experience at the centre of service development.

**Methods and results**

The project explored how care was delivered by staff and received by patients. It included 36 filmed patient narratives, 60 staff interviews, and ethnographic observation of clinical areas. Patient and staff interviews were analysed to identify themes and issues which were feedback to patients and staff at various group events. Through a facilitated three-stage change process which will be described, patients and staff agreed on joint priorities for improvement and then worked together in co-design groups that focused on identified priority areas (for example information provision, day surgery, continuity of care, diagnosis and outpatient care).

**Discussion and conclusions**

The paper reflects on lessons learned for improving patient/staff experiences through the use of EBCD. It explores the value of the EBCD approach, the use of narratives, observation and film (excerpts will be shown) as a way of humanising health care and engaging staff and patients in a change process to facilitate meaningful and lasting improvements in service provision.

**References**


THE METAMORPHOSIS OF MELANOMA FROM FORGOTTEN DISEASE TO POSTER CHILD

Professor Grant A McArthur
Peter MacCallum Cancer Centre, St Andrews Place, East Melbourne, VIC, Australia

Sustained investment in the science of cancer has uncovered key molecules that control the growth of melanoma and the bodies immune response to the disease. This investment has now transformed the disease clinically with novel systemic therapies currently leading a paradigm shift in how melanoma patients are managed. The greatest transformation is in the area of immune therapies, where very sustained responses are suggesting “clinical cure” is in sight for some patients with advanced disease. The new immune therapies raise challenges in the management of toxicity and need for well-organised survivorship programs. The immune therapies generate inflammatory and autoimmune toxicities in some patients that can be life threatening. However the efficacy of these agents is striking. The CTLA4-inhibitory antibody ipilimumab can improve overall survival in patients with advanced disease leading to 20% of patients obtaining long-term clinical benefit. Even more promising are antibodies to the programmed death-1 receptor (PD-1) or its ligand PD-L1 that generate responses in an even higher proportion of patients. The melanoma genome is now well described with over 60% of patients having genomic events that activate the BRAF pathway. This has led to systemic therapies that improve overall survival in the advanced disease setting, and new combination treatments with response rates of almost 90% moving us into a precision medicine approach for melanoma patients with BRAF mutations. Perhaps the greatest promise to impact mortality from melanoma, a disease characterized by the development of metastases from small primary tumours, is the combination of systemic therapies in patients with low volumes of disease, such as in the adjuvant setting. The future is bright for patients with this challenging disease where multidisciplinary care is poised to substantially reduce mortality and vastly improve quality of life.

CONCURRENT SESSION A:
MODELS OF CARE (A)

EPWORTH HEALTHCARE LEADERSHIP PROGRAMS: DEVELOPING NURSE LEADERS

Esther J Yeoman1, Margaret Hjorth1
1. Epworth HealthCare, Richmond, VIC, Australia

Introduction
Nurse leaders can positively impact the standard of clinical care and workplace culture within an organisation. For this to be realised, it is critical that nurses have the necessary skills and experience. Historically, leadership training has not formed part of nursing education. Epworth Healthcare recognises the benefit of building leadership capability within its nursing workforce. Since 2009, Epworth has delivered its Leadership Program to staff working in both clinical and non-clinical areas. To date, this is the most significant investment that Epworth has committed to the development of its leaders and this investment is unparalleled in the healthcare industry.

Objectives/Aims
To develop leadership competencies that will contribute to the success of employees in leadership roles through a structured leadership program.

Description/Methodology
Delivered over a 12 month period, the program is aligned with Swinburne University’s Diploma of Management. The program places an emphasis on skills based/action learning curriculum and also includes completion of a significant project over the program period. Content of the program was determined through analysis of the ‘success profiles’, the skills, behaviours and knowledge, of high performing leaders within the organisation.

Results
Evaluation surveys are undertaken three months after completion of the program involving participants, their managers and peers. Results are consistently indicative of significant positive behavioural change in participants and overwhelming acceptance of the program across the organisation.

Conclusions
A structured approach to leadership development has been an effective way of enhancing the leadership capabilities of emerging and operational nurse leaders.

THE NEW ZEALAND CANCER NURSE COORDINATOR INITIATIVE: ESTABLISHING A NEW MODEL OF NURSING CARE

Natalie James1, Saskia Booman2
1. National Nurse Lead - cancer nurse coordinator initiative, Ministry of Health, Auckland, New Zealand
2. Cancer Services, Ministry of Health, Wellington, New Zealand

Introduction
In 2012 funding was approved to appoint 40 cancer nurses across NZ who would focus on coordinating patient care along the cancer pathway; with at least one cancer nurse coordinator (CNC) in each District Health Board (DHB). Consultation with Australian nurse-leaders raised concern that these roles might not be well supported because the 20 DHB’s in NZ could result in different versions of the roles. It was proposed that a National Nurse Lead (NNL) be appointed to provide professional leadership and to ensure a strategic and consistent approach

Objectives/Aims
To develop a national CNC service that improves the timeliness and quality of care for NZ’ers with cancer.

Description/Methodology
The NNL worked with the CNC’s to establish regional groups that support networking and communication. These groups have been instrumental in ensuring the nurses remain focused on the common purpose and outcome of the roles, even
though their positions are configured differently. They also provide a consistent forum to share information about care and service improvements. Further underpinning this approach to care has been the development and implementation of tools and resources that support the establishment of the role and the day to day work of CNC’s.

Results
The CNC’s and DHB’s have responded well to national leadership. Nurses routinely attend service development and education meetings. The implementation and evaluation of specific tools also point to early success. A full evaluation is planned with initial data in June.

Conclusions
The establishment of a NNL has been important factor in progressing this initiative.

FINDING THE KEY TO THE LOCK: DEVELOPMENT OF THE ACCESS CO-ORDINATOR ROLE IN A CANCER IMAGING DEPARTMENT

Jac Mathieson1, Donna Milne1
1. Peter MacCallum Cancer Centre, East Melbourne, VIC, Australia

Background
The diagnosis of cancer and decisions about optimal management are reliant on timely access to a Cancer Imaging Department (CID). The CID at Peter MacCallum Cancer Centre completes an average of 31,000 scans (CT, PET, US, MRI) and interventions per year but until recently did not have an established triage process resulting in lengthy delays for clinicians and patients.

Aim
To establish timely and appropriate access for patients, reduce interruptions for reporting radiologists and improve workflow within the department.

Methodology
A CID Access Co-ordinator role was developed and became the central point of access for referring clinicians. This role was filled by a specialist cancer nurse. All procedures, inpatient and outpatient bookings that were not able to be booked in the required time frame were triaged by the Access Co-ordinator. Essential clinical information was gathered and discussed with the triaging radiologist, radiographers working in the modalities as well as the referring clinicians to ensure an appropriate time was allocated.

Results
The wait time for imaging decreased from six weeks to same day and reports are finalised within 48 hours (previously 72). Interrupting phone calls to the radiographers (staff performing the scan) have decreased from approximately 25 per day to zero and there has also been a reduction in the interruptions to the reporting radiologist (staff reporting the scans). Clinician feedback indicates satisfaction with the efficiency of the triaging process, timeliness of imaging and access to results.

Conclusion
Overall the introduction of CID Access Co-ordinator has established timely and appropriate access for patients, promoting optimal patient care in the CID.

THE DEVELOPMENT OF THE CANCER NURSE PRACTITIONER ROLE IN AUSTRALIA: A QUALITATIVE STUDY

Ruth McConigley1, Keith Cox2, Samantha Gibson3
1. Curtin University, Bentley, WA, Australia
2. Chris O’Brien Lifehouse, Camperdown, NSW, Australia
3. St John of God Hospital, Subiaco, WA, Australia

Introduction
Nurse Practitioners (NPs) were introduced in Australia in the 1990s, primarily as an innovative way of providing health care in rural and remote areas. NPs are now found in many practice settings and the role has evolved to be more of a specialist nurse position. Little is known about the development of the nurse practitioner role in cancer settings in Australia.

Aims/Objectives
The aim of this project was to examine the current role of cancer nurse practitioners (CNPs) and nurse practitioner candidates and to explore ways of developing the role further. The specific objectives were to:

- Define the CNP role
- Describe the settings where CNPs work in Australia
- Describe the duties performed by CNPs
- Explore potential to expand or improve the CNP role
- Consider possible barriers to further development of the CNP role.

Methodology
A descriptive, exploratory qualitative design was used for this study. Focus groups and individual interviews were held with 8 CNPs and a comprehensive survey describing their clinical practice was completed by 25 CNPs and candidates.

Results
The results of this study show that CNPs have varied roles across many disciplines in the cancer field, however there are similarities in some areas of practice, including having leadership, teaching and mentoring roles and promoting clinical excellence. Issues faced by CNPs include accessing funding and continued stability of CNP positions.

Conclusions
The CNP has a wide scope and each position varies in what is expected. However, similarities suggest that it would be prudent for CNPs to work together to promote and develop this role.
MEASURING WHAT MATTERS: QUANTIFYING THE ACTIVITY OF RADIOTHERAPY NURSES IN A PATIENT CENTRED MODEL OF CARE

Esther J Yeoman¹, Margaret Hjorth¹
¹. Epworth HealthCare, Richmond, VIC, Australia

Introduction
Nurses play an essential role in improving the experience of patients undergoing radiotherapy treatment. However, the role of the radiotherapy nurse is not well defined with vast differences across departments in relation to model of care, clinical responsibilities, EFT requirements, education and training. This has direct implications on resource planning, credentialing, and furthering radiotherapy nursing as a specialty field. In our department, we have approached the challenge of understanding the role of the radiotherapy nurse by utilising information technology to track and quantify nurse activity.

Objectives/Aims
To obtain a clearer understanding of the role of the radiotherapy nurse through analysis of activity tracking, based on our experience in a busy radiotherapy department at Victoria’s largest not-for-profit private health care group.

Description/Methodology
Our paperless department utilises an oncology patient management system, Varian Medical System’s ARIA. All activity based care is captured by data entry as episodes of care are delivered. The system will be used to closely track the clinical activity of radiation oncology nurses over a set period of time. Activity reports will be generated to facilitate analysis of data.

Results
The data obtained from tracking clinical activity of radiotherapy nurses over a six week period will be presented.

Conclusions
Understanding the breadth and depth of clinical roles is a vital component of workforce management. Utilisation of computer information systems to track activity may be an effective strategy towards understanding the role of the radiotherapy nurse working with a patient centred model of care.

CONCURRENT SESSION B: EDUCATION FOR NURSES (A)

AN EVALUATION OF REGISTERED NURSES’ ORAL CRYOTHERAPY KNOWLEDGE AND CONFIDENCE IN THE ACUTE HAEMATOLOGY/ONCOLOGY SETTING: A PRE-TEST/POST-TEST PILOT STUDY

Polly Dufton¹, Liz Pascoe¹
¹. School of Nursing & Midwifery, La Trobe University, Bundoora, VIC, Australia

Introduction
Oral cryotherapy is an established intervention for preventing chemotherapy induced oral mucositis (Keefe et al., 2007). Nurses have a primary role in the initiation of oral cryotherapy. An education session was delivered to oncology/haematology nurses with the aim of increasing their knowledge and confidence in the correct administration of oral cryotherapy.

Objectives/Aims
Evaluate nurses’ knowledge and confidence of oral cryotherapy best-practice evidence and its administration before and after an educational intervention.

Description/Methodology
Thirty-two nurses located in an acute haematology/oncology setting participated in a 20-minute oral cryotherapy education session. Supporting visual educational materials comprising posters and laminated personal tags as prompts to practice, and self-adhesive labels for recording the administration of oral cryotherapy were provided to nurse participants. All participants completed a questionnaire before and immediately after the education intervention. Twenty-two nurses (70%) provided feedback approximately 4 weeks post intervention on the supporting visual materials as prompts to practice.

Results
A statistically significant increase (p< 0.05) in nurses’ knowledge and confidence of oral cryotherapy best practice evidence and its administration were reported post intervention. Statistical package: SPSS Version 20 for Windows (SPSS Inc. IL USA).

Conclusions
A short education session on oral cryotherapy accompanied by supportive visual materials may be an effective way to increase nurses’ knowledge and confidence of the administration of oral cryotherapy.
ADAC – STANDARDISING SKILLS FOR ALL CLINICAL STAFF

Leisa M Brown¹, Maree A Bransdon¹
1. CIRCS, QLD Health, Bowen Hills, QLD, Australia

Introduction
Queensland undertook to standardise the skills required to safely handle and/or administer cytotoxic medications by implementing ADAC. Queensland determined that ADAC was relevant to all clinical staff who may be involved with cytotoxic waste management or administration of oral cytotoxic medications for malignant and non-malignant disease. To achieve course requirements and address geographical disparity, Telehealth was engaged to enable clinical practice and competency completion.

Objectives/Aims
To provide all clinical staff with the skills to meet the National Safety and Quality Health Service Standards (2012) for Medication Safety: 4.11 and High Risk Medicines – Medication Safety Self Assessment (2012): 10.38 by using a blend of face-to-face and Telehealth to deliver ADAC.

Description/Methodology
ADAC implementation and sequencing was modified to meet Queensland’s needs. A model was developed to demonstrate the complexity of this process and the importance of networking and communication using a ‘top down’ ‘bottom up’ approach. Telehealth was made available to ensure timely access to expertise, enable resource sharing and provide flexible delivery and rostering options due to small staff numbers.

Results
There are currently over 400 participants enrolled in ADAC with the use of Telehealth for clinical practice demonstrations, competency assessment and delivery of the ADAC Train the Trainer and skills workshop.

Conclusions
ADAC has enabled the standardisation of safe handling, oral and IV cytotoxic medication administration. The innovative delivery of ADAC in Queensland helps to provide a supply of skilled health professionals to manage safe handling and administration of cytotoxic medications.

LEADING IN A TIME OF CHANGE – PREPARING NURSES FOR THE FUTURE OF THE DEADLY DUST

Judy Rafferty¹, Glenda Colburn¹, Nigel McPaul¹
1. Lung Foundation Australia, Brisbane, QLD, Australia

Introduction
Australia has the highest incidence of Mesothelioma per capita in the world (1). The recent epidemic of mesothelioma is closely associated with past occupational exposure to asbestos. There is increasing evidence that a third, non-occupational wave of mesothelioma cases has developed in Australia, with a projected increase of 79% by 2020 (2).

Objectives/Aims
To meet the needs of the increasing number of patients diagnosed with an asbestos-related disease (ARD) specifically Malignant Pleural Mesothelioma (MPM), in 2013, Lung Foundation Australia developed and piloted a Clinical Education Program for nurses. The objective of the program was to develop knowledge and specialised skills to enable nurses to provide quality care and more timely intervention for patients and carers affected by ARD/MPM.

Description/Methodology
Ten nurses from around Australia were selected to pilot the ARD/MPM Online Nurses Program. The program was developed, an advisory committee of health professionals established, online developers engaged, and nurses’ knowledge (including pre and post program questionnaire, post module quizzes, post program exam and case history, six clinical practice components) and program processes were evaluated. Evaluation data demonstrated increased knowledge and positive appraisal of the program from the ten nurses.

Results
These Specialist MPM Nurses will be Australia’s first. They will provide leadership and mentorship in conjunction with existing Specialist Lung Cancer Nurses throughout Australia to improve outcomes for this unique group of patients.

Conclusions
A national online, evidence based, flexible, education program is an effective strategy to develop nurses’ knowledge and skills to enable them to meet the unique needs of this growing population.

References

INTRATHecal PAIN MANAGEMENT: DEVELOPMENT OF A SELF-DIRECTED LEARNING PACKAGE

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1. SJOG Hospital Subiaco, Perth, WA, Australia

Introduction
Cancer nurses play a crucial role in assessing and managing patients with complex pain. Nursing care for patients requiring pain management through the use of intrathecal analgesia requires nurses to have expert knowledge and skills in managing this specialised route of analgesia administration. Exposure and experience for nurses managing these devices is limited. A self-directed learning package (SDLP) was considered a sound educational tool that was easily accessible to all nurses working within the cancer centre.

Objectives
To improve nursing knowledge and skill development in the management of patients receiving intrathecal analgesia.
Description
It was identified through education gap analysis that nurses required extended education and support to feel confident in managing patients receiving intrathecal analgesia. Clinical and education stakeholders identified the essential criteria to be included in the development of a SDLP pertaining to intrathecal pain management. The package included aetiology of cancer pain, effects of uncontrolled pain, spinal anatomy, intrathecal opioid analgesics, nursing considerations, side effects/complications and troubleshooting. The package required each registered nurse to successfully complete 24 questions in addition to a procedural competency assessment.

Results
Twenty-five nurses have completed the intrathecal SDLP demonstrating a greater understanding and competence in management of intractable pain through the use of intrathecal analgesia drug delivery.

Conclusion
Through the development and implementation of a SDLP on intrathecal pain management, nurses developed sufficient knowledge to safely and effectively care for patients receiving intrathecal pain relief.

A QUASI EXPERIMENTAL RANDOMISED CONTROLLED TRIAL UTILISING A TRANSLATIONAL RESEARCH INTERVENTION TO IMPROVE CANCER NURSES ADHERENCE WITH RECOMMENDED PAIN SCREENING AND ASSESSMENT PRACTICES

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3. University of Technology, Sydney, NSW, Australia
4. Hong Kong Institute of Education, Hong Kong, SAR, China
5. Sydney University, Sydney, NSW, Australia

Introduction
Unrelieved cancer pain continues to be a major public health concern with timely access to best-practice, evidence-based assessment and care integral to improving cancer pain management. This project utilised a tailored, online learning module to translate the evidence that exists for comprehensive pain assessment, management and regular re-assessment of pain into routine nursing practice.

Objectives/Aims
To test the impact of a tailored case-based pain assessment online learning module (Qstream©) and pain assessment audit and feedback, on inpatient cancer nurses pain assessment capabilities and practices.

Description/Methodology
Study design: Pre-post-test prospective follow-up study with a quasi-experimental wait-listed randomised controlled trial (RCT) at one site.

Methods: Survey and chart audit data collected: pre (T1) and post (T2-T3) intervention, and final chart audit 4 weeks (T4) post audit and feedback.

Intervention: 11 case based pain assessment scenarios delivered to participants’ emails over 28 days via the ‘Qstream© methodology; plus audit and feedback of pain assessment documentation (T1-T2 data).

Results
Nurses who completed the on-line learning module (n=51) significantly increased their pain assessment knowledge, knowledge of pain assessment tools and confidence conducting pain assessments, out to 10 weeks. There was a significant increasing linear trend in documented pain assessments in patients chart from T1-T2 and T4 and an increased median quality of pain assessment documentation scores across time.

Conclusions
Integrating specialised on-line clinical content and audit feedback improves nurses’ pain assessment practices, which needs to be confirmed in a larger RCT.

Disclosure: This project was supported by a Cancer Institute NSW grant.

CONCURRENT SESSION C:
EVIDENCE BASED PRACTICE

A NATURAL OIL-BASED EMULSION CONTAINING ALLANTOIN VERSUS AQUEOUS CREAM FOR MANAGING RADIODERMATITIS IN PATIENTS WITH CANCER: A PHASE III DOUBLE-BLIND RANDOMISED CONTROLLED TRIAL

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Introduction
Radiodermatitis is a distressing symptom frequently experienced by patients undergoing radiotherapy.

Aims
To investigate the effects of a natural oil-based emulsion containing allantoin (NOCA) versus aqueous cream (AC) on reducing radiodermatitis in patients with breast, lung and head and neck cancer receiving radical radiotherapy.
Methodology
A total of 174 patients were randomised to either receive NOCA or AC. Participant and clinical characteristics, Common Terminology Criteria for Adverse Events skin toxicity, pain, itching and skin-related quality of life (SRQoL) scores were collected weekly up to 4 weeks after radiation treatment completion.

Results
Patients who received NOCA had a significantly lower average level of skin toxicity at week 3 (p<0.05), but had significantly higher average levels of skin toxicity at weeks 7, 8 and 9 (all p<0.001). The AC group had a significantly higher average levels of worst pain (p<0.05) and itching (p=0.046) compared to the NOCA group at week 3, but not at other weeks. There were no major differences in SRQoL between groups. Results of the multivariate regression model indicate that there was a strong trend for AC to reduce the incidence of grade 2 or more skin toxicity in comparison to NOCA (p=0.056).

Conclusions
Although the NOCA appeared to be more effective for managing skin toxicity compared to AC at the early stage of treatment, AC appears to be a more preferred option.

ACUTE TRANSFUSION REACTION KNOWLEDGE AND MANAGEMENT – HOW WELL ARE WE DOING?
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Introduction
The Australian Commission on Safety and Quality in Healthcare Health Service Standard 7 has increased the emphasis to assess risks associated with transfusion practices. In 2013, Blood Matters audited ‘Acute transfusion reaction (ATR) knowledge and management’.

Objectives/Aims
The aim was to determine if transfusion policies included the ATR management and confirm policies were available, based on national guidelines, understood and practised.

Description/Methodology
Four state and territory health services (n=146) were invited. Three electronic audit forms to assess policy, management (up to 10 retrospective ATRs within 12-months) and survey of clinical staff about ATR recognition and management (up to 30).

Results
One hundred hospitals submitted at least one part of the audit, with all reporting a written policy including guidelines for management of an ATR. 286 ATRs were reported. Haematology/oncology were the largest clinical specialty at 35% (n=101). Febrile and allergic reactions were commonly reported (n=156/286) and for this specialty (n=54/101). In haematology/oncology ATRs occurred in the first 1-2 hours (44%), with 29% occurring < 30 minutes after commencement, reinforcing why strict monitoring of the patient is required.

The staff survey demonstrated good knowledge of recognising an ATR (average 3.7/4), and knowing first line management to “stop the transfusion” (97%). Actual practice audited reported 88% (n=202/230) of transfusions in progress were stopped.
Conclusion
Nurses were the largest group (n = 1788/2089) of respondents who demonstrated they understood and practiced ATR management well. Health services were also keen to utilise answers to the survey as a follow up education tool.

SPEEDING TO ZERO: A NURSE LED PROJECT TO REDUCE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTIONS IN HAEMATOLOGY/ONCOLOGY INPATIENTS

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Introduction
Central line associated blood stream infections (CLABSI) are a preventable cause of morbidity and mortality in patients with cancer. Standard guidelines aimed at avoiding CLABSI are available, but not widely implemented. We undertook a nurse-led project to monitor CLABSI incidence in our unit and then systematically introduced guideline compliant practice to reduce the CLABSI rate.

Objectives/Aims
To efficiently determine the baseline rate of CLABSI in our unit, implement existing guidelines and monitor impact.

Description/Methodology
We undertook a monthly review of all blood culture results on the inpatient haematology/oncology ward. National Healthcare Safety Network (NHSN) criteria were used to define CLABSI. Ward management practices including chlorhexidine at line insertion, closed system fluid infusions and nurse education were then systematically altered to comply with NHSN guidelines.

Results
In the six months form Jan-Jun 2013 we identified 15 CLABSI from 1668 line days to give a rate of 9.0 per 1,000 line days. In the subsequent six months from Jul-Dec we observed a significant decrease in the CLABSI rate to 4 CLABSI from 1787 line days (2.2 per 1,000 line days, p=0.001), with a further reduction to zero in January 2014 from 227 line days. In the initial establishment period we required an extra six hours per month of extra nursing time. Now, no extra nursing time is required.

Conclusions
In this nurse led project requiring minimal nursing resources, we were able to implement changes in central line nursing management that significantly improve patient outcomes.

RANDOMISED CONTROLLED TRIALS OF AN ENERGY CONSERVATION AND MANAGEMENT INTERVENTION FOR CANCER-RELATED FATIGUE IN MEN TREATED FOR PROSTATE CANCER

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Introduction
Cancer and its treatment result in a number of side effects. Cancer-related fatigue (CRF) is one of the more debilitating side effects, and often is not assessed or well managed. For men treated for prostate cancer, only a few interventions have evidence of effectiveness or benefit.

Objectives/Aims
To assess the effectiveness of an energy conservation and management intervention for reducing the impact of CRF on men who are commencing treatment or who have completed treatment within the previous twelve months.

Methods
30 men commencing treatment and 31 men who had completed treatment for prostate cancer were randomised to either intervention or control groups. Participants completed a demographics form and three questionnaires: Schwartz Performance Inventory. The intervention group received three weekly telephone calls providing targeted education about CRF in relation to prostate cancer, strategies for balancing energy expenditure and rest, sleep hygiene and dietary advice. The control group received the same number of phone calls providing dietary and nutrition advice. The three questionnaires were repeated at one month and two months following the provision of education.

Results
In both studies, the intervention groups showed significant improvements in fatigue, vigor and functional performance compared to control groups following the delivery of the energy conservation and management intervention.

Conclusion
An energy conservation and management intervention that incorporates targeted information relevant to prostate cancer may be an effective strategy for managing CRF in men treated for this cancer.
CONCURRENT SESSION D: SUPPORTIVE CARE (BREAST)

MEN GET BREAST CANCER TOO: AN INFORMATION RESOURCE FOR MEN WITH BREAST CANCER

Annie Gayed¹, Kathy Wells¹, Maxine Morand¹
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Introduction
The vast majority of Australians diagnosed with breast cancer are women, however around 125 men in Australia are diagnosed each year. BCNA sometimes hears from men diagnosed with breast cancer about a lack of information that addresses their specific needs. This can leave them feeling isolated and distressed. A web-based review found very little Australian information specifically prepared for men.

Objectives/Aims
BCNA aimed to develop an information resource for men to address this unmet need.

Description/Methodology
An informal working group was established to guide development of the resource. The group included eight men diagnosed with breast cancer, family members, and health professionals including medical oncologists, surgeons and psycho-oncology practitioners.

Results
An information booklet was developed specifically for men newly diagnosed with breast cancer. Men get breast cancer too provides tailored information about the types of breast cancer, breast cancer treatments, follow-up care, lymphoedema, secondary breast cancer and ways to deal with common challenges that men may face, such as coping with their diagnosis and concern about the cancer coming back. The booklet also lists other resources and emotional and practical support services available for men diagnosed with breast cancer.

Conclusions
There is a pressing need for information specifically for men diagnosed with breast cancer which the new booklet provides. BCNA needs the vital support of health professionals, including cancer nurses, to help us reach men with this resource.

A MELBOURNE BASED NURSING PERSPECTIVE ON ADVANCED BREAST CANCER (ABC) SUPPORTIVE CARE: IS ABC AS EASY AS 1, 2, 3?

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2. Royal Melbourne Hospital, Melbourne, VIC, Australia

Introduction
Due to advancements in management women diagnosed with breast cancer are living longer with significant disease related issues. The need for an established pathway reflecting best practice has been recognised locally by North Eastern Integrated Cancer Services (NEMICS) and internationally with The 1st International Consensus Guidelines for Advanced Breast Cancer¹

A gap in service provision for Advanced Breast Cancer (ABC) was identified by the project partners – Western Health (WH), Melbourne Health (MH) and the Royal Women’s Hospital (RWH).

Objectives/Aims
To develop and implement a pathway for ABC patients, resulting in timely MDM discussion, supportive care screening and improved communication/ coordination between hospital and primary care providers.

Description/Methodology
Initially a retrospective (pre pilot) audit of all ABC diagnosed patients at participating sites was undertaken, and information about diagnosis, coordination of care, supportive care and MDM discussion analysed. These patients and their GP’s were surveyed to identify deficiencies in care, thus informing the development of a best practice Model of Care (MOC) which was piloted for a three month period.

Following this period, another audit was conducted, with the same methodology as previous, on ABC patients diagnosed within the pilot period.

Results
Increased number of patients with ABC were discussed at MDM meetings within three weeks of diagnosis (WH 9%; MH/ RWH 52% improvement).

There were increased number of patients with ABC who underwent supportive care screening, assessment and subsequent referral (WH 64%; MH/RWH 36% improvement).

Communication with GP’s improved (WH 16%; MH/RWH 35% improvement).

Conclusions
We have demonstrated that implementing a best practice pathway for ABC patients is a simple and effective process to ensure optimal and coordinated medical and psychosocial ongoing care.
THE ROLE OF THE AUSTRALIAN BREAST CARE NURSE: A SELF-REPORT ONLINE SURVEY

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2. School of Nursing, Midwifery and Paramedicine, Australian Catholic University, Brisbane, QLD, Australia

Introduction
Since the establishment of the breast care nurse (BCN) role in Australia in the mid-1990s, their role in different practice contexts and geographical locations has yet to be reported. To address this gap, a self-report online survey exploring current BCN roles in different geographical areas was undertaken.

Aim
The study aimed to investigate:
1. In what ways do rural and remote BCN roles differ to urban BCN roles?
2. What are the range of roles performed by a BCN in the provision of information and support and to what extent do these roles match the Australian Specialist Breast Nurse Competency Standards.

Method
Australian BCNs were recruited using snowball sampling. In 2013, a cross-sectional online survey was developed, pilot tested and issued to participants. Statistical data were analysed using SPSS software and qualitative data were analysed thematically.

Results
Fifty BCNs completed the survey, 40% from major cities, 42% from inner regional Australia and 18% from outer regional, remote and very remote Australia. Just over half worked part-time in their BCN role, with two-thirds having less than 5 years’ BCN experience. The majority held a BCN qualification, regardless of geographic location. Patterns of service indicated higher caseloads in urban areas, with fewer kilometres served. BCNs in outer regional, remote and very remote areas spent longer (an hour or more) consulting patients. There were many perceived barriers to fulfilling competencies including knowledge based limitations, limited time, and covering large geographic areas.

Conclusions
Breast care nurses perform a wide variety of roles, with some variations according geographical location. BCNs report they do undertake roles matching the competency standards, however there are barriers to fulfilling some of these competencies.

ENHANCED SURVEILLANCE OF GESTATIONAL BREAST CANCER

Nasrin Javid1, Christobel Saunders2, Fran Boyle1, Angela Ives2, Jan Dickinson2, Elizabeth Sullivan1, on behalf of AMOSS investigators
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2. University of Western Australia, Perth, WA, Australia
3. University of Sydney, Sydney, NSW, Australia

Introduction
Gestational breast cancer (GBC) refers to the initial diagnosis of breast cancer during pregnancy or within 12 months of delivery. GBC has a low incidence rate of approximately 23-29 per 100,000 births [1-3], but only 1/3 of those were diagnosed during pregnancy. GBC poses a clinical dilemma for the clinicians and there is limited information about what is the best management for the mother and her baby. One of the challenges in studying GBC is that oncology and obstetric care is delivered by multiple services, based at different sites.

Objectives/Aims
To develop an enhanced network surveillance of GBC and to describe current pregnancy, cancer management, maternal and neonatal outcomes.

Description/Methodology
A prospective population study using Australasian Maternity Outcomes Surveillance System (AMOSS). AMOSS conducts surveillance and research into rare and serious maternal morbidity and has a network of almost 300 participating maternity units throughout Australia and New Zealand (ANZ). National Breast Cancer Audit (NBCA) was approached to identify ways to enhance case ascertainment using their database.

Results
NBCA did not collect information on pregnancy and therefore could not be used to identify GBC cases. Following consultation, NBCA agreed to permanently collect information on ‘gestational status’ in the audit form. Between January 2013- 2014, 29 GBC cases have been notified to AMOSS. Among those 3 were notified from NZ and 26 from (7 of 8 states) Australia. Women’s age ranged from 23 to 53.

Conclusions
Streamlined surveillance has been implemented to improve case ascertainment. Development of ‘gestational status’ in NBCA form will provide ongoing surveillance of women with GBC.

References

Disclosures: Funding gratefully acknowledged from National Breast Cancer Foundation.
‘I WISH I COULD FIX IT’: SUPPORTING YOUR PARTNER THROUGH BREAST CANCER: AN INFORMATION RESOURCE FOR PARTNERS OF WOMEN WITH BREAST CANCER

Annie Gayed†, Kathy Wells†, Maxine Morand†
1. Breast Cancer Network Australia (BCNA), Camberwell, VIC, Australia

Introduction
A diagnosis of breast cancer has a significant impact not only on the woman diagnosed, but also on her partner. Research shows that partners often experience levels of distress equal to those experienced by women. Women’s distress usually falls once treatment has begun, but partners’ distress can remain high.

Objectives/Aims
This project aimed to address the unmet needs of partners through the development of an information resource specific to them.

Description/Methodology
A background paper was developed to examine existing information resources for partners and their unmet needs. The paper recommended the development of an information resource specifically for partners. An informal working group, including women diagnosed with breast cancer, male and female partners of women, and a psycho-oncology practitioner, was established to guide the resource development.

Results
An information booklet was developed for partners (male and female) of women diagnosed with breast cancer within the last 12 months. It provides them with information about breast cancer, its treatments and common challenges to help them better cope with the diagnosis, and to consequently better support the women diagnosed.

Conclusions
There is a pressing need for information for partners of women with breast cancer which the new booklet provides. BCNA needs the vital support of health professionals, including cancer nurses, to help us reach women and their partners with this resource.

EVIQ EDUCATION – SUPPORTING BEST PRACTICE THROUGH PATIENT FOCUSED EVIDENCED BASED RADIATION ONCOLOGY MODULES.

Kim Faulkner†, Karen Cooper†, Sarah Graham†, Pauline Rose†, Adam Rutyna†, Margaret Hjorth†, Lisa King†, Catherine Johnson†, Danielle Peterman†
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2. Radiation Oncology Mater Centre, Princess Alexandra Hospital, Brisbane, QLD, Australia
3. Radiation Oncology, Peter MacCallum Cancer Centre, Melbourne, VIC, Australia
4. Radiation Oncology, Epworth Healthcare, Melbourne, VIC, Australia

Introduction
As part of the Commonwealth Government of Australia Better Access to Radiation Oncology funding, the Cancer Institute NSW has developed evidence based, flexible, point of care radiation oncology education modules linked to the eviQ Cancer Treatments Online program.
Objectives/Aims
To provide education modules focussing on supportive care management. The target audience is radiation oncology clinicians (nurses, radiation therapists and allied health professionals) who are new to radiation oncology centres. They are also suitable for primary and community care settings.

Description/Methodology
In 2012, pilot sites in NSW, SA and WA were identified, with nursing, radiation therapists and allied health professionals interviewed to identify their learning needs. From this, point of care learning outcomes were identified.

Five learning modules (Overview of Radiation Therapy, Patient case studies - Head & Neck, Colorectal, Lung and Prostate cancers) have been developed. These modules have been piloted in the 3 sites by the target audience.

Results
Pilot results indicate that the education modules meet the needs of the target audience with both inexperienced (<12 months in radiation oncology) and experienced clinicians reporting the modules were relevant for the clinical setting and target audience. Of the 68 pilot participants, 64 rated the modules as good or excellent. Experienced participants (40/41) would recommend the modules to other clinicians. Majority of participants indicated that interactive module activities (videos, questions, reflective practice, workplace focuses) enhanced their learning.

Conclusion
Feedback indicates the modules support the learning needs of new radiation oncology clinicians.

THE EFFECT OF LANGUAGE ON CANCER NURSING PRACTICE
Olayinka Akinsanmi1
1. Princess Alexandra Hospital, Brisbane, QLD, Australia

Introduction
Cancer is a stigma laden condition for both patients and clinicians which could have a marked effect on nursing care provided.

Objectives/Aims
To explore how specialist cancer nurses’ perceive and construct “cancer” and “cancer patients”, the purpose and potential effects on nature of the nursing care they provide in one acute oncology setting.

Description/Methodology
Faircloughs’ Critical Discourse Analysis (FCDA) guided the data collection and analysis in this study. Semi-structured interviews of 12 experienced specialist cancer nurses were undertaken in a hospital setting. Stern questions elicited participants’ expert knowledge, attitudes and behaviours towards cancer and cancer patients. Interviews further probed participants’ construct on expectations of patients’ attitudes and behaviour whilst in their care in this high acuity context.

Results
Interim analysis indicates participants’ stream patients and cancer into two categories which are either negative or positive. The words used to portray cancer were destructive, and pessimistic. On examination of data from nursing interactional perspective, the language and tones used by the participants that tacit norms and practices and unspoken rules and models of socially acceptable behaviours were expected of both cancer nurses and patients in this setting. Further exploration of social process that govern how cancer and cancer patients in this setting, demonstrated how structural, organisational, societal and health system expectations mediated cancer nursing attitudes and practices.

Conclusions
A significant theme in this part of the analysis revealed the reciprocal power relations between nurses, patients and the system in which they are embedded shape patients’ behaviour towards treatment compliance.

EVIQ BRIDGING THE GAP – REAL-TIME EVIDENCE RETRIEVAL USING A BIBLIOMETRICS SOLUTION
Catherine Johnson1, Lisa King1
1. Cancer Institute NSW, Eveleigh, NSW, Australia

Introduction
Nurses face significant challenges in finding evidence supporting best practice and this is particularly significant in oncology where the knowledge base is dynamic. Challenges include time constraints and a lack of search and critical appraisal skills.

eviQ is a widely utilised point of care cancer treatment resource, providing evidence-based, peer-maintained, best practice cancer treatment protocols and clinical information for health professionals and consumers.

Objectives/Aims
In 2012-2013, eviQ partnered with Flinders Filters to develop a system to harvest the highest level literature to support making relevant evidence more easily and readily available to nurses at point of practice.

Description/Methodology
Each search was developed and validated through text word and MeSH term frequency analysis. This was then tested against a convenience set of references from NCCN Guidelines. Individual protocol searches were tested against the retrievals of existing eviQ references. These searches were then reviewed by eviQ experts and either approved or further refined by Flinders Filters.

Results
All search components have been written for use in PubMed to enable open hyperlinked access allowing more widespread usage.

Protocols now have a ‘literature tab’, enabling the retrieval of evidence related to that protocol in one mouse click and

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allowing nurses to use these robust literature-searching tools available through eviQ.

Conclusions

eviQ now has a sustainable bibliometrics solution ensuring the latest high level evidence is instantaneously retrieved. This plays a pivotal role in the facilitation of evidence into practice at point of care.

QUEENSLAND’S EXTENSION OF EDCAN TO QUEENSLAND-CANCER EDUCATION PROGRAM (Q-CEP)

Leisa Brown¹, Maree A Bransdon¹
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Introduction

EdCaN was launched in 2008 and provided cancer educators with an evidence-based resource to assist in the development of cancer education. Queensland have taken EdCaN resources and tailored them to meet the needs of staff involved in caring for people affected by cancer across all services. Central Integrated Regional Cancer Service’s (CIRCS) dedication to provide equitable access to standardised cancer education led to the development of Q-CEP using an innovative, blending learning approach.

Objectives/Aims

To provide:

• a program focused on developing the core knowledge and skills necessary to provide safe and effective care to people affected by cancer
• participants the ability to tailor their learning to reflect local context such as practice setting and case mix
• a resource to all staff with an interest in cancer care to enhance professional development and/or facilitate post graduate learning.

Description/Methodology

CIRCS partnered with the EdCaN project team to inform Q-CEP content and adaptation of the EdCaN capabilities and learning resources.

To ensure academic rigour, content was derived from EdCaN and three core documents were developed:

• Curriculum Document
• Participant Guide
• Assessments.

Results

The provision of a structured comprehensive program in line with the Australian Qualifications Framework (AQF: 2012) has provided educators and participants with tertiary level guiding documents to enhance participation.

Conclusions

Implementation of Q-CEP supports recruitment and retention and helps to ensure a sufficient critical mass of appropriately skilled cancer nurses are working in Queensland Health facilities.

CONCURRENT SESSION F: SURVIVORSHIP

NURSE-LED SURVIVORSHIP CLINIC IN PRACTICE

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Introduction

Survivorship Care (SC) has gained prominence as the number of patients disease free after cancer treatment increases and the specific needs of these patients are recognised.

This paper presents the practical elements of developing and managing a nurse-led survivorship clinic. It includes identification of eligible patients, screening tools used, and transition to shared GP/specialist follow-up care.

Aims

Aims of the nurse-led SC clinic are to educate and empower patients; provide a Health and Wellbeing care plan and co-ordinated follow up schedule; and facilitate active engagement of the GP.

Methodology

Breast services of the Royal Melbourne/Royal Women’s Hospitals, Western Health, Primary Care Physicians and BreaCan collaborated to implement a comprehensive SC program for breast cancer patients 6-12 months post diagnosis. Developed, implemented and evaluated under a Victorian Cancer Survivorship Project Pilot Program, funded by the Department of Human Services.

During the nurse-led consultation the diagnosis history, treatment outcomes and follow-up are discussed, psychosocial issues, unmet needs and future priorities addressed, and a personalised SC plan developed.

Results

296 consultations have been completed, 74 patients declined invitation. Evaluation included satisfaction surveys with patients and primary care physicians which were very positive.

Conclusion

This program continues beyond the project with all sites keen to embed it into routine practice. Specialist nurses can play an integral role in delivering survivorship care. This work may be transferable to other tumour streams, especially those with significant proportions of patients who are long term survivors of cancer.
WOMEN’S EXPERIENCE OF BREAST CARE NURSES IN A SURVIVORSHIP CLINIC

Lee Kennedy

Introduction

Objectives/Aims
This presentation aims to outline the results of project evaluation pertaining to the BCN role and to highlight further ways the strong rapport developed between women and BCNs could be utilised for secondary prevention.

Description/Methodology
Acceptability, effectiveness and impact of the process and its elements including the Nurse-led clinic process were evaluated with a follow up survey to 107 participants with 70 (65%) returned. Twenty telephone interviews with participants were undertaken to capture qualitative information about the process, outcomes and impact and to identify areas for improvement.

Results
A key feature that emerged was the value of continuity of care from the BCN over the course of their treatment. Patient ratings of the BCN consultations were overwhelmingly positive. However only 39% reported having made lifestyle changes as a result of their appointment with BCN.

Conclusions
While the evaluation has shown a high level of acceptance of this approach, opportunities exist to utilise the strong rapport developed to enhance positive lifestyle change through the use of evidence based interventions such as Motivational Interviewing.

HELPING INDIGENOUS PEOPLE WITH CANCER TO BETTER NAVIGATE TOWARDS OPTIMAL CARE: A PILOT STUDY

Christina Bernardes, Gail Garvey, Phillipa Cole, Patricia Valery

Introduction
Indigenous Australians have higher incidence of cancers, higher mortality rates and poorer survival compared to other Australians. This poor prognosis and the unique barriers Indigenous patients face to access quality cancer treatment means that they have specific and high levels of unmet supportive care needs. We propose to examine the efficacy of an intervention that combines navigation, cancer education, and communication coaching.

Objectives/Aims
The aim of this study is to develop the protocol and assess the feasibility of a randomised controlled trial (RCT) that will examine the efficacy of the patient navigation intervention.

Description/Methodology
The study protocol was developed in collaboration with the hospital oncologists, cancer care nurses and cancer support services staff. The recruitment of patients occurred via the ‘Cancer Clinics’ and Indigenous Liaison Officers from the Princess Alexandra Hospital, Brisbane. The approach used for Navigation is the ‘Navigator’ and ‘study nurse’ working as a team.

Results
The study protocol includes the development of a guidebook for training Navigators and a ‘step-by-step’ manual to be used by Navigators to conduct the screening and address the patients’ needs. Patients recruited by the Navigator were assisted through the following actions: education, referral, accompaniment, arrangement, and support.

Conclusions
We propose for the first time in Australia to examine the effectiveness of an intervention to reduce the inequity in cancer outcomes for Indigenous patients. Results of the pilot study will inform the development and implementation of the proposed RCT (the RCT is planned to start in 2015 if funding is granted).

References
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DEVELOPING A REHABILITATION FRAMEWORK FOR CANCER SURVIVORSHIP

Trish Calder, Catherine Carracher

Introduction
One of the consequences of cancer treatment is that patients experience a degree of functional decline that impacts on their ability to transition back to their pre-cancer lifestyle. There is growing evidence that a holistic, multidisciplinary rehabilitation program can improve the quality of life of cancer survivors. In the private healthcare sector there is often limited opportunity for multidisciplinary involvement in cancer care and this has implications on patients’ supportive care needs.

Objectives/Aims
The aim is to demonstrate the conceptual framework for the development and implementation of a cancer survivor rehabilitation program in a private healthcare institution.

Description/Methodology
Steps to establishing a cancer rehabilitation program in the private sector: 1. A literature review; 2. Convened a multidisciplinary group to discuss the needs of the cohort; 3. A preliminary framework and business plan was developed; 4.
Discussion with health insurers regarding rebates; 5. Engaged researchers for the purpose of evaluating the program; 6. Set a date for an 8-week pilot program and recruited participants to act as key informants for the future development/enhancement of the program.

Results
A physical and psychological rehabilitation program with four key concepts integrated into the design was developed and piloted. 1. All participants had 1:1 session with a psychologist; 2. The exercise program was individually tailored and supervised; 3. Single tumour stream, and; 4. Closed group format.

Conclusions
The integrated rehabilitation design was well received by participants who valued being able to address both psychological and physical needs as well as being able to share their experiences and discuss tumour stream specific issues.

BREAKING DOWN THE BARRIERS: EXAMINATION OF THE BARRIERS TO PSYCHOLOGICAL SCREENING AND REFERRAL OF MEN WITH CHRONIC ILLNESS DISPLAYING SIGNS OF DISTRESS  

Georgina Wiley
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Introduction
Chronic illness and associated treatments impose an immense psychological burden on the individual. Provision of information and counselling services has been demonstrated to be effective in increasing coping ability, reducing levels of anxiety and depression, and increasing satisfaction with personal participation in medical decision-making to patients across all phases of the illness. Men with chronic illness are less likely to report anxiety or depression and it is unknown what barriers may prevent men with chronic illnesses from accepting referrals for psychological support.

Objectives/Aims
1. Identify the number of patients presenting to a day oncology unit who experience distress.
2. Identify male perceptions towards, and usage of, support services and determine the barriers to follow up care with support services.

Description/Methodology
The project is a two phase exploratory study. A mixed method approach, incorporating both quantitative and qualitative research designs, were employed, The sample population were patients presenting to the Day Oncology Unit at Cabrini Malvern for treatment.

Phase One: Quantitative research in the form of a questionnaire which included the collection of demographic information and the Hospital Anxiety and Depression Scale (HADS) from 231 participants at the Day Oncology Unit at Cabrini Malvern.

Phase Two: Qualitative data collection. Selection was purposive. 20 male participants were asked to take part in a questionnaire and semi structured interview.

Results
The results of this study will identify gaps in service delivery for men with chronic disease and will inform the development of recommendations to improve support services for those affected by anxiety and depression.

References

PLENARY SESSION 2

DRESSING AND SECUREMENT OPTIONS FOR CENTRAL VENOUS ACCESS DEVICES: DO THEY WORK, OR ARE THEY JUST MORE WORK?!

Professor Claire Rickard
NHMRC Centre for Research Excellence in Nursing, Griffith Health Institute, Griffith University, Brisbane, QLD, Australia

During treatment for oncological or haematological conditions CVADs are a necessary device, a resource that we have to nurture and maintain to ensure the completion of essential therapies for our patients. These patients are already vulnerable to complications and disability associated with their underlying health condition. This vulnerability is worsened by the risk of adverse events associated with the insertion and management of CVADs.

Current all-cause failure incidence for CVADs in cancer care has been reported at between 20 and 50% in both adults and children. This includes failure due to local or systemic infection, thrombosis, occlusion and breakage. These failure rates suggest that current practices of CVAD management are inadequate. All CVAD failure has a serious multifocal impact on the patient’s health. The immediate interruption to necessary treatment results in an inability to receive prescribed chemotherapy, fluids, nutrition, antibiotics or other necessary medicines. The requirement for insertion of a replacement CVAD after failure brings additional risk of dangerous procedural complications.

Evidence-based strategies have been developed to prevent CVAD failure by focussing on different aspects of infectious and mechanical complications and their pathogenesis. The ideal CVAD dressing and securement device should:
1. provide a barrier protection from colonisation and infection, preventing CVAD-related infection;
2. provide adequate securement to prevent catheter tip movement, 
3. be comfortable and non-irritating for the patient;
4. be easy to use; and
5. be cost-effective.
There is a plethora of CVAD dressing and securement options from which clinicians may select. These vary from simple sterile gauze and tape, to suture-less securement devices and medication-impregnated discs. But which of these strategies have been proven to be effective for patients with CVADs requiring treatment for oncological or haematological conditions? Do they work or are they just more work?

FACING AN UNCERTAIN FUTURE: CANCER CARE IN THE ERA OF ANTIMICROBIAL RESISTANCE

Associate Professor Karin Thursky
Peter MacCallum Cancer Centre, Melbourne, VIC, Australia.

Antimicrobial resistance will become a major challenge for clinicians and nurses managing the patient with cancer. Multidrug resistance (MDR) is already a serious problem in many parts of the world, in particular Southern Europe and Asia. The rates of infection, neutropenic fever and sepsis in the cancer patient lead to much higher rates of antimicrobial consumption as well the risk of acquisition of resistance pathogens compared to the non cancer patient. While Australia does not as yet have the same magnitude of resistance, it is very important that measures are put in place to manage the risk. Antimicrobial stewardship (AMS) describes the processes that need to be undertaken in order to monitor the emergence of resistance and appropriateness of antimicrobial use, and the measures taken improve patient outcomes and reduce the emergence of resistance. National hospital accreditation standards for AMS and the new, as yet to be implemented national clinical care standards for AMS will result in improved quality of care. The role of the cancer nurse in understanding these principles of care will be discussed. In addition, the talk will provide an overview of the burden and epidemiology of MDR organisms such as vancomycin-resistant Enterococcus faecium (VRE), Clostridium difficile and MDR gram-negatives and review the potential intervention strategies aimed at addressing their impact; including infection prevention, screening and fluoroquinolone prophylaxis.

We take cancer personally

Patients are at the heart of everything we do at Roche. They motivate and inspire us to search for and develop innovative medicines and therapeutic solutions with the goal of transforming the lives of people with cancer around the globe.

We’ve come a long way, but there’s still a long way to go.
PLENIARY SESSION 3

IMPROVING THE PATIENT JOURNEY THROUGH BETTER MENTAL HEALTH CARE: CORE BUSINESS FOR ALL NURSES

Adjudnt Associate Professor Kim Ryan
Australian College of Mental Health Nurses, Deakin, ACT, Australia

There is a well-documented but complex inter-relationship between chronic disease such as cancer and mental health, which can represent challenges for nurses in terms of recognition and management. Mental health problems can reduce a person’s capacity to optimally self manage chronic disease, increase the burden of symptoms of the disease, and create additional functional impairment.

Approximately half of all patients with terminal or advanced cancer suffer poor mental health. In particular, depression and anxiety are associated with poor treatment adherence, poorer quality of life and an increased risk of morbidity and mortality. People with cancer who are depressed and/or anxious have a poorer quality of life, are less adherent to treatment and have a diminished will to live. Death rates are as much as 25% higher in cancer patients who are depressed and 39% higher in cancer patients who receive a diagnosis of depression. Less than half of cancer patients receive treatment for depression.

Physical health outcomes are better when a person’s mental health needs are addressed and worse when they are not.

The Australian College of Mental Health Nurses Inc (ACMHN) has recently undertaken a ‘Chronic Disease’ project, funded by the Commonwealth Department of Health & Ageing, which included developing eLearning resources for non-mental health nurses, around mental health and chronic disease issues.

This keynote will discuss the issues relevant to cancer and mental health and highlight the innovative project that the College has undertaken, in collaboration with colleagues from a range of nursing organisations including CNSA, to develop a high quality, free, online CPD product for nurses.

CANCER CARE IN INDIGENOUS COMMUNITIES, WITH ADVANCES IN PERSONALISED MEDICINE ARE WE CLOSING THE GAP IN HEALTH OUTCOMES?

Associate Professor Gail Garvey
Menzies School of Health Research, NSW, Australia

Cancer is a leading cause of death for Aboriginal and Torres Strait Islander Australians. The implications and considerations of the move towards personalised cancer care and treatment raises important questions for Australia’s Indigenous people. Firstly, what does this mean in an Indigenous context? Given the challenges Indigenous people face in gaining access to cancer care and the significant differences in cancer outcomes between Indigenous and non-Indigenous populations will personalised cancer treatment ameliorate these health disparities? Clearly health services and systems have a major role to play in reducing the disparities in outcomes. This presentation will highlight the cancer disparities faced by Indigenous Australians and current research efforts and approaches to reducing disparities across the cancer control continuum.

CONCURRENT SESSION G: EDUCATION FOR PATIENTS

EXPLORING THE MENOPAUSE AND FERTILITY INFORMATION NEEDS OF PREMENOPAUSAL WOMEN WITH NEWLY DIAGNOSED GYNAECOLOGICAL CANCERS

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2. University of Melbourne, Melbourne, VIC, Australia
3. Peter MacCallum Cancer Centre, Melbourne, Australia

Women diagnosed with gynaecological cancers may undergo treatments that have the capacity to cause permanent infertility and early menopause. This may impact on emotion and physical wellbeing of these women.

The body of evidence pertaining to menopause and fertility information needs of premenopausal female cancer patients centers on women with breast cancer, with little evidence to inform clinicians of the informational needs of women with a gynaecological cancer, prior to commencing treatment.

This mixed-methodology study set out to explore the menopause and fertility information needs of premenopausal female cancer patients with newly diagnosed gynaecological cancers. Twenty-one women, recruited from a major metropolitan hospital, were invited to participate in a focus group and complete a satisfaction scale to explore their satisfaction with the information they received about fertility and menopause prior to commencing their cancer treatment.

Focus group data was analysed using thematic analysis and satisfaction scale results were analysed descriptively using the Statistical Package for Social Science. Key themes were identified from the data. Results from the satisfaction scale supported these findings with only 43% and 29% of women very or completely satisfied with information pertaining to the impact of treatment on fertility and menopause status.

The outcomes of this study suggest that the development of resources to address the timely delivery of fertility preservation information, clarity and treatment of menopause symptoms, and information resources to address specific menopause and fertility information needs could make a valuable contribution to the wellbeing of these women and prevent decisional regret.
“RESILIENCE” SUPPORT GROUP MODEL:
A TAILORED INFORMATION AND PEER SUPPORT PROGRAM FOR WOMEN NEWLY DIAGNOSED WITH OVARIAN CANCER AND THEIR CARERS

Tarnya Hotchkin¹, Jane East¹
1. Ovarian Cancer Australia, Melbourne, VIC, Australia

Introduction
Ovarian Cancer Australia has developed a support program model for newly diagnosed women, during one of the most challenging stages of their disease. Resilience was developed in response to women’s feedback and aims to facilitate early engagement and continued connection.

Objectives/Aims
- To develop and pilot a program tailored to newly diagnosed women, ensuring its structure, content and delivery is shaped by their needs and preferences.

Description/Methodology
An online survey was developed and distributed via Survey Monkey© to Ovarian Cancer Australia’s survey group, consisting of women diagnosed with ovarian cancer.

The survey explored demographics, the structure and format of the Resilience program, and potential session topics.

Results
Of the 240 surveys distributed, 73 women responded with the following preferences: monthly sessions (52%), 4 sessions maximum (70%), and a session duration of 2 hours (42%). 83% of respondents recognised the importance of peer involvement in the program.

Topics identified include; understanding and managing ovarian cancer diagnosis; its treatment and side effects; clinical trials; and available supports.

Conclusions
Women newly diagnosed with ovarian cancer need a support and education program suitably tailored to meet their specific needs. Our aim is to implement and deliver a program to support, educate and empower women, their partners and carers, to give them the strength and capacity to adapt well in the face of adversity.

CANCER COUNCIL HELPLINE – HOW MANY PEOPLE USE THIS INFORMATION AND SUPPORT SERVICE AND WHY NOT?

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2. Cancer Council NSW, Woolloomooloo, NSW, Australia
3. Cancer Council VIC, Melbourne, VIC, Australia
4. Cancer Council WA, Perth, WA, Australia
5. Cancer Council QLD, Brisbane, QLD, Australia

Introduction
The 13 11 20 Helpline lies at the heart of Cancer Council information and support services and is a gateway to a myriad of programs providing informational, emotional and practical support.

Objectives/Aims
Research was undertaken to understand the reasons for calling the Helpline, satisfaction with the service, and barriers to using the Helpline.

Description/Methodology
A market research company was commissioned to undertake a community attitudes online survey of people touched by cancer (n=428) including patients (n=128) and carers (n=300; 84% response rate of identified sample). Key questions included awareness of Helpline; who referred, awareness of assistance that could be provided by Helpline, and reasons for calling (or not) Helpline.

Results
People affected by cancer reported seeking information mainly through internet (32% of respondents) and doctors (31%). Only 3% of respondents had contacted the Helpline and 11% had sought information on the Cancer Council website in the last 2 years. Most common reasons for not contacting the Helpline was not feeling the need to call, seeking information from doctor or other information sources usually online, and low awareness of the service.

Conclusions
The perception of not wanting or needing help is a barrier preventing calls and there is a need to widen understanding of the information and support that can be provided by the Helpline. Knowing more about what is actually on offer would provide people greater clarity about why to call the service. Strategies that engage medical professionals to recommend people call is absolutely critical and should be an ongoing focus.
USING WEB-ENABLED TECHNOLOGY TO SUPPORT MEN WITH PROSTATE CANCER
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2. Epworth Prostate Centre, Epworth Healthcare, Richmond, VIC, Australia

Introduction
Access to appropriate information and support remains problematic for many men diagnosed with prostate cancer, especially in rural and remote areas of Australia. We have developed an online clinical support program, PROSTMATE, which aims to overcome these barriers to access.

Objectives/Aims
PROSTMATE is a secure portal that provides telehealth consultations with nurses and psychologists, tailored information, a place to record treatments, test results and appointments, online tracking tools and self-directed support programs to improve health and wellbeing.

Description/Methodology
PROSTMATE (www.prostmate.org.au) is freely accessible to men affected by prostate cancer, their families and others interested in prostate cancer. PROSTMATE launched in November 2013 and we have monitored its uptake, user engagement and participant feedback.

Results
Over 500 people have registered. 72% of members are from metropolitan areas, 22.5% from regional or remote areas. The majority of members (56.5%) are men who have been diagnosed with prostate cancer. Self-reported problems at registration indicated that 17.2% of men with prostate cancer reported at risk levels of mood problems and 41.4% reported at risk levels of sexual intimacy problems. Telehealth consultations have steadily grown and appear to be an acceptable delivery mode for men and their families.

Conclusions
PROSTMATE shows promise in supporting men and offering access to specialist prostate cancer nurses and allied health services. This paper will explore how PROSTMATE could provide a novel way of improving care, and potentially see the integration of these systems into routine care.

THE DEVELOPMENT AND EVALUATION OF RESOURCES FOR FRIENDS OF YOUNG PEOPLE LIVING WITH CANCER
Erin Griffiths1, Marika Franklin1, Elizabeth Kelly-Dalgety1, Pandora Patterson1
1. CanTeen Australia, Sydney

Introduction
Young people living with cancer (YPLWC) report a loss of connection with friends as one of the key challenges they deal with. Furthermore, research exploring the needs of friends of YPLWC shows that friends desire to know more about the effects of cancer and what they can do to help.

Objectives/Aims
To redress this, CanTeen Australia developed the “Wait…Did You Say Cancer?!?” resources to inform friends’ understanding of the lived experience of YPLWC and the types of support they can provide. An evaluation was undertaken to ascertain the usefulness, utility, satisfaction with, and perceived outcomes of the resources.

Description/Methodology
A review of the literature and semi-structured interviews and surveys with YPLWC, their friends and cancer health professionals, were used to elicit friends’ informational requirements and guide the development of the resources. The resources developed were then evaluated using two web-based surveys (one each for YPLWC and friends) sent out six weeks after receipt of the resource.

Results
Overall, the resources were found to be easy to use and beneficial in helping friends to understand and support YPLWC. Positive changes in friends’ thoughts and behaviour regarding friends’ understanding of, and type and level of support shown to YPLWC were evident.

Conclusions
CanTeen’s “Wait…Did You Say Cancer?!?” resources were shown to be effective in supporting young people’s psychosocial experiences of living with cancer. Nurses’ promotion of the resources can help address the information gap for friends of YPLWC and ensure that YPLWC are more fully supported.
A SHIFT IN PARADIGM – CENTRAL INTEGRATED REGIONAL CANCER SERVICE (CIRCS) CANCER EDUCATION PROGRAM

Leisa Brown1, Maree A Bransdon1
1. CIRCS, QLD Health, Bowen Hills, QLD, Australia

Introduction
Telehealth improves equitable access to care which is a major ethical benefit for patients (Australian College of Rural and Remote Care: 2012). CIRCS is committed to providing all health professionals with access to evidence-based education and support to acquire knowledge and skills necessary to deliver optimal care for people affected by cancer. The expansion of Telehealth infrastructure across Queensland enabled the evolution of the CIRCS Cancer Education Program.

Objectives/Aims
To shift the paradigm of education delivery from face-to-face to Telehealth by providing access to quality cancer education and information to health professionals regardless of their geographical location.

Description/Methodology
The CIRCS Cancer Education Program was initially delivered face-to-face; however this was not sustainable therefore the option of Telehealth delivery was explored.

The shift from face-to-face to Telehealth required consideration of:
- Telehealth training
- Equipment availability
- Appropriate room selection
- Modification of information delivery to maintain an inclusive and interactive learning experience

Results
Over 400 participants attended training offered within the CIRCS Education Program in 2013. The program received positive feedback with an average of 4 on a Likert Scale of 1–5. Providing interactive Telehealth sessions that equate to face-to-face delivery has seen participant numbers double in 2014 with over 20 sites participating at any one time.

Conclusions
A successful shift in paradigm has been achieved and the results demonstrate that Telehealth is a viable option to deliver quality clinical education across vast distances.

CONCURRENT SESSION H:
SUPPORTIVE CARE

THE ROLE OF TEAM LEADER IN PROMOTING SUPPORTIVE CARE SCREENING AMONG CANCER NURSES.

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Introduction
Distress impacts significantly on a patient’s capacity to cope effectively with cancer, (NCCN, 2013). Screening for Supportive Care needs is currently not part of routine care; Victoria's Cancer Action Plan (2008-2011) aims to build capacity for supportive care screening, so screening occurs in 50% of newly diagnosed cancer patients by 2012.

Aims
Cancer nurses will routinely and competently screen patients for supportive care needs, provide appropriate support, and action referrals.

Methodology
A team leader was appointed for twelve months to implement a supportive care screening program for inpatient cancer nurses at a tertiary oncology centre. Nurses participated in education sessions on supportive care screening, and were followed up with 1:1 support. Nurses also completed questionnaires pre and post training, to assess knowledge around Supportive Care Screening principles, policies and referral processes, and participated 1:1 interviews. Supportive care screening tools from June 2013-July 2013 were audited for content.

Results
Eighty-five nurses participated in training. Response rate pre and post questionnaires was 20%. At baseline 9 nurses reported little knowledge about screening and actioning referrals. Post training 21 nurses reported training had improved practice around supportive care needs. Training also correlated with improvement in documentation, and how nurses evaluated issues and actioned referrals.

Conclusion
The presence of a team leader to support and educate cancer nurses was considered a useful strategy and a positive and effective means of achieving supportive care training.

References
DISTRESS SCREENING AND SUPPORTIVE CARE NEEDS OF CANCER PATIENTS AND CARERS IN REGIONAL WESTERN AUSTRALIA

Allison Fosbery¹, Louise H Good¹, Kaaren J Watts¹, Sandy McKiernan¹

1. Cancer Council Western Australia, Shenton Park, WA, Australia

Introduction
The role of a regional Cancer Support Coordinator (CSC) is to provide people affected by cancer with supportive care services including: information, practical, and psychosocial support. Our nine CSC have a background in either cancer nursing (n=8) or social work (n=1) and are well equipped for this role. Cancer Council WA (CCWA) implemented distress screening of new clients accessing our regional CSC, in March 2013. The implementation process is described, and a case study and preliminary distress screening results (Midwest region), are presented.

Objectives/Aims
To implement distress screening for regional clients and to report preliminary data on supportive care needs.

Description/Methodology
CSC received training in distress screening, using the Distress Thermometer and Problem List (DT-PL); screening commenced and progress was monitored. The DT-PL was administered face-to-face, by phone, or electronically, together with the client assessment form. The CSC reviewed screening results with the client and provided support and referrals.

Results
Implementation involved: (i) training in distress screening; (ii) start-up and monitoring; and (iii) data collection. Since March 2013, 108 new clients (98 patients, 10 carers - Midwest) were screened (M distress = 4.4, SD = 2.7). Physical and emotional problems were the most common needs. The five most frequently endorsed problem areas were fatigue (62%), worry (59%), sleep (44%), memory/concentration (40%), and nervousness (40%).

Conclusions
Distress screening of regional clients has been implemented by CCWA. Physical and emotional problems are priority areas. Screening will assist cancer nurses and other health professionals to identify and target clients’ supportive care needs.

SAME SAME BUT DIFFERENT: COMPARISON OF ONCOLOGY NURSES FAMILY PRACTICES IN AUSTRALIA AND DENMARK

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Introduction
This study extended previous Australian research to explore oncology nurses family practices in Denmark. The role of the family varies in different countries. In Australia, family is noted to provide close emotional and physical support (Coyne, 2013). However in Denmark the family may form a less involved role often decided by the patient (Dieperink, Wagner, Hansen, & Hansen, 2013). The oncology nurse is the key point of contact for the patient and becomes the gatekeeper to inform tailored support.

Method
A comparison of oncology nurses practices in relation to family assessment was conducted. Focus groups [N=22] were conducted with oncology nurses in both Australia and Denmark [N=62]. A concept analysis of transcribed audio data was conducted.

DIGITAL INFORMATION SERVICE AND CANCER SUPPORTIVE CARE: A VICTORIAN PERSPECTIVE

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Introduction
Supportive care (SC) enables cancer patients to maintain their quality of life. However, screening for SC is only available to newly diagnosed Victorians with cancer. Cancer survivors and carers are left on their own to identify and seek help for their emotional, physical, social, spiritual and information support needs. A research project is currently underway using one of the Integrated Cancer Services (ICSs) to examine this issue. Preliminary findings strongly support the extension of this service.

Objectives/Aims
The project aims to develop a new digital information service that supports people to learn about SC and be guided to identify their SC needs and where to seek help across all stages of cancer journey.

Description/Methodology
As a multidisciplinary and translation research, it uses a mixed methods. The basic research, in two stages, involves using preliminary focus group and pilot clinical trials to survey the SC needs of people affected by cancer. Software engineering research (notably prototyping) methods are used to analyze SC practices for building an integrated SC learning and screening system-tool, and formulating the SC survey questions. Survey samples are chosen from one of the Victorian ICSs.

Results
We have conceptualised and prototyped the architecture design of an integrated SC learning and screening system-tool. The preliminary results suggest that SC is needed by cancer consumers across all stages of cancer journey.

Conclusion
This paper provides important insights about SC and its role across the entire cancer journey. The access and availability of SC-screening anytime and anywhere is emphasised.
Results
Across the two countries family assessment formed a part of the nurses’ initial contact with the patient. In Australia, family was often present, however in Denmark this was often completed just with the patient. In Denmark the nurse provided the main aspect of support and direction for the family, however in Australia nurses described their role as one to identify concerns and refer to a specialist. Similar concerns of time and space were voiced and that the level of experience and expertise influenced the nurse’s role in family assessment.

Conclusion
Whilst family assessment was similar across the two countries, the cultural aspect of family support influenced how the nurse engaged in family assessment. The development of simple questions to engage the family may improve overall family support.

THE IMPLICATIONS OF THE WITHDRAWAL OF THE LIVERPOOL CARE PATHWAY IN THE UK FOR AUSTRALIA: A DISCUSSION PAPER

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Introduction
The Liverpool Care Pathway (LCP) is an integrated care pathway designed to guide care for people with cancer who are in their last days of life. Over the last decade, the LCP has been widely adopted in various settings across the UK and Australia. In 2013, the UK Government made a decision to withdraw the LCP in the UK following an independent review.

Aims
The aim of this paper is to critically discuss the implications of the withdrawal of the LCP for Australia.

Methodology
The critical discussion draws on sources from (1) the independent review commissioned by the UK government, (2) a Cochrane systematic review recently updated in 2014, and (3) other relevant literature.

Results
In total 151 notes were audited. Less than 4% (n=5) had entries indicating discussion about the sexual impact of treatment prior to completing the SNST. The nurse coordinator completed BSHA for 74% (n=112) of new referrals. Of these, more than half (62% n=69) reported being in a relationship, 8% (n=9) of these being same sex. Less than 10% (n=11) reported decreased sexual interest in the two week time-frame sexually active. More than a third (37% n=41) reported vaginal bleeding or discharge. Two thirds (69% n= 77) reported having been through menopause with 4.5% (n=5) using hormone replacement. Over half (55% n=62) reported having a discussion concerning the impact of treatment on fertility.

Conclusion
The addition of BSHA to the SNST supports nurse-led discussions about sexual matters with women attending for treatment for gynaecological cancer. Timing is critical as BSHA at first consultation may not be appropriate. Absence of documentation does not equate to no discussion having taken place.

EVALUATION OF THE GYNAECOLOGY BASIC SEXUAL HEALTH ASSESSMENT QUESTIONS INCLUDED IN THE SUPPORTIVE NEEDS SCREENING TOOL

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Introduction
The supportive needs screening tool (SNST) used at Peter MacCallum Cancer Centre is completed at first appointment only. The original tool contained one question concerning sexual health issues. Typical questions used for basic sexual health assessment (BSHA) were added to allow sexual issues to be discussed openly.

Aim
To evaluate the addition of BSHA questions and describe the results.

Method
A retrospective audit of notes was conducted for new patient referrals between August 2010 to January 2012.

Results
In total 151 notes were audited. Less than 4% (n=5) had entries indicating discussion about the sexual impact of treatment prior to completing the SNST. The nurse coordinator completed BSHA for 74% (n=112) of new referrals. Of these, more than half (62% n=69) reported being in a relationship, 8% (n=9) of these being same sex. Less than 10% (n=11) reported decreased sexual interest in the two week time-frame prior to first appointment and only 20% (n=23) reported being sexually active. More than a third (37% n=41) reported vaginal bleeding or discharge. Two thirds (69% n= 77) reported having been through menopause with 4.5% (n=5) using hormone replacement. Over half (55% n=62) reported having a discussion concerning the impact of treatment on fertility.

Conclusion
The addition of BSHA to the SNST supports nurse-led discussions about sexual matters with women attending for treatment for gynaecological cancer. Timing is critical as BSHA at first consultation may not be appropriate. Absence of documentation does not equate to no discussion having taken place.
CONCURRENT SESSION I: MODELS OF CARE (B)

WESTERN HEALTH ONCOLOGY HOSPITAL IN THE HOME: ISSUES FOR PATIENTS, CAREGIVERS AND THE HEALTH SYSTEM SPECIFIC TO HOME-BASED CANCER TREATMENT.

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Introduction
Home-based care (HC) is the fastest growing health service delivery model in industrialised nations, providing complex nursing and paramedical treatment to patients in the comfort of their own homes. Advances in technology and greater improvements in cancer treatment modalities have made it possible to offer some forms of chemotherapy, antineoplastic and supportive treatments safely at home under strict conditions.

Objectives/Aims
To demonstrate service delivery within a home-based care model, can reduce patient anxiety, decrease hospitalisations and ambulatory chair time, increase patient compliance and subsequent satisfaction within the services of Western Health.

Description/Methodology
Using a blend of a case-series quantitative research and phenomenology qualitative research designs, data collected on patient hospitalisation is analysed within the broader context of clinical chemotherapeutic administration. This data is then synthesised against the context of an extensive literature review, dealing with operational and administrative management of home-based care delivery. Patient participants were also asked to complete a satisfaction questionnaire pertaining to home-based cancer treatment, which was compared against similar data gathered from traditional ambulatory cancer delivery.

Results
Preliminary findings indicate that within an average year, approximately 1800 home-based care visits were made, resulting in an obvious decrease on demand for traditional ambulatory chair time. The data also indicated an average of 1 visit per month required a hospital admission. The content of the patient satisfaction survey indicates an overall surge in gratification and compliance.

Conclusions
Establishing safe chemotherapy administration practices at home may be an effective strategy for decreasing hospitalisation and increasing patient satisfaction and compliance.

INNOVATIVE NURSING WORKFORCE STRATEGY... INCORPORATING AN ENDORSED ENROLLED NURSE INTO A CHEMOTHERAPY DAY UNIT.

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Introduction
The Chemotherapy Day Unit (CDU) at Western Health has traditionally been staffed by Division One Registered Nurses. A service review identified that approximately 30 per cent of the work conducted in the unit did not require a Chemotherapy trained nurse. Reviewing our staffing profile identified an opportunity to incorporate an Endorsed Enrolled Nurse (EEN) into our skill mix. Anticipated expansion of our service will increase demand for patients to attend our procedure room for radiological and diagnostic procedures.

Objectives/Aims
Our aim was to successfully incorporate, support and expand the scope of practice of an Endorsed Enrolled Nurse within the CDU.

Description/Methodology
A Clinical Practice Development Nurse was appointed to educate the CDU staff, coordinate patient and staff satisfaction surveys pre and post implementation of the new role and support the EEN to extend their scope of practice. This included competency in managing Central Venous Access Devices¹, coordinating care of patients undergoing diagnostic procedures and completion of the EVIQ Antineoplastic Drug Administration Course (ADAC).

Results
Preliminary findings indicate that within an average year, approximately 1800 home-based care visits were made, resulting in an obvious decrease on demand for traditional ambulatory chair time. The data also indicated an average of 1 visit per month required a hospital admission. The content of the patient satisfaction survey indicates an overall surge in gratification and compliance.

Conclusions
Establishing safe chemotherapy administration practices at home may be an effective strategy for decreasing hospitalisation and increasing patient satisfaction and compliance.
IMPROVING CANCER SYMPTOM AND CHEMOTHERAPY TOXICITY MANAGEMENT FOR PATIENTS UNDERGOING CHEMOTHERAPY AT WESTERN HEALTH

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Introduction
As delivery of chemotherapy is increasingly transferred to the outpatient setting, patients and families are faced with the challenges of managing cancer symptoms and chemotherapy toxicities at home. A 6 month analysis of patients undergoing chemotherapy revealed 40% of patients presented to ED for cancer symptom or chemotherapy toxicity management on at least one occasion. Of these patients, 36% were discharged directly from ED with a further 20% discharged within 24 hours.

Objectives/Aims
Development of a Symptom and Urgent Review Clinic (SURC) in the Chemotherapy Day Unit (CDU) with dedicated space and personnel to manage patients who experience cancer symptoms and chemotherapy toxicities.

Description/Methodology
Consultation with stakeholders including radiology, pathology, bed management ED, surgical units to develop clear and agreed pathways for patients presenting to the SURC

Development of a comprehensive triage tool to guide decision making around telephone advice and management of patients presenting to the unit for care.

Development of an Advanced Nursing Practice (ANP) role to triage patients either by phone or face to face. Utilisation of the existing medical resources within the CDU to support the ANP role.

Results
5 months since its commencement, SURC has had 206 telephone consults and 208 clinic attendances. Only 6% of these patients have required inpatient admission indicating better outpatient management of symptoms. Surveying of patients has revealed the majority would otherwise have presented to ED. 98% patients reported very high satisfaction with SURC.

Conclusions
Provision of a SURC model of care can reduce ED presentations and give patients undergoing chemotherapy a more favourable experience.

EXPANDING THE SCOPE OF PRACTICE OF THE ENROLLED NURSE TO INCLUDE ADMINISTRATION OF ANTINEOPLASTIC AGENTS: KEY ISSUES AND RECOMMENDATIONS OF THE CNSA EDUCATION COMMITTEE

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5. Chris O’Brien Lifehouse, Camperdown, NSW, Australia
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7. Fiona Stanley Hospital, Perth, WA, Australia
8. Cancer Institute NSW, Sydney, NSW, Australia
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10. La Trobe University, Bundoora, VIC, Australia

Introduction
In response to the increased demand for antineoplastic agents used in cancer control, fiscal pressures, and workforce reform, the scope of practice of the Enrolled Nurse (EN) has been expanded to include administration of antineoplastic agents (AAs). Without specific practice guidelines, administration of AAs in Australia poses safety concerns for both cancer patients and the nurse.

Objectives/Aims
This paper presents the review completed by the Cancer Nurses Society of Australia (CNSA) Education Committee.

Description/Methodology
A review of literature and current policies was completed outlining the key issues and recommendations was developed for the CNSA National Executive Committee. Key focus areas included context of practice, patient outcomes and RN / EN scope of practice.

Results
Increased use of antineoplastic agents will directly influence the nursing workforce. Changes to care delivery must consider the capabilities of the health service, nurse sensitive patient outcomes and ensure patient safety. Stratifying antineoplastic agents into groups according to administration complexity is one approach which requires further exploration. There is no professional framework or competencies currently supporting EN administration of AAs. A framework to guide the RN in issues such as delegation, appropriate supervision, and clarity of scope of practice and support for the EN is required.
Conclusions
The literature and policy review identified a practice gap in safe administration of AAs. A framework for nurses which provides guidelines for scope of practice, delegation and supervision is required to ensure safe and sustainable practice for the cancer patient.

“LET’S TALK ABOUT SEX ” – THE IMPLEMENTATION OF A NURSE PRACTITIONER (NP) LED SEXUAL HEALTH AND ERECTILE DYSFUNCTION (SHED) CLINIC AT PETER MACCALLUM CANCER CENTRE (PETER MAC)
Kath Schubach
1. Peter Mac, East Melbourne, VIC, Australia

Introduction
Sexual dysfunction is often under diagnosed and underappreciated particularly in a cancer population. A diagnosis of cancer and potential treatment options can impact greatly on patients and their partner’s quality of life. The importance of addressing patient’s sexual concerns can have a positive effect on their wellbeing.

Objectives/Aims
The development and implementation of a NP sexual health and erectile dysfunction clinic aims to provide comprehensive care to cancer patients experiencing sexual health issues.

Description/Methodology
The clinic was established following a clinical research project to meet patient’s sexual concerns. The clinic is available to patients with a cancer diagnosis who have concerns or issues relating to erectile dysfunction and sexual health.

Results
The NP led sexual health and erectile function clinic was established in 2012. Approximately 150 patients have attended the clinic. More than half of the patients attended with their partners. The majority of patients had a diagnosis of prostate, colorectal and haematology cancers. The common treatment interventions are oral therapy, penile injection and vacuum erectile device therapy.

Conclusions
Sexuality is a fundamental aspect of every individual. The NP led sexual health and erectile dysfunction clinic involves utilising expert knowledge and clinical skills to assess, diagnose, educate and manage patient’s sexual health issues. This will provide patients with information to make an informed decision about how to manage their sexual concerns.

HOW DO PROSTATE CANCER SPECIALIST NURSES’ PROFESSIONAL DEVELOPMENT NEEDS CHANGE OVER TIME?
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2. Queensland University of Technology IHBI, Brisbane, QLD, Australia

Introduction
In 2012, Prostate Cancer Foundation of Australia established a prostate cancer specialist nursing service, which funds placement of nurses in hospitals across Australia in partnership with health service providers. Nurses were provided with continuing professional development and peer support.

Objectives/Aims
We aimed to understand how nurses’ professional development needs changed as they worked in the role.

Description/Methodology
In online questionnaires at the beginning and mid-point of the program, nurses rated their levels of professional competencies on a 5-point scale against their practice framework, in four domains: provision and coordination of care; collaborative and therapeutic practice; professional practice; and critical thinking and analysis.

Results
All 12 nurses completed both questionnaires. Overall, in each sub-domain, >50% of nurses reported their competency levels improved or remained stable. The greatest number of nurses reported competency improvements in: identifying adverse effects of cancer and therapies; providing access to supportive care services and interventions; and initiating ongoing improvements in collaborative relationships with patient and healthcare teams. The fewest number of nurses reported improvements in three areas: participating in activities contributing to reducing the risk of developing cancer; identifying health needs of the person affected by cancer; and developing therapeutic relationships with people affected by cancer.

Conclusions
A program comprising continuing professional development and peer support enabled the nurses to develop confidence in core areas of specialist practice. This model’s applicability to other groups should be investigated.
DEVELOPING COMMUNITY PATHWAYS FOR PEOPLE LIVING WITH AND BEYOND CANCER

Dr Theresa Wiseman
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Advances in cancer research and treatments have led to more people living with and beyond cancer. Macmillan estimate that by 2020, 1 in 2 people will get cancer; almost 4 in 10 won’t die. Many cancer patients complete their primary treatment and return, more or less, to the same level of health and wellbeing that they enjoyed before their diagnosis. However, 53% people surveyed 6 months after cancer treatment had moderate or severe unmet needs.

At present Follow-up care is focussed on monitoring recurrence and is based in the hospital setting. Yet recurrence is rarely picked up in routine follow up. In fact there are significant numbers of patients who delay seeking help when they find further lumps as they know they are due for a routine appointment.

Existing services focus on acute phase which can leave patients feeling abandoned at the end of treatment, with low confidence to get back to their “usual” life. We need a model which risk stratifies people and balances some care into community. The purpose of this project was to develop and pilot a model of care which focused on the transition from acute services into the community. Seven roles were tested: support workers in the hospital (2) and a specialist cancer community team (5), alongside a generic and tumour specific care pathway.

This paper sets out the care pathways and new roles; highlights what worked well and what worked less well; and details lessons learnt and future recommendations.
1. A SEVERE DOCETAXEL SKIN REACTION: A CASE REPORT

Gillian Blanchard¹
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Docetaxel is a microtubular agent used in a variety of cancer treatments. In recent years it has become commonplace in the adjuvant treatment of breast cancer.

Many conventional chemotherapy agents are reported as having the potential to cause Hand Foot Skin Reaction (HFSR), including Docetaxel

It has been our experience that severe skin reactions from Docetaxel are a rare event and present mainly on the extremity used to infuse the drug. A literature review of both Medline and the Cochrane data base did not reveal any reports of Docetaxel skin reaction without extravasation, nor were there any case reports of HFSR from single agent Docetaxel use. The Landmark FNCLCC PACS01 trial of sequential FEC-D also did not report any Grade 3/4 skin disorders.

This report is our institution’s experience of a 66 year old female receiving adjuvant Docetaxel in October 2013. After infusion of her third Docetaxel within 24 hours she developed Grade 3 HFSR with severe skin changes with bilateral erythema, blistering and pain. This occurred untypically on the tops of both her hands resulting in limiting both instrumental and self-care ADL’s.

Our patient was treated with oral anti-biotics, steroids and topically with Mepilex Foam Dressing which is commonly used to treat radiation desquamation. Analgesia was commenced by the GP. The wound was assessed every other day and was dressed for 24 days. By day 29 only mild scaling of the skin remained and functional ability had returned to pre-treatment capacity.

2. CO-ORDINATION OF SUPPORTIVE CARE NEEDS IN METASTATIC BREAST CANCER

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2. The Royal Marsden NHS Foundation Trust, London, United Kingdom

Introduction
Metastatic breast cancer (MBC) is increasingly acknowledged as a separate disease and this review highlights the often unique characteristics and supportive care needs of patients with MBC and the role of the Clinical Nurse Specialist (CNS) in co-ordinating their care.

Objectives/Aims
To advance cancer nurse’s knowledge on the supportive care needs of patients with MBC and the role of the CNS in co-ordinating their care.

Description/Methodology
A review of the literature on the supportive care needs of patients with MBC drawing on the standards of care developed by the UK charity Breast Cancer Care and the role and efficacy of CNS’s, undertaken by two CNS’s working within the MBC specialty.

Results
Key areas of supportive care provision were co-ordinated, timely information and assessment of need. The CNS role is pivotal in meeting these areas of supportive care and spans the gap between specialists in the hospital setting and community services so patients are supported to live as well as possible and access treatments and interventions with ease, in a timely fashion.

Conclusions
Although specialist nursing services for MBC are in their infancy the momentum started by Breast Cancer Care and others needs to be maintained to promote the best possible support to this group of patients as more treatments are developed. Cancer nurses involved in the care of patients with MBC should challenge the service provision and may need to start exploring different models of care, such as non face- to-face care and support.

3. PROMOTING AWARENESS IN QUALITY RADIOThERAPY NURSING

Kathryn Watty¹
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Introduction
Eastern Health Nursing Education and Peter Mac Box Hill Radiotherapy Nurses recognised a gap in knowledge, of radiotherapy, by nurses working in medical oncology in an acute hospital setting. A project involving the implementation and evaluation of a one day program called ‘A Day in Radiotherapy Nursing’ was undertaken

Objectives
The project aimed to enhance the understanding and knowledge of radiation oncology nursing to optimise best patient outcomes. The objective was to work towards standardising care for oncology patients undergoing radiotherapy across Eastern Health. This was to be achieved through educating oncology nurses about radiotherapy techniques, side-effects and best-practice strategies to manage patient care

Description
A one hour Radiobiology lecture was presented to nurses at Eastern Health on four occasions through the year. Twelve Nurses from an Eastern Health medical oncology ward spent a single day at Peter Mac Box Hill attending a seven hour program. Feedback was sought using the developed evaluation tool

Results
Feedback from twelve nurse participants and both Eastern Health Nursing Education and Peter Mac Radiotherapy Staff was overwhelmingly positive with strong support for the initiative to be ongoing. Measures showed that knowledge of radiotherapy increased after the nurse undertook “A Day In Radiotherapy”.

44
Conclusions
Formal collaboration and a professional relationship has been developed and strengthened between Eastern Health and Peter Mac Box Hill by the sharing of knowledge, including the latest evidence based, best practice in radiotherapy nursing. The program continues to be offered in 2014 to Eastern Health Nurses.

4. MY JOURNEY AS A NOVICE RESEARCHER: A JOURNEY WORTH TAKING!

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Introduction
Professionally, research forms a component of senior cancer nurses job descriptions, yet in the rural setting it is often difficult to undertake research, as access to academic institutions is limited by geographic isolation. As ground level practitioners and patient advocates we are often in a position to see the need for sound research to inform change to improve patient outcomes.

Objectives/Aims
This abstract describes a personal experience of a cancer nurse as a novice researcher undertaking a research project in conjunction with the Rural Research Capacity Building Program (RRCBP) run by the Health and Education Training Institute.

Description/Methodology
The RRCBP builds research skills in the NSW rural workforce through a work based novice researcher development program and through this I undertook a qualitative research project that sought to better understand the experience of the rural patient with colorectal cancer. Data from a reflexive journal will provide insight into the personal challenges and breakthroughs, navigating the project from initial application to completion of the program, including ethics, identification of participants, interviews, transcription, thematic and analysis and writing the final report.

Results
The RRCBP has provided a structured and supportive environment for a novice researcher to produce research that has the potential to shape future practice. It develops many workplace skills including critical thinking skills.

Conclusions
The RRCBP provides a unique opportunity for rural cancer nurses to participate and learn how to do translational research; Research that has tangible outcomes that can be used for the benefit of your patients.

5. PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) CUSHIONING MATERIAL: A PILOT STUDY COMPARING GAUZE WITH SILICONE FOAM FOR CHEMOTHERAPY PATIENTS

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2. Deakin University, Melbourne, VIC, Australia

The distal portion of a peripherally inserted central catheter (PICC) can cause pressure and subsequent loss of skin integrity when contained under the transparent dressing unless there is a cushioning layer between the PICC and skin. This pilot study compared two different materials, their impact on nursing practice and the skin of oncology patients.

Sterile gauze is used to cushion the PICC line when replacing the weekly PICC dressing. This is in line with organizational guidelines. However the use of gauze is not consistent with international recommendations which recommend replacement of gauze dressings every 24-48 hours (Grady et al, 2011, CNSA, 2007 and INS, 2011). The aim of this study was to compare a silicone foam material with gauze using three primary measures: ease of removal, skin irritation and itch.

Patients (n = 40) were alternately allocated to the silicone foam or gauze group. Each of the three outcome measures was given a rating from 0-2 with 0 being the most positive response (i.e. dressing easily removed, no skin irritation, and no itch). Data was collected weekly, over four consecutive weeks.

The results for the silicone foam group were more positive for each of the three outcome measures compared to the gauze group. The silicone foam material reduced the odds of the dressing being difficult to remove by 64% (statistically significant), reduced skin irritation by 44% and itch by 29%.

The silicone foam cushioning material is equal, and possibly superior to gauze.

References:
3. INS, 2011, J of Infus Nursing. 34 (1S 1-110).
6. CROWNING GLORY – IS THAT THE WHOLE STORY? IMPLEMENTING SCALP COOLING IN AN AUSTRALIAN SETTING.

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Chemotherapy induced alopecia (CIA) is a significant source of distress, physically and psychologically and should not be underestimated in women with early breast cancer (EBC)¹ ²

Scalp cooling technology for prevention of CIA during appropriate treatment regimens (eg TC and FEC-D in EBC) has been standard of care throughout Great Britain and Europe for over 10 years. Uptake in Australia has been low until recently, when new generation coolant circulating devices have become available (Paxman, Dignitana). Recent publications of data from the Dutch registry have been reassuring regarding safety and efficacy³ and patients are accessing information about this approach with interest.

The Mater Hospital North Sydney, commenced scalp cooling with Penguin Cold Caps in 2010 for women with EBC. Digitana and more recently Paxman devices have been subsequently introduced. Barriers addressed have included funding of devices, oncologist perceptions of efficacy and safety, scheduling and chair time, hair care and patient comfort and support.

A prospective audit of our initial experience with scalp cooling⁴, reported 50% of patients on Deans Alopecia scale had Grade 2 or less hair loss when receiving standard dose Docetaxol 75mgs/m² and Cyclophosphamide 600mgs/m² for Grade 1,2 EBC. Currently cooling has been extended to metastatic breast and prostate cancer patients receiving Docetaxel. Feedback from patients has been encouraging, highlighting a greater sense of control and improved body image.

Scalp cooling is now established at our facility and we are actively assisting with the establishment of scalp cooling at other centres. We are also participating in international research developing better measurement tools for the impact of CIA and scalp cooling.

References
4. Boyle et al, COSA 2014

7. PSYCHOSOCIAL NURSING INTERVENTIONS FOR PATIENTS WITH CANCER

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Meeting the psychosocial needs of people with cancer and their families is challenging for nurses in busy inpatient settings. This study investigated nurses’ understanding of best practice guidelines for psychosocial care in adult cancer and their self-perceived skill in utilising them in practice.

The study aimed to understand and identify the importance nurses place on intervening with patient and family members psychosocial needs and their self-perceived skill level in meeting those needs. Nurses’ preferred form of education delivery was also explored.

A two-stage study utilised a mixed-method design within a large, acute-care private health service. In stage 1, 46 nurses completed a survey, based on the work of Frost, Brueggen and Mangan (1997) and the Clinical practice guidelines for the psychosocial care of adults with cancer (National Breast Cancer Centre and National Cancer Control Initiative 2003). In stage 2, 13 frontline clinicians participated in three focus group interviews that further explored nurses’ views. Ethics approval was received from the affiliated university and hospital.

While nurses recognised the importance of patient and family needs for psychosocial care, they were not well informed about best practice guidelines and perceived their skill to be moderate to low. Local in-service was the preferred method of education delivery. Key barriers included time constraints, work environment and access to education.

The findings of this study inform context specific support needs of nurses who care for patients with cancer. The outcomes may have broader relevance for the preparation of nurses to deliver psychosocial care to patients receiving cancer treatment.

References
2. National Breast Cancer Centre and National Cancer Control Initiative 2003, Clinical practice guidelines for the psychosocial care of adults with cancer, Camperdown, NSW.
8. WHO ARE TODAY’S LEADERS?

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Introduction
With the ongoing 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 pressure on Haematology/Oncology nurses increase. Are we ready to lead? Current training provides the basis for nurses to enter the workforce and practice their profession and the workplace allows for the development of these basic skills to a higher level of knowledge and expertise however, how are nurses learning to lead?

Objectives/Aims
This study sought to identify: Who do nurses recognise as leaders? What leadership qualities do nurses expect within leaders? Who inspires today’s nurses? The study also sought to identify the nurses’ perception of their role within the leadership structure of their ward.

Description/Methodology
This descriptive study focused on Haematology/Oncology nurses in an inpatient acute care hospital setting in South Australia. 35 registered and enrolled nurses were surveyed, with their experience ranging from newly graduated nurses to nurses with experience of 20 plus years.

Results
After extensive feedback from participants no contemporary leader was identified. There were generational differences in specific characteristics that nurses identified as necessary in a leader. Participants were hesitant to acknowledge themselves as leaders.

Conclusions
Nurses do not necessarily see themselves as leaders and tend to recognise a structure of management as leading their practice. It is necessary to recognise leadership is a quality required in all nurses.

9. PICCS, PORTS AND PERIPHERAL CANNULAS – THE PATIENTS’ PERSPECTIVE

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Introduction
Many women who have breast cancer will require chemotherapy as part of their treatment. Nurses are often the ones to assess women’s veins and can give information about different venous access devices.

Objectives/Aims
To explore women’s experiences of the venous access devices used in the administration of their chemotherapy.

Description/Methodology
Women who had surgery and chemotherapy for breast cancer were invited to attend a focus group. Two focus groups were held and a total of 10 women attended. Questions were asked about the type of venous access device and why this was chosen, the advantages and disadvantages and if sufficient information was given. The focus groups were recorded and following verbatim transcription two researchers independently read the transcripts and coded themes and subthemes.

Results
The themes that emerged were that before starting chemotherapy it was a blur and overwhelming and women unsure if they were given oral or written information about venous access devices. During chemotherapy the theme of familiarisation emerged with the access devices, blood tests and a feeling of safety of having treatment and also know that a PICC or port could be used if in hospital. On completion of treatment the theme of finality arose with finishing treatment and having their venous access device removed, which women who had a port stated could be traumatic.

Conclusions
Guidelines to be developed as to who needs a PICC or port.

10. PROSTATE CANCER SPECIALIST NURSES – INFLUENCING CARE BEYOND THE BEDSIDE

Julie Sykes¹
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Introduction
The PCFA Prostate Cancer Specialist Nursing (PCSN) service has been operational since 2012 and currently consists of 12 nurses located across Australia. Since the program commenced, the specialist nurses have been involved in variety of strategic activities. This has been in their local areas and also on a state and national level alongside their clinical work.

Objectives/Aims
The aim of the strategic role is to improve the quality and standard of care delivered to men with prostate cancer, through improvements at a systems level and in additional to their patient care roles.

Description/Methodology
Prostate Cancer Specialist Nurses are involved in a wide range of activities; including research, quality improvement and participation in education at a local and national level.

Results
Examples of these activities include the provision of education sessions to peers and medical staff within their organisation, at conferences, within the primary care setting and through formal university contexts. They also participate in PCFA specific activities and programs, such as presenting at The PCFA Rural
Conclusions
The purpose of these strategic activities is to provide awareness and education to the wider communities impacted by prostate cancer and influencing improvements to the patient’s cancer care experience.

11. EXTENDING THE SCOPE OF PRACTICE OF AN ENDORSED ENROLLED NURSE IN A CHEMOTHERAPY DAY UNIT.... WHAT CAN THEY DO?

Jade Roether

Introduction
The Chemotherapy Day Unit (CDU) has traditionally been staffed by Division 1 Registered Nurses (RN Div 1). Patient flow audits demonstrated that 30% of unit activity was patient care other than chemotherapy administration taking up time of highly skilled chemotherapy trained nurses. Patients attending the CDU for radiological and diagnostic procedures could be managed by an Endorsed Enrolled Nurse (EEN) with the right support.

Objectives/Aims
To develop a nursing model of care that fits within the scope of practice of an EEN under the supervision of a RN coordinating the care of patients attending the CDU for procedures.

Description/Methodology
A dedicated Clinical Practice Development Nurse was appointed to support the EEN to extend their scope of practice within the CDU.

Patient and Staff surveys were conducted to establish a benchmark and identified specific education requirements for the CDU staff.

A skills assessment was conducted enabling targeted learning opportunities for the EEN to extend their scope of practice within the CDU.

Results
5 months post implementation of the EEN role there has been:

- Approximately 175 interactions with patients attending the CDU, diverting the work from an RN Div 1.
- Significant growth in the scope of practices of the EEN from an initial task list of 52 activities to 161.
- Staff satisfaction and acceptance of the EEN role has improved with 88% of staff indicating they want the EEN to remain permanently.

Conclusions
Incorporating an EEN into the skill mix has been beneficial for the care and coordination of patients attending the CDU and staff satisfaction has improved.

12. DABRAFENIB, A NEW ERA - TARGETED THERAPIES AND SIDE-EFFECTS.

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1. Royal Prince Alfred Hospital, Camperdown, NSW, Australia

Introduction
The drug Dabrafenib has recently been added to the PBS and is used for the treatment of unrespectable Stage IIIC & IV melanoma positive for V600 BRAF mutation. It is an oral targeted therapy that works by specifically blocking a growth signalling pathway in melanoma cells that is overactive due to a mutation in the gene called Braf. The most common side effects are drug related fevers and skin toxicities.

Objectives
Targeted therapies have a very different side effect profile to standard chemotherapy. Establishing and implementing an educational program for staff and patients is a key feature in early detection and effective management of side effects. It is important to empower patients, their families and carers with the knowledge of recognising symptoms.

Description
Education about Dabrafenib is provided to patients and /or carers by the Melanoma Clinical Nurse Consultant. Side effects and management are discussed as well as the importance of contacting the CNC or after-hour’s on-call oncology registrar if patients experience any symptoms. An information brochure was developed for patients being treated with Dabrafenib which highlights the management of fevers and skin reactions.

Results
Early reporting of side effects allows for better management of patient care and minimizes possible hospital admissions. Utilising the expertise of the Dermatology team including the CNC to assist with the management of skin toxicities has made an enormous impact on patient and quality of life.

Conclusions
Treatment for stage IIIC & IV unrespectable melanoma has changed dramatically in the past 4 years. The introduction of new therapies and recent PBS listing of Dabrafenib provides patients with improved survival outcomes. The side effects and management of targeted therapies differ from chemotherapy.
13. ONLINE PATIENT-HELD RESOURCES FOR IMPROVING CANCER PAIN MANAGEMENT

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2. Sydney Medical School, The University of Sydney, Sydney, NSW, Australia
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4. Faculty of Health, University of Technology, Sydney, NSW, Australia
5. South Western Sydney Clinical School, University of New South Wales, NSW, Australia
6. CanSpeak, NSW, Australia
7. Cunningham Center for Palliative Care & University of Notre Dame Australia, Darlinghurst, NSW, Australia
8. The Patricia Ritchie Centre for Cancer Care and Research, Mater Hospital, Sydney, NSW, Australia
9. School of Nursing, Johns Hopkins University, Baltimore, USA

Introduction
Cancer pain is a common distressing problem that is under-treated due to numerous healthcare system, provider and consumer barriers. The current team adapted international guidelines for use in Australia and embarked on research to find the best means of supporting implementation.

Aim
To develop a patient-level strategy to support evidence-based, person-centred care for pain, complemented by an existing patient pain education booklet available from the Cancer Council Australia(10).

Description/Methodology
The following methods were used to inform optimal content of the patient-level strategy:

1. An online survey of current practice;(2,3)
2. A systematic literature review meta-synthesis of qualitative studies concerned with barriers and facilitators to cancer pain management;(4)
3. A systematic review and theory-based meta-analysis of the effectiveness of patient education for improving cancer pain outcomes;(5)
4. Clinical process mapping and patient interviews at a single palliative care unit.

Results
Results indicated that resources should be developed to help patients reframe their pain as controllable to enhance self-efficacy and encourage reporting, take an active role in self-management and care coordination, and expect and advocate for person-centred evidence-based care from their medical team. A pain diary, self-management plan, and tools to support self-reflection and goal setting were developed and are available on the Cancer Council Australia Cancer Guideline Wiki. They are currently being piloted to assess acceptability and utility and inform further development.

Conclusions
Implementing evidence-based cancer care requires strategies across patient, provider and healthcare system levels. Patient resources will be tested alongside other strategies in a future randomised controlled trial.

References:

14. NURSE CARE GUIDES – A COMMUNICATION, EDUCATION AND DOCUMENTATION TOOL

Linda McGinn1, Margaret Hjorth1

1. Epworth Healthcare, Richmond, VIC, Australia

Introduction
Epworth Healthcare introduced care guides as part of its ongoing commitment to provision of high quality patient care. The care guides include key elements of evidence based care to ensure consistent care delivery, documentation and communication across all care settings. The introduction of equivalent care guides has had a positive impact on patient outcomes at other health institutions (Medves, Godfrey et. Al., 2009).

The majority of patients receives radiotherapy in the outpatient setting, however up to 20% will be admitted to hospital for symptom management and supportive care. It is recognized that patients undergoing radiotherapy have specific care needs and site specific radiotherapy care guides were developed accordingly.
Objectives/Aims
To develop a tool that assists staff to deliver a high standard of evidence based nursing care, specific to patients undergoing radiotherapy.

Description/Methodology
Site specific radiotherapy care guides were developed to provide an overview of radiotherapy, relevant definitions and site specific patient assessment criteria.

The care guides are filed in the Patient Medical Record for reference during an admission.

Results
Radiotherapy care guides have been developed and implemented into clinical practice for inpatients at Epworth Healthcare. The Care Guides not only define consistent delivery of evidence based patient care, they are also an excellent communication tool to aid in care planning, while inadvertently educating health practitioners in radiotherapy patient care principles.

Conclusions
The development of tools such as care guides are an effective way to address gaps in health practitioner knowledge as patients move between the inpatient and outpatient setting.

15. THE ESTABLISHMENT OF CHEMO@HOME – AN INTEGRATED MODEL OF PATIENT CENTRED SERVICE DELIVERY FOR CHEMOTHERAPY PATIENTS
Lorna Rogers¹, Julie Wilkes¹, Zelda Haskins¹, Stacy McGreal¹
1. Chemo@home, North Perth, WA, Australia

Introduction
A staggering one in two people will experience cancer by the time they reach 85 years of age. The impact on patients and the health system demands new service delivery models. Home based chemotherapy addresses not only hospital capacity issues, but also assists patients and their families, especially those at risk of sub optimal outcomes due to gaps in the current service delivery model. In WA, a new model of care for home chemotherapy treatment has been established and evaluated.

Aim
To outline the need for, and the establishment and evaluation of “Chemo@home”, a home-based chemotherapy service.

Method
The available evidence supporting the development of home-based chemotherapy programs was reviewed. In addition, key recommendations which particularly related to consumer expectations, gaps in service delivery and the strategic direction of cancer services, from WA Health’s Cancer Services Plan 2012-2017, and other pivotal information, were identified.

A business model was determined and the service was successfully established. It has since achieved ACHS accreditation and continues with ongoing assessments and evaluations, particularly of patient experiences/satisfaction.

Outcomes
Chemo@home, a domiciliary chemotherapy service was established in the Perth metropolitan area over the past 12 months. It integrates with current treatment strategies and is now transitioning as standard cancer care for patients.

Results
To date over 500 treatments have been delivered with overwhelming positive satisfaction from patients and participating medicos. The service is expanding to other specialised medical areas and it is anticipated that this type of domiciliary infusion service will soon become the norm for patients with cancer and other chronic illnesses.

16. DEVELOPMENT AND IMPLEMENTATION OF AUSTRALIAN CONSENSUS GUIDELINES FOR THE SAFE HANDLING AND ADMINISTRATION OF MONOCLONAL ANTIBODIES FOR CANCER TREATMENT BY HEALTHCARE PERSONNEL
M. Alexander¹, J. King², A. Bajel³, C. Doecke³,⁵, P. Fox⁶,⁷, S. Lingaratnam¹, J.D. Mellor⁸, L. Nicholson⁹, I. Roos⁹, T. Saunders¹, J. Wilkes¹¹,¹², R. Zielinski¹³, J. Byrne¹³, K. MacMillan³, A. Mollo³, S. Kirs⁴ and M. Green²
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5. School of Pharmacy and Medical Sciences, University of South Australia, Adelaide, Australia,
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7. University of Western Sydney, Sydney, Australia
8. Roche Pty Ltd, Melbourne, Australia
9. Royal Hobart Hospital, Hobart, Australia
10. Youth Research Centre, University of Melbourne, Melbourne, Australia
11. View Health Pty Ltd, Perth, Australia
12. Chemo@home Pty Ltd, Perth, Australia
13. Western and Central Melbourne Integrated Cancer Service (WCMICS), VIC, Australia

Introduction
Monoclonal antibodies (MABs) are rapidly emerging into clinical oncology and haematology practice. Healthcare personnel have few available resources to evaluate risks and inform safe handling practices.

Objective/Aims
Development of Australian Consensus Guidelines for safe handling and administration of MABs for cancer treatment by healthcare personnel. Development of a guideline implementation package, including organisation readiness tool and e-learning modules, to assist healthcare services with implementation of guideline recommendations.

Method
A rigorous methodological approach including critical appraisal of available evidence, survey of current practice, and formal
consensus meetings was undertaken in the development of the guidelines. Guidelines were developed in accordance with principles outlined by the National Health and Medical Research Council and led by a multidisciplinary guideline written group with strategic oversight from a steering committee including clinical and operational experts. The implementation package will be developed based on needs assessed during focus group sessions, with refinements following a planned pilot phase, followed by public dissemination.

Results
The developed guidelines include seven recommendations: 1) appropriate determinants for evaluating occupational exposure risk; 2) occupational risk level compared with other hazardous and non-hazardous drugs; 3) stratification of risk based on healthcare personnel factors; 4) waste products; 5) interventions and safeguards; 6) operational and clinical factors; and 7) handling recommendations. The implementation package is currently under development and due for completion by mid-2014 (in line with CNSA conference).

Conclusions
The developed guidelines evidence-based directives for the safe handling of MABs across a variety of clinical settings.

17. URGENT CARE OF THE ONCOLOGY PATIENT – ANALYSIS FROM A CROSS SECTIONAL STUDY OF THE CLINICAL CHARACTERISTICS OF ONCOLOGY PATIENTS PRESENTING TO ONE SYDNEY TERTIARY REFERRAL EMERGENCY DEPARTMENT
Meredith Oatley¹, Lesley Mullens¹, Margaret Fry¹
1. Royal North Shore Hospital, St Leonards, NSW, Australia

Introduction
The study analysed the trends and characteristics of adult oncology patients presenting emergency department (ED). The demand on Australian EDs has increased 4.2% each year between 2007-2008 and 2011-2012. At the same time the cancer rate has doubled in size since 1991. According to Australian Institute of Health and Welfare many oncology patients present to EDs rather than seeking treatment at alternative healthcare services. To develop new models of care that better manage oncology patients, we need to explore the reasons for ED presentations.

Aims
The aim of this study was to explore adult medical oncology patient presentations to one tertiary referral hospital.

Methodology
A 12 month audit (1st January 2012 – 31st December 2012) was conducted of ED oncology patient presentations. A random sample was then selected of adult oncology patients (n=286) admitted to the hospital for analysis.

Results
Data collection and analysis is in progress. Preliminary analysis will be completed by June. Preliminary results:
Oncology presentations 993 (2%), mean age 65 years (SD +/- 15.22)
Males 516 (52%) compared to females 447 (48%).
Admission: 957(96%) compared to Discharged: 30 (3%)
Admitted to ward: 922 (93%)
Admit to critical care area: 34 (3%)
Transfer to another hospital: 4 (0.4%)
Died in ED: 3 (0.27%)
Triage Category 3 or 4: 598(61%)

Conclusions
The majority of patients that present to the ED require admission. Understanding the characteristics of why adult oncology patients require urgent care helps us to develop new models of care that will improve patient outcomes and reduce pressure on the ED.

18. PROFESSIONAL CHALLENGES AND SUPPORT MECHANISMS FOR BREAST CARE NURSES IN RURAL AND REMOTE QUEENSLAND.
Pammie Ellem¹
1. Central Queensland University, Bundaberg, QLD, Australia

Breast Care Nurses (BCNs) have been increasingly employed to coordinate and provide ongoing psychosocial support to women with breast cancer and their families (Rogers-Clark, 2002). As with other specialities becoming established, issues are now arising in relation to professional support, education and networking for BCNs who anecdotally report that they work alone and feel isolated, particularly those working in rural areas.

This paper presents the literature review of a study in progress that is using Participatory Action Research (PAR) as a method for both the study and providing a model of professional development for BCNs in rural Queensland.

According to Reason and Bradbury (2008) PAR seeks to involve the community. It is evident from the literature review that while BCNs are valued, and there have been some moves to better support BCNs, much needs to be done in this space. This paper will also provide an overview of how PAR has been used to support professional development previously and why this may provide a realistic model for BCNs professional development into the future.

It is intended that the model of support will be transferable to different cancer modalities and geographic regions.
19. A TABLET A DAY? INTRODUCING A MOBILE ELECTRONIC DEVICE INTO HOME BASED CANCER CARE.

Robyn Wilson¹
1. Healthcare at Home Australia, Melbourne, VIC, Australia

Introduction
Healthcare at Home (HaH) is a specialist home nursing service which provides complex care for people in their homes, workplaces or school settings, including cancer treatment and support.

It is paramount for cancer nurses to be able to conduct a comprehensive patient assessment at each home visit and communicate findings in a secure and timely manner to the oncologist, and the nurse who delivers the next episode of care.

Objectives/Aims
To provide a secure and efficient means of communicating patient care between the treating nurse, the consultant and the HaH team.

Description/Methodology
A comprehensive validated assessment tool was developed incorporating internationally recognised grading systems. The assessment tool was formatted to be completed on a tablet device by the nurse during a home visit. Nurses were trained in the use of the tablet, the client management system and the assessment tool and the process was measured over a 4 month period.

Results
100% of patient assessment forms were forwarded to the treating oncologist within 24 hours of the patient visit.

75% of patient assessment forms in the patient history were available to nurses at the time of the next visit. The nurses reported that the tablet and the format were easy to use however they would have preferred further training in the use of the client management system.

Conclusions
The electronic format for the assessment of oncology patients by HaH nurses proved to be a secure, efficient and effective way of managing patient information. Further training will be provided in the future.

20. IPILIMUMAB: THE IMPORTANCE OF NURSING EDUCATION AND PATIENT ASSESSMENT

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2. Chris O’Brien Lifehouse, Camperdown, NSW, Australia

Introduction
In August 2013, the monoclonal antibody Ipilimumab was approved for PBS in the treatment of Stage IV Melanoma. Ipilimumab targets cytotoxic T-lymphocyte-associated antigen 4 (CTLA-4), blocking a negative regulatory signal in T-cell function, which in turn results in T-cell activation and an anti-tumour immune response. The side effects of Ipilimumab are immune related, so early recognition, assessment and intervention are pivotal in the care of patients.

Objectives/Aims
Adverse reactions to Ipilimumab can range from mild to potentially life threatening, therefore educating patients, carers and staff about the side effect profile of Ipilimumab is essential. The aim of this project was to provide Clinical Nurse Consultant (CNC)-lead written and oral education to patients, families and medical registrars.

Description/Methodology
Patients commenced on treatment with PBS-funded Ipilimumab between August 1st 2013 and June 1st 2014 were provided with written and verbal education prior to treatment commencement and follow-up telephone support. Post commencement CNC support interactions, and treatment-related admissions were recorded.

Results
During the study period 26 patients were registered for ipilimumab treatment of which 22 received at least 1 dose. CNC led education was provided to 22 patients. There were 154 post commencement support interactions and 5 admissions to hospital for ipilimumab-related toxicity. There were 8 episodes of ipilimumab-related toxicity. Low-grade toxicities were successfully managed in an outpatient setting through CNC support with medical officer back-up in 4 patients preventing 4 admissions and ED presentations.

Conclusion
Through on-going education, assessment and early recognition of side-effects by the patient, carer and staff, potentially life-threatening side-effects of ipilimumab were effectively managed, and hospitalisations avoided. Ongoing nursing education and assessment of patients being treated with Ipilimumab is critical in managing treatment-related toxicities.
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**17th Winter Congress**

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Kristen Scott, NSW
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Penny Reed
Sarah Northfield
NIOSH, ISOPP and ASHP all advocate consideration of using a **closed system transfer device** to minimise occupational exposure to hazardous drugs.¹,²,³

**“ CLOSED SYSTEMS LIMIT THE POTENTIAL FOR GENERATING AEROSOLS AND EXPOSING WORKERS TO SHARPS ” **

NIOSH, 2004

Guidelines for Cytotoxic Drug Handling

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<tr>
<th>Guidelines</th>
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<td>NIOSH Alert. Preventing Occupational Exposures to Antineoplastic and other Hazardous Drugs in Health Care Settings</td>
<td>2004</td>
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<tr>
<td>ISOPP Standards of Practice. Section 7- Special Devices</td>
<td>2007</td>
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<tr>
<td>ASHP Guidelines on Handling Hazardous Drugs</td>
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<tr>
<td>WorkSafe Victoria. Handling Cytotoxic Drugs in the Workplace</td>
<td>2003</td>
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<tr>
<td>Workcover NSW. Cytotoxic Drugs and Related Waste - Risk Management</td>
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<tr>
<td>SHPA Standard of Practice for the Safe handling of Cytotoxic Drugs in pharmacy department</td>
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Health and Safety Legislation

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<td>Occupational Health and Safety (Safety Standards) Regulations 1994</td>
<td>1994</td>
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¹. NIOSH Alert, Preventing Occupational Exposures to Antineoplastic and Other Hazardous Drugs in Health Care Settings, Department of Health and Human Services, Centres for Disease Control and Prevention, 2004.