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Company Profiles

Notes
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We’ve come a long way, but there’s still a long way to go.
Welcome to Perth!

The Local Organising Committee for the 18th CNSA Annual Winter Congress would like to welcome you to Perth, a city of great beauty and prosperity. Our theme “Cancer Nursing: Expanding the Possibilities” will focus on exploring the opportunities that exist in cancer nursing in 2015 and beyond. This year, for the first time, we welcome the National Breast Care Nurse Conference into its new home within CNSA Winter Congress.

The program will incorporate a blend of invited plenary speakers, abstract presentations and integrated workshops, both within the Congress format, and prior to the commencement of Congress. For 2015, delegates can expect to be offered greater insights from radiation oncology, research, advanced practice, breast cancer care, education and evolving clinical care.

For the first time in Congress history, Perth will host three international invited speakers, providing a program that is diverse, stimulating and appealing to nurses from all disciplines of cancer care. Dr Carrie Tompkins Stricker, a nurse practitioner from Pennsylvania, is an expert in breast cancer care and survivorship, a cancer nurse researcher, and a business woman and founder of a technology based, personalised medicine cancer platform. Professor Alex Molasiotis, a renowned cancer nursing researcher from Hong Kong Polytechnic, who is extensively published in the area of complex symptom management, and Professor Lesley Fallowfield from the University of Sussex, who is an international expert in quality of life measures and communication skills training for health care professionals. This trio of international experts will ensure that 2015 will be the best Congress yet.

Perth, and its surrounding regions, are known for their pristine beaches and waterways, magnificent scenery, fine produce, exceptional dining and friendly and diverse cultures. We look forward to you joining us for a scientifically robust meeting in a city that is second to none and hope that you may also stay to enjoy some time in Western Australia.

Dr Ruth McConigley
Local Organising Committee Chair

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Invited Speaker Profiles

International Keynote Speakers

Dr Carrie Tompkins Stricker
Dr. Carrie Tompkins Stricker is Clinical Assistant Professor in the School of Nursing at the University of Pennsylvania, serving member of faculty, Nurse Practitioner at the Abraham Cancer Centre and co-founder and Chief Clinical Officer of OnQ Health.

Dr. Stricker is recognised for her clinical and research expertise in cancer survivorship care and evidenced-based symptom assessment and management. Her research has focused on development, implementation and evaluation of nurse practitioner led clinical survivorship programs for breast cancer survivors. She has collaborated on a US federally funded project, investigating the feasibility and impact of survivorship care planning. Her research findings and desire to overcome gaps in cancer care has led her to develop an interactive technology based solution for cancer clinicians and patients. She has taken opportunities throughout her career to optimise patient outcomes, clinically, through research, academia and now at an executive level.

Professor Alex Molasiotis
Professor Alex Molasiotis is Chair Professor of Nursing, Angel S.P. Chan Lau Endowed Professor and Head of the School of Nursing, Hong Kong Polytechnic University. Prior to moving to Hong Kong, he was Professor of Cancer & Supportive Care at the University of Manchester, UK, and Head of the Academic Cancer Nursing Research Unit, Christie Hospital NHS Foundation Trust in Manchester. He has been a Bloomberg International Distinguished Visiting Professor at the University of Toronto and a Visiting Professor at the Australian Catholic University (Sydney), and the National University of Singapore. He is currently Visiting Professor at The University of the Witwatersrand, Johannesburg, South Africa and Jiagnan University, Wuxi, China.

Professor Molasiotis is the Editor-in-Chief for the European Journal of Oncology Nursing. He serves on editorial board for multiple high quality journals, and on the Board of the Multinational Association of Supportive Care in Cancer (MASCC) and the Nurses committee of the International Association for the Study of Lung Cancer (IASLC). His research focus is complex symptoms, currently focusing on cancer-related fatigue, chemotherapy-related nausea and vomiting, peripheral neuropathy and cough/breathlessness in lung cancer.

Professor Lesley Fallowfield
Lesley Fallowfield is Professor of Psycho-oncology at Brighton & Sussex Medical School, University of Sussex where she is Director of the Sussex Health Outcomes Research & Education in Cancer (SHORE-C) group. Professor Fallowfield originally trained as a nurse at Guy’s Hospital London but then did a BSc in Experimental Psychology at Sussex. Research for her doctorate in psychophysics was completed at the Universities of Sussex and Cambridge. In 1991 she became the full-time Director of a Psychosocial Oncology Group and was awarded the first European chair in Psycho-oncology from University College London in 1997. Her research interests are wide and include the measurement of quality of life in clinical trials of cancer therapy and the training of communication skills for health care professionals in cancer. She has published over 350 papers, many book chapters and 3 text books. She lectures and runs training workshops throughout the world in psychosocial oncology, quality of life assessment and communication skills. In 2008 she was made a Fellow of the Academy of Medical Sciences. In 2010 she was shortlisted for the British Medical Journal’s Lifetime Achievement Award and won the Pfizer/British Oncology Association’s Excellence in Oncology, Lifetime Achievement Award. She sits on the Advanced Breast Cancer Guidelines Panel and the ASCO Breast Cancer Endocrine Guidelines Panel and is currently Chair of the multidisciplinary British Breast Cancer Group. Professor Fallowfield lives in Brighton, and has 2 adult children; one a consultant hepatologist and the other a paediatric community nurse.

Speaker support kindly provided by:
Ms Kylie Ash
Kylie Ash is a Registered Nurse with over 20 years experience in clinical and education roles in oncology and haematology practice settings. Kylie completed a Masters of Nursing (Cancer Nursing) from QUT in 2008. A variety of roles in clinical and academic settings over the past 10 years have further developed Kylie’s experience and knowledge in education and project management. Kylie is currently the Project Coordinator for EdCaN and PSGC. She is active in CNSA as the current Chair of the Education Committee.

Mr Michael Cain
Michael Cain is the Oncology Clinical Lead Pharmacist at Sir Charles Gairdner Hospital, Perth. He has over 25 years of experience in oncology contributing textbook chapters, journal articles and regular reviews to literature. He has lectured in formal and informal educational programs in Australia. He has served a variety of State, National, and International professional groups with involvement in working parties, advisory groups, and scientific review committees and as editorial board member. In the treatment of cancer, Michael has sought to enhance quality in the delivery of anticancer therapies through a focus on academic review and practical facilitation within the Sir Charles Gairdner Cancer Centre. In 2011 Michael was recognised as the Australian Pharmacist of the Year by the Pharmaceutical Society of Australia.

Mr Tony Connell
Mr Tony Connell is a Plastic & Reconstructive Surgeon practicing in Perth, Western Australia. He trained in Plastic & Reconstructive Surgery in Perth from 1993 to 1996, and in 1997 was the Hand Surgery and Micro Surgery Fellow at the Miami Hand Centre, Florida. In 1998 he was the Clinical Fellow at the Cleveland Clinic in Ft Lauderdale, Florida, and then he returned to Western Australia in 1999 to commence both public and private practice in Plastic & Reconstructive Surgery.

Professor Jon Emery
Professor Jon Emery is the Herman Professor of Primary Care Cancer Research at the University of Melbourne within the Victorian Comprehensive Cancer Centre. He is an NHMRC Practitioner Fellow, Director of the Cancer Australia Primary Care Collaborative Cancer Clinical Trials Group (PC4), a Visiting Research Fellow at the University of Cambridge and a GP.

He studied medicine at Cambridge and Oxford and obtained his DPhil at Oxford on computer decision support to assess cancer risk in general practice. His research interests are in the role of primary care in cancer prevention, diagnosis and management, genetic medicine and primary care trials of complex interventions. Much of his research entails parallel programs of work in Australia and Cambridge on cancer screening, early diagnosis and follow-up care. He has published over 150 papers and has been a Chief Investigator on research grants and awards totalling over $AUD15 million and GBP11 million.

For the past twelve years he has specialised exclusively in Aesthetic and Reconstructive Breast Surgery and his practice currently involves breast reconstruction, breast augmentation, revisional implant surgery, breast lift and breast reduction and congenital breast surgery.

In 2008 he undertook the PACE I Trial whereby seven patients had 10 AirXpanders placed for both immediate and delayed breast reconstructions. In 2010 the PACE II Trial involved another thirty nine patients undergoing unilateral and bilateral breast reconstruction with insertion of a further 62 AirXpanders. In 2011 the ASPIRE Trial involved the use of the AirXpander device in breast reconstruction patients undergoing adjuvant radiotherapy and in patients who were allowed to fly with the device in-situ.

He is currently the Principal Investigator for the AirXpander company in the Australian trials and has lectured worldwide on the use of this device, as he has the world’s largest clinical experience of its use in breast reconstruction.

He is the immediate past President of the Western Australian Society of Plastic Surgeons and continues to be involved in research in the use of 3D imaging in aesthetic and reconstructive breast surgery.
Professor Daniel Galvão

Daniel Galvão is Professor of Exercise Science and Co-Director of the Edith Cowan University Health and Wellness Institute, Perth, Western Australia, and a Cancer Council Western Australia Research Fellow. He received his B.Sc. (1998, Brazil) in Physical Education, M.Sc. (2003) in Clinical Exercise Science from the University of Queensland and his Ph.D. (2006) in Exercise Science from Edith Cowan University.

Professor Galvão’s research program focuses on applications of exercise as medicine for the prevention and management of cancer treatment side effects and survival and has received funding from NHMRC, Cancer Australia, and the Prostate Cancer Foundation of Australia. His research has been published in the Journal of Clinical Oncology, European Urology and Cancer and he has co-authored the Exercise and Sports Science Australia position stand in exercise and cancer (2009) and the American College of Sports Medicine’s exercise guidelines for cancer survivors (2010).

These guidelines, recently endorsed by the American Cancer Society, contributed significantly to a major modification in clinical recommendations for individuals to avoid physical inactivity and return to normal activity as soon as possible after cancer diagnosis or treatment.

Ms Melissa Hegarty

Melissa Hegarty graduated from Edith Cowan University with a Bachelor of Nursing in 2006. She then completed the Graduate Program at the Mount Hospital in 2007. Melissa has continued to work at the Mount Hospital in reconstructive plastics and ENT since finishing the Graduate Program and has been a Clinical Nurse in this area since 2009. In the last year Melissa has also been working as a nurse in Mr Tony Connell’s rooms.

Mrs Catherine Hunt

Catherine Hunt is a registered physiotherapist who has been working with Cancer Services at Sir Charles Gairdner Hospital since 1989.

In 2000 she completed a QI looking at functional outcomes for breast cancer surgery patients. At that stage Professor Lesley Fallowfield (U.K.) and others reported that 97% of women had some physical morbidity after breast cancer treatment.

The Breast Care CNS suggested Catherine commence attending the Breast Centre on call. This enabled Catherine to institute early self management strategies for patients on an ad hoc basis. In 2007 the SCGH Breast Centre Team initiated a dedicated physiotherapy role focusing on early intervention and prevention of functional morbidity for their patients.

This role has facilitated Catherine’s development of her physiotherapy skills and knowledge in the rehabilitation of women having breast cancer treatment.

Catherine is an active member of many societies and organisations including: The Chartered Society of Physiotherapists in Oncology and Palliative Care, the Australasian Lymphology Association, the W.A. Breast Cancer Collaborative and the W.A Cancer Survivorship Collaborative.

She enjoys contributing to Undergraduate and Postgraduate Physiotherapy Student education.

Professor Mei Krishnasamy

Professor Mei Krishnasamy is Executive Director of Cancer Nursing and Allied Health at the Peter MacCallum Cancer Centre in Melbourne and Professor of Cancer Nursing-Translational Research, in the Department of Nursing at the University of Melbourne. Mei works with specialist and advanced practice nurses and allied health clinicians to develop, implement and evaluate models of patient-centred care. She is chief investigator on several research grants that focus on improving patient experiences of cancer, and has a particular interest in the relationship between patient experience and health outcomes. She is President of the Clinical Oncology Society of Australia and a past President of the Cancer Nurses Society of Australia.

Mr Jim McGinty

Jim McGinty is a former Labor Health Minister in Western Australia and former Chair of Health Workforce Australia.

During his time as Member for Fremantle in the Western Australian Parliament he held the positions of Attorney General, Leader of the Opposition and several other ministerial positions in addition to the health portfolio.

As Health Minister he was responsible for devising and implementing the Health Reform Plan which has largely survived the change of government in 2008.
Key elements of that plan were the new Fiona Stanley Hospital, the new Perth Children’s Hospital and significant expansion of the secondary hospitals servicing Perth’s suburbs.

Mental health, primary health care and community based ambulatory care were also important aspects of the plan. Cigarettes and junk food were targeted during Mr McGinty’s tenure as Health Minister.

After retiring from political life in 2009, Mr McGinty continued an active involvement in health matters on the Boards of Telethon Kids Institute (child health medical research) Australian Medicare Local Alliance, Fremantle Medicare Local, and Brightwater (disability and aged care service provider).

Mr McGinty is also a member of the Independent Media Council, a Board member with Access Housing and a skipper with Fremantle Volunteer Sea Rescue Group.

In 2014 Mr McGinty’s contribution to law reform, health and the Western Australian parliament and community was recognised when he was made a Member of the Order of Australia.

Ms Lucy Patton
Lucy Patton is the Senior Project Coordinator of Education and Training for the Perth Children’s Hospital Project; in addition, she currently coordinates both oncology and palliative care specialty streams in the Master of Clinical Nursing at Edith Cowan University. As a nurse Lucy worked for many years in both inpatient and outpatient haematology and oncology settings in direct care and clinical education roles.

Lucy has previously held roles as a Staff Development Educator at Sir Charles Gairdner Hospital, Perth, Western Australia. She holds a Postgraduate Diploma in Training and Development and a Masters in Nursing. Lucy has extensive experience in curriculum design and implementation across the scaffold of training and education from professional development to postgraduate study. This is in addition to experience in the application of open and flexible technologies in teaching and learning and ensuring accessibility and relevancy for the adult learner.

In her current role Lucy is responsible for the planning, development, delivery and evaluation of a comprehensive, collaborative induction and orientation program for 3000 staff transitioning to a new Health Service site in 2016.

Professor Jane Phillips
Professor Jane Phillips is the Director of the Centre for Cardiovascular and Chronic Care and Professor Nursing (Palliative Care) at UTS. She has an in-depth understanding of palliative care and experience in delivering best-evidenced based palliative care across diverse settings, including rural and regional Australia and considerable expertise in leading and evaluating complex, health service reforms. Jane has led a number of major cancer and palliative care reform initiatives, at the local and national levels. She has the capacity to navigate the complex interplay between the clinical, research, policy and professional environments.

Jane graduated from the University of Western Sydney with a PhD in 2008. She holds a Bachelor of Science – Nursing and a post-graduate Diploma in Health Promotion from Curtin University, Western Australia. In 2005, she completed the ‘Program in Palliative Care Education and Practice’ at Harvard Medical School in Boston.

She is currently an Editor of ‘Collegian’ the Australian Journal of Nursing and on the Editorial Board of the International Journal of Palliative Nursing. In late 2013, she co-edited a special issue on Geriatric Oncology for the ‘Cancer Forum’ Journal. She is a member of the Palliative Care Nurses Australia national committee and holds an honorary clinical appointment at Sacred Heart Hospice and St Vincent’s Hospital, Sydney.

Ms Shannon Philp
Shannon Philp is a Nurse Practitioner with 20 years experience in cancer nursing, working clinically at Chris O’Brien Lifehouse in Gynaecological Oncology. Shannon is also a Lecturer and Course Coordinator of Cancer and Haematology Nursing at Sydney Nursing School, The University of Sydney. Shannon holds a Master of Nursing (Nurse Practitioner) and Graduate Certificate’s in Cancer Nursing and Women’s Health Nursing. She is a member of the Cancer Nursing Research Unit, a consortium of Sydney Nursing School and the Sydney Local Health District and on the Executive Committee of the NSW ACI Gynaecology Nurses’ Group.

Shannon has research interests in many aspects relating to the care of women with gynaecological cancers, particularly patient satisfaction and experience, quality of life and fast track surgical care. Shannon runs a Nurse Practitioner Clinic which provides a comprehensive service to women with a low risk of cancer recurrence, post-operative patients and women with Gestational Trophoblastic Disease.
Invited Speaker Profiles

Professor Christobel Saunders
Professor Christobel Saunders is a Consultant Surgeon at Royal Perth and St John of God Hospitals in Perth, Western Australia. She is the Professor of Surgical Oncology and Head of Unit, General Surgery at The University of Western Australia; and holds both clinical and research roles in the breast and melanoma cancer field. She is closely involved in strategic planning and management of cancer services nationally as a member of the National Lead Clinicians Group and Cancer Australia Advisory Council, Board Member of Cancer Council Australia and Breast Cancer Network Australia, and past President of Cancer Council Western Australia. Christobel has been involved in the development of numerous best practice guidelines for both patients and clinicians and her work is embedded in a firm evidence base implementing the latest research.

Christobel has worked in the breast cancer field for over 13 years and in 2010 received the National Breast Cancer Foundation (NBCF) Patron’s Award for achievement in breast cancer research. Christobel’s research covers a wide diversity of areas including clinical trials of new treatments, psychosocial research and translational and health services research. She has an exceptional funding track record, having attracted a career total of nearly $23 million in over 55 grants awarded in Australia since 2001. Christobel has published over 90 scientific papers in refereed journals, two books and 18 book chapters. She is a co-author of the book Breast Cancer - a guide for every woman and Breast Cancer: The Facts, which was shortlisted for the BMA Book of the Year in 2010.

Christobel has a passion for health and medical research, patient advocacy and an exceptional clinical track record in the management and treatment of breast cancer.

Professor Eric Visser
Professor Eric Visser holds the Inaugural Churack Chair in Chronic Pain Education and Research at the University of Notre Dame Australia and St John of God Health Care, and is a pain medicine physician and anaesthesiologist at PainScienceWA® at Joondalup Health Campus.

He is also a clinical senior lecturer in the School of Pharmacology and Anaesthesiology at the University of Western Australia.

Eric’s wide-ranging interests include developing best-practice pain education systems, acute pain service applications and chronic post-surgical pain.

Ms Julie Wilkes
Julie Wilkes graduated from Curtin University in WA with a Bachelor of Pharmacy degree in 1986. She went on to complete her Post Graduate Diploma in Hospital Pharmacy in 1995, and in 1999 she successfully obtained Board Certification in Oncology Pharmacy (US). Julie has worked in the area of oncology and haematology for the past 26 years, in a number of hospitals (both public and private) in Western Australia. In 2000, she was successful in obtaining a grant from the Health Department of WA to establish the Home Cancer Care Service, which enabled oncology and haematology patients to receive their chemotherapy and supportive care therapy at home. In 2013 Julie with her business partner, Lorna Rogers, started a private home health service company – View Health and its related subsidiary chemo@home. chemo@home is an innovative service which enables patients with cancer and other chronic health conditions to receive highly specialised care (including chemotherapy and monoclonal antibodies) in their own home. Her interests include drug therapy of haematological malignancies, bone marrow transplantation, infectious complications and service delivery change management and research.

Professor Patsy Yates
Professor Patsy Yates is jointly appointed as Head, School of Nursing at Queensland University of Technology and Director for Queensland Health’s statewide Centre for Palliative Care Research and Education (CPCRE).

She has over 30 years experience in research, education and clinical practice in cancer and palliative care. She leads a range of research and service improvement programs focused on developing workforce capacity in cancer and palliative care, advancing the management of cancer related symptoms and treatment side effects, and strengthening the nexus between research, policy and practice in cancer care. She is currently President for Palliative Care Australia.

She is regularly invited to provide expert advice to professional groups and government bodies, and has held ministerial appointments on a number of Boards and Committees for Federal and State Governments.

Patsy has received awards in recognition of her research, teaching and service, including being awarded the Tom Reeve Oration Award for Outstanding Contribution to Cancer Care and Life Membership from the Cancer Nurses Society of Australia as well as the Clinical Oncological Society of Australia. In 2010, she was awarded a Citation
Invited Speaker Profiles

Dr Nik Zeps

Dr. Zeps is a PhD scientist involved in translational research in breast, gastrointestinal and gynaecological malignancies. He is the Director of Research at SJGH Subiaco Hospital and head of a translational research program that has established a biobank and clinical registry as a part of routine multidisciplinary cancer care.

He is an Adjunct Professor in the School of Health Sciences at Curtin University and in the Centre for Comparative Genomics at Murdoch University. He is an Adjunct Associate Professor in the School of Surgery at the University of Western Australia and at Notre Dame Medical School. He is a member of Research Committee of the National Health and Medical Research Council (NHMRC) of Australia. He is the chair of the Cancer Biology Group of the Clinical Oncology Society of Australia and the Biological sub-committee of the Australasian Gastro-intestinal Trials Group and a member of the Research and Data Advisory Committee of Cancer Australia. He is the Australian representative on the Ethics and Policy Committee of the International Cancer Genome Consortium. He is a founding Board Member of the Australian Clinical Trials Alliance.

His objective as Director of Research is to integrate clinical research and teaching into routine healthcare delivery to improve the lives of patients and their families.

Travel Grant Acknowledgements

CNSA would like to acknowledge the generous support offered from organisations to enable participation at Winter Congress.

Thank you to Ipsen for the ongoing contribution to support CNSA Members to participate in the annual CNSA Winter Congress.

Congratulations to the recipients of this year’s Ipsen CNSA Winter Congress Travel Grant:

Sarah Northfield, QLD  Julie Flynn, QLD

CNSA WA REGIONAL GRANTS

Holly Elliott  Fleur Holland  Susanna Murphy  Russell Reyes

Cancer Council Victoria Breast Care Grant Recipient:

Laura Levett

Cancer Council Queensland Travel Grant Recipients:

Leisa Brown  Stephen Smith  Marion Strong
Breast Cancer Network Australia (BCNA) is the peak national organisation for Australians affected by breast cancer.

BCNA:
- represents more than 100,000 members across Australia
- reaches 84% of women diagnosed with early breast cancer through our My Journey Kit
- is the voice for Australians affected by breast cancer
- ensures women are ‘at the table’ wherever an important decision is made about breast cancer
- works with health professionals to support women diagnosed with breast cancer
- advocates for better treatment and care for those diagnosed.

For more information, visit www.bcna.org.au or phone BCNA on 1800 500 258.

Progress your nursing career

ACN offers a selection of courses to help you excel in your area of specialty.

Our postgraduate courses prepare nurses for a rewarding career in the health and community services sector. They are designed to meet contemporary industry needs and provide the knowledge, skills and attitudes directly suited to working in specialist areas of health care.

Nurses working with cancer patients can choose from the following postgraduate opportunities in July 2015:
- Graduate Certificate in Cancer Nursing
- Graduate Certificate in Breast Cancer Nursing.

Not ready to commit to a full postgraduate course? ACN offers over 20 single subjects related to cancer nursing, including: Blood and marrow transplantation, Breast cancers, Haematology nursing and more.

July intake is closing soon, so don’t wait and enrol today!
Getting Social
with Winter Congress

If you have a Twitter or Facebook account, you can join in on the conversation at this years’ Winter Congress. During the congress, 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 #cnssa2015 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. The hashtag will also appear within the event feed of the congress app.

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 Winter Congress. Share your photos on Facebook using #cnssa2015 – the best ones will be added to the official CNSA Facebook 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 everyone know that you’re involved with the 2015 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.

facebook.com/CNSA.ORG
@CNSA_ORG
Join the conversation #CNSSA2015
Welcome Reception
Sunday 14 June 2015, 5.00pm – 7.00pm
Perth Convention and Exhibition Centre, BelleVue Ballroom 1
The Welcome Reception is included in the registration fee for full registrants and includes canapés and drinks.

Dress: Smart Casual

Congress Gala Dinner
Monday 15 June 2015, 7.30pm – 11.30pm
Perth Convention and Exhibition Centre, River View 4 and 5

Dress: Dress to impress!
Ticket price: $110.00 p/person for CNSA Delegates or $140 p/person for partners/guests.

You gave us your feedback and we have listened – the 2015 Gala Dinner will be a seated three-course meal, featuring award winning cuisine using the freshest, premium and local produce.

Dress to impress! – something that you can rock your best moves on the dance floor in as you are entertained by one of Perth’s most renowned bands, “Murphy’s Lore”. Who will be crowned the 2015 dancing queen?

This is a ticketed event, should you wish to purchase a ticket or if you have selected to attend but no longer wish to please contact the Registration Desk immediately.

Registration Desk
The registration desk will be located on level 3 of the centre, just outside the exhibition area (BelleVue Ballroom). The opening times are as follows:
Sunday 14 June:  3.00pm – 7.00pm
Monday 15 June:  6.30am – 5.00pm
Tuesday 16 June:  6.30am – 4.15pm

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 Sunday 14 June 2015.
• 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 3 of the centre, BelleVue Ballroom 1.

Monday 15 June 2015
10.20am – 10.50am  Morning Tea
12.20pm – 1.20pm  Lunch
3.20pm – 3.50pm  Afternoon Tea

Tuesday 16 June 2015
10.50am – 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.

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 (Meeting Room 12 on level 2 of the centre) at least 2 hours prior to the start of their session time. Presentations must be brought on a USB memory stick.

Poster Display
The poster display will be located within the exhibition area. Don’t forget to vote on the congress app for your favourite poster. Click “live polls” to view the poster listing.

Internet Access
All congress delegates can now stay connected to the web and their emails via the free PCEC wireless internet service which is available throughout the venue. Access to the free wireless internet service is available via the main PCEC internet portal page and is limited to 60 minutes upon agreeing to the terms and conditions. Please note that this service is limited to 256Kb per user, the actual speed of the connection will be influenced by the number and density of concurrent users within the centre; and is intended for general web browsing and checking web-based email only.

To access the free wireless internet:
• Connect to the PCEC_Wireless network.
• Open an Internet Browser, which will get redirected to the PCEC Portal Page.
• Select the Free Wifi option.

Transport to Perth Convention and Exhibition Centre
Trains
Esplanade train station is located at the doorstep of the Centre and services the Mandurah and Joondalup Railway Line. Other train stations within close proximity of the centre include:
• Perth Underground station (Mandurah and Joondalup Railway Line) located on the corner of William Street and Murray Street Mall.
**Congress Information**

- Perth Central station (Armadale-Thornlie Railway Line, Fremantle Railway Line and Midland Railway Line) located along Wellington Street (across from Forrest Place).
- An underground walkway connects the Perth Central station to the Perth Underground station.

**Buses**

Esplanade Busport is located adjacent to Perth Convention and Exhibition Centre. Many bus services depart and arrive at the Esplanade Busport including the free CBD ‘Blue CAT’ service.

**Taxis**

Perth Convention and Exhibition Centre is a designated Cab Spot location. A taxi phone is located at the Plaza Entry doors on Level 1. The Cab Spot number is 1088. Alternatively, to book a taxi, please contact:
- Swan Taxis 13 13 30
- Black and White Taxis 13 10 08

**Walking**

Walking access into the Centre on Level 1 is via Mill Street or Mounts Bay Road. Level 2 can be accessed via the Esplanade Busport overpass.

**Driving**

Access to the City of Perth Convention Centre Car Park is via Mill Street, Mounts Bay Road and the Riverside Drive off ramp from the Mitchell Freeway. Access to our Level 1 Plaza area is from Mill Street or Mounts Bay Road.

**Car Parking**

Parking is available directly under the Centre and is managed by the City of Perth.

**Open:** 24 hours, 7 days a week  
**Access:** via Mill St, Mounts Bay Rd, or the Riverside Dv off-ramp from the Mitchell Freeway  
**Payment:** cash, credit card, or City of Perth Parking Card  
**Centre access:** direct access to PCEC during opening hours via central foyer lift and staircases  
Contact: 1300 889 613

**Rates (correct at time of printing)**

Monday – Sunday, hourly rate: $5.50  
10 hour maximum (Monday – Friday): $23.40  
12 hour maximum (Monday – Friday): $32.30  
24 hour maximum (Monday – Friday): $55.30  
Early Bird (entry before 7am, Monday – Friday, 10 hour maximum): $22.30  
Weekend and Public Holiday Day Rate (10 hour maximum between 6am & 6pm): $16.50

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### Room Allocations

**Sunday 14 June 2015**

- **Advanced Practice Workshop**  Meeting Room 1  
- **New Researchers Workshop**  Meeting Room 2  
- **Communication Workshop**  Meeting Room 3  
- **Expanding the Possibilities for Breast Cancer Care**  River View Room 4  
- **Radiation Oncology Workshop**  Meeting Room 7  
- **Optimising Outcomes with Vascular Access Devices in the Cancer Care Setting**  Meeting Room 8

**Specialist Practice Network Meetings**

- **Cancer Nurse Practitioners**  Meeting Room 1  
- **Gynaecologic Oncology**  Meeting Room 2  
- **Breast Cancer**  River View Room 4  
- **Radiation Oncology**  Meeting Room 7  
- **Vascular Access Device and Infusion Therapy**  Meeting Room 8  
- **Welcome Reception**  BelleVue Ballroom 1  
- **BMS Educational Dinner**  River View Room 5

**Monday 15 June 2015**

- **Breakfast Session 1: Hospira**  Meeting Room 7  
- **Breakfast Session 2: Roche**  River View Room 4  
- **Opening Ceremony and Plenary Session 1 and Plenary Session 2**  BelleVue Ballroom 2  
- **Concurrent Session 1: Advanced Practice**  Meeting Room 1  
- **Concurrent Session 2: Rural and Remote**  Meeting Room 2  
- **Concurrent Session 3: Breast Cancer Update**  River View Room 4  
- **Concurrent Session 4: Education and Research**  Meeting Room 3  
- **Concurrent Session 5: Cancer Nursing Education Where do I start?**  Meeting Room 7  
- **Concurrent Session 6: AYA**  Meeting Room 8  
- **Plenary Session 3**  BelleVue Ballroom 2  
- **Gala Dinner**  River View Room 4 and 5

**Tuesday 16 June 2015**

- **Breakfast Session 3: MSD**  Meeting Room 7  
- **Breakfast Session 4: Novartis**  River View Room 4  
- **Plenary Session 4**  BelleVue Ballroom 2  
- **CNSA AGM**  BelleVue Ballroom 2  
- **Concurrent Session 7: Radiation Oncology Nursing**  Meeting Room 1  
- **Concurrent Session 8: Hot Topics**  Meeting Room 2  
- **Concurrent Session 9: Breast Cancer Care**  River View Room 4  
- **Concurrent Session 10: Clinical Practice**  Meeting Room 3  
- **Concurrent Session 11: Advanced Research Workshop**  Meeting Room 7  
- **Concurrent Session 12: Practice Implications**  Meeting Room 8  
- **Plenary Session 5 and closing address**  BelleVue Ballroom 2
**YERVOY NOW TGA APPROVED FOR FIRST-LINE**

Start first with YERVOY® (ipilimumab), the metastatic melanoma treatment with proven durable long-term survival

*In a phase III trial of previously-treated metastatic melanoma patients, there was a 34% reduction in the risk of death with YERVOY 3 mg/kg monotherapy vs. gp100 (HR=0.66 [95% CI: 0.51–0.87], p=0.003; median follow-up 27.8 months). Objective responses maintained beyond 44 months in some patients.*

YERVOY® is now approved for first-line treatment of adult unresectable/metastatic melanoma patients.

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**WARNING: IMMUNE-MEDIATED ADVERSE EVENTS**

YERVOY therapy should be administered and monitored under the supervision of physicians experienced in the treatment of cancer. YERVOY can cause severe and life-threatening immune-related adverse reactions (irARs), including enterocolitis, intestinal perforation, hepatitis, dermatitis (including toxic epidermal necrolysis), endocrinopathy (which may not be reversible), neuropathy, as well as irARs in other organ systems [see PRECAUTIONS and DOSAGE AND ADMINISTRATION].

Early diagnosis and appropriate management are essential to minimise life-threatening complications.

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**PBS Information:** Section 100 Authority Required. Refer to PBS Schedule for full authority information.
Exhibition Opening Hours

Sunday 14 June 2015
1700 – 1900  Welcome Reception

Monday 15 June 2015
1020 – 1050  Morning tea
1220 – 1320  Lunch
1520 – 1550  Afternoon tea

Tuesday 16 June 2015
1050 – 1120  Morning tea
1320 – 1420  Lunch
1420    Exhibition closes

Exhibitor Listing

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<td>Cancer Council Australia</td>
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<td>Australian Medical Couches</td>
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<td>Westmead Breast Cancer Institute</td>
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<td>AstraZeneca</td>
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<td>17</td>
<td>Psycho-Oncology Co-Operative Research Group, University of Sydney</td>
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<td>Boehringer Ingelheim</td>
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<td>Fresenius Medical Care Seating</td>
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<td>Palliative Care Nurses Australia</td>
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<td>Smiths Medical Australasia</td>
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Win an iPad mini

Collect your exhibitor stamps in your ‘mini passport’ then hand into the registration desk at lunchtime on Tuesday to be in with a chance to win!
**Sunday 14 June | Pre-Congress Workshop Program**

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<tr>
<th>WORKSHOPS</th>
<th>Meeting Room 1</th>
<th>Meeting Room 2</th>
<th>Meeting Room 3</th>
<th>River View Room 4</th>
<th>Meeting Room 7</th>
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<tr>
<td>0900 – 1600</td>
<td>Advanced Practice Workshop</td>
<td>New Researchers Workshop</td>
<td>Communication Workshop</td>
<td>Expanding the Possibilities for Breast Cancer Care</td>
<td>Radiation Oncology Workshop</td>
<td>Optimising Outcomes with Vascular Access Devices in the Cancer Care Setting</td>
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**SPECIALIST PRACTICE NETWORKS MEETINGS**

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<th>Meeting Room 1</th>
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<th>River View Room 4</th>
<th>Meeting Room 7</th>
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<tr>
<td>1600 – 1700</td>
<td>Cancer Nurse Practitioners</td>
<td>Gynaecologic Oncology</td>
<td>Breast Cancer</td>
<td>Radiation Oncology</td>
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<tr>
<td>1700 – 1900</td>
<td>Welcome Reception and Networking Opportunity</td>
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<td>Vascular Access Device and Infusion Therapy</td>
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<td>1915 – 2145</td>
<td>BMS Educational Dinner</td>
<td>Optimising supportive care in Immuno-Oncology (I-O): The VOYCE nurses network</td>
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**Monday 15 June | Winter Congress Program Day One**

<p>| 0700 | Registration |
| 0715 – 0815 | <strong>Breakfast Session 1</strong>: Experience of two major hospital oncology units, Royal Melbourne Hospital and Peter MacCallum Cancer Centre, with the Neutron™ Catheter Patency Device on PICCs/CVCs. <strong>Supported by:</strong> Hospira |
| 0830 – 0840 | Welcome to Country – Indigenous representative |
| 0840 – 0850 | <strong>Presidental Congress address</strong> – CNSA President, Dr Ray Chan |
| 0850 – 0900 | <strong>Congress Address</strong> – WA Chief Nurse, Karen Bradley |
| 0900 – 0910 | Welcome to Congress 2015 – LOC Chair, Dr Ruth McConigley |
| 0910 – 0950 | Cancer nursing opportunities beyond the bedside – Dr Carrie Tompkins Stricker |
| 0950 – 1020 | The changing cancer nursing workforce – Mr Jim McGinty |
| 1020 – 1050 | Morning Tea, Poster Viewing and Exhibition Networking |
| 1050 – 1120 | Symptom awareness and help-seeking in rural Australia: Is there a problem and can we change it? – Professor Jon Emery |
| 1120 – 1150 | Strengthening the relationship between acute cancer care and palliative care – Professor Patsy Yates |
| 1150 – 1220 | Why patient reported outcomes matter (PROs) when assessing new breast cancer treatments – Professor Lesley Fallowfield |
| 1220 – 1320 | Lunch, Poster Viewing and Exhibition Networking |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Chair/Representative</th>
<th>Location</th>
<th>Topic</th>
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<tbody>
<tr>
<td>1320</td>
<td>1: Advanced Practice</td>
<td>Gillian Blanchard</td>
<td>Meeting Room 1</td>
<td>Antineoplastic drug administration competency for rural cancer nurses: Expanding the possibilities Christine Henneker</td>
</tr>
<tr>
<td>1320</td>
<td>2: Rural and Remote</td>
<td>Ruth McConigley</td>
<td>Meeting Room 2</td>
<td>Air expander reconstruction Mr Tony Connell</td>
</tr>
<tr>
<td>1320</td>
<td>3: Breast Cancer Update</td>
<td>Kerry Patford</td>
<td>River View Room 4</td>
<td>Chemotherapy Credentialing: The way forward Catherine Barratt</td>
</tr>
<tr>
<td>1320</td>
<td>4: Education and Research</td>
<td>Leanne Monterosso</td>
<td>Meeting Room 3</td>
<td>This interactive workshop will provide practical information on educational options for cancer nurses in Australia. A panel of education experts will highlight the range of pathways for extending the cancer nurse role. Attendees are encouraged to submit comments and questions for the panel members who will offer hints and tips for successful professional development. Shannon Philip, Patsy Yates, Lucy Patton, Jane Phillips</td>
</tr>
<tr>
<td>1320</td>
<td>5: Cancer Nursing Education – Where do I start?</td>
<td>Kylie Ash</td>
<td>Meeting Room 7</td>
<td>Sub Specialisation in Cancer Nursing: Youth Cancer Specialist Nurse Role Contribution and Collaboration Janine McDonald</td>
</tr>
<tr>
<td>1320</td>
<td>6: AYA</td>
<td>Meg Plaster</td>
<td>Meeting Room 8</td>
<td>Piloting an Individual Psychosocial Support Model for young people impacted by cancer Pandora Patterson</td>
</tr>
<tr>
<td>1340</td>
<td>Infusion related reactions: Differentiating and managing hypersensitivities, anaphylaxis and tumour lysis</td>
<td>Michael Cain</td>
<td>Exhibition Area, BelleVue Ballroom 2</td>
<td>Supportive Care: A new Cancer Council Western Australia role for provision of psychosocial support to regional patients and carers staying in Perth Karen Davis</td>
</tr>
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<td>1340</td>
<td>Expanding the role of Advanced Practice Nurse, the legal and professional perspectives</td>
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<td>Nurses as trainers: Delivering training, knowledge and skills to cancer support group leaders Sally Carveth</td>
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<td>1400</td>
<td>Improving patient experience across multiple sites and disciplines</td>
<td>Rose Cook</td>
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<td>Community and Cancer Care RN Rotation Project Louise Maher</td>
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<td>1420</td>
<td>Corticosteroids: The highs and the lows</td>
<td>Julie Wilkes</td>
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<td>Progression of the enrolled nurse in an oncology day unit Corrie Miles</td>
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<td>1420</td>
<td>Doing what I need to do: A qualitative research study of experiences of colorectal cancer in rural NSW</td>
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<td>Developing research capacity to achieve clinical excellence: The Cancer Nursing Professorial Precinct Initiative Alanna Geary</td>
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<td>1440</td>
<td>Professional challenges and support mechanisms for Breast Care Nurses in rural and regional Queensland</td>
<td>Pammie Ellem</td>
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<td>Development of a simple adherence assessment tool for clinical use for anti-infective prophylaxis in adolescent and young adults with a haematological malignancy Peter Haywood</td>
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<td>1500</td>
<td>Reducing the impact on rural breast cancer patients by improving the knowledge, confidence and competence of community nurses Michelle Hamblin</td>
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<td>Patient access to high cost, non-PBS listed drugs Danielle Spence</td>
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<td>1500</td>
<td>Patient access to high cost, non-PBS listed drugs Danielle Spence</td>
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<td>Process evaluation of the Young People Living with Cancer (YPLWC) E-mental Health Service Liz King</td>
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<td>1520</td>
<td>Afternoon Tea, Poster Viewing and Exhibition Networking</td>
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<td>Pilot a model for young people living with cancer (YPLWC) Liz King</td>
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<td>PLENARY SESSION 3</td>
<td>Chair: Sam Gibson</td>
<td>Exhibition Area, BelleVue Ballroom 1</td>
<td>The highs and the lows Julie Wilkes</td>
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<td>1550</td>
<td>Personalised medicine, an unravelling era of treatment – Dr Nik Zeps</td>
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<td>Process evaluation of the Young People Living with Cancer (YPLWC) E-mental Health Service Liz King</td>
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<td>1600</td>
<td>Genetics and the changing world of cancer care – Professor Christobel Saunders</td>
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<td>Process evaluation of the Young People Living with Cancer (YPLWC) E-mental Health Service Liz King</td>
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**Tuesday 16 June | Winter Congress Program Day Two**

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<td>Meeting Room 7</td>
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<td>0800</td>
<td>Breakfast Session 4: Addressing the patient adherence challenges of new oncology treatments</td>
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<td>Meeting Room 2</td>
<td>Expanding the role of Advanced Practice Nurse, the legal and professional perspectives – Professor Alex Molasiotis</td>
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<td>0910</td>
<td>Exercise Medicine and Cancer Survivorship: From Symptom to Survival – Professor Daniel Galvão</td>
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<td>Meeting Room 2</td>
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<td>Expanding the role of Advanced Practice Nurse, the legal and professional perspectives – Professor Alex Molasiotis</td>
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<td>Exhibition Area, BelleVue Ballroom 1</td>
<td>Expanding the role of Advanced Practice Nurse, the legal and professional perspectives – Professor Alex Molasiotis</td>
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## CONCURRENT SESSIONS

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<td>Sharon Ray</td>
<td>A Survey Of Australian Cancer Nurses: The Prevention And Control Of Non-Communicable Diseases- CaNPaC study</td>
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<td><strong>8: Hot Topics</strong></td>
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<td>Narelle Smith</td>
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<td>1120 – 1200</td>
<td><strong>9: Breast Cancer Care</strong></td>
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<td>Collaborative review of evidence-based guidelines in central venous access device (CVAD) management</td>
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<td><strong>10: Clinical Practice</strong></td>
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<td><strong>11: Advanced Research Workshop</strong></td>
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<td>Moira Stephens</td>
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<td><strong>12: Practice Implications</strong></td>
<td>Meeting Room 8</td>
<td>Lucy Patton</td>
<td>Assessment of health professionals’ perspectives of a program to implement routine screening for psychosocial distress into the admission and discharge process</td>
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<td>1140 – 1200</td>
<td><strong>Implementing a Model of Care into a Radiation Therapy</strong></td>
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<td>Michelle Roach</td>
<td>Process mapping the patient’s journey: Enhancing the quality of care across the colorectal cancer pathway</td>
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<td>1200 – 1220</td>
<td><strong>Radiation induced skin toxicities, experiences of patients and effectiveness of interventions</strong></td>
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<td>Nicole Rozanc</td>
<td>Cancer Survivorship 101: Findings from the Victorian pilot projects of post-treatment survivorship care</td>
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<td>1200 – 1220</td>
<td><strong>Liposuction for advanced lymphoedema – Impact of liposuction on limb volumes</strong></td>
<td>BelleVue Ballroom 4</td>
<td>Linda McGinn</td>
<td>Meeting the information needs of women from culturally and linguistically diverse backgrounds diagnosed with breast cancer</td>
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<td>1200 – 1220</td>
<td><strong>The Challenges of Conducting Clinical Research on Central Venous Access Devices</strong></td>
<td>BelleVue Ballroom 4</td>
<td>Sarah Northfield</td>
<td>Hickman vs PICC: A comparison of central venous access device complications in patients undergoing intensive chemotherapy for acute myeloid leukaemia</td>
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<td>1220 – 1240</td>
<td><strong>Cancer Nursing in Denmark and Australia – A comparison between two hospitals</strong></td>
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<td>Noeline Rozanc</td>
<td>Broadening Our Horizons: Clinical Nurses and Their Role in The Successful Adoption of Information Technology Systems</td>
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<td>1220 – 1240</td>
<td><strong>The Breast Care Nurse Supportive Care Model</strong></td>
<td>BelleVue Ballroom 5</td>
<td>Tracey Ahern</td>
<td>Sterile vs aseptic non-touch technique for needle-less connector care on central venous access devices in a bone marrow transplant population: A comparative study</td>
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<td>1220 – 1240</td>
<td><strong>Publication workshop: International publication opportunities, increasing your publication outputs</strong></td>
<td>BelleVue Ballroom 5</td>
<td>Alex Molasiotis</td>
<td>Publication workshop: International publication opportunities, increasing your publication outputs</td>
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<td>1240 – 1300</td>
<td><strong>Nurse led review clinics, a positive impact on patient care</strong></td>
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<td>Gabrielle Vigar</td>
<td>The Palliative Approach within the Acute Hospital Setting</td>
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<td>1240 – 1300</td>
<td><strong>The development of a model of care and nursing role to address the supportive care (SC) gap of metastatic breast cancer (MBC) patients</strong></td>
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<td>Tracey Ahern</td>
<td>Red blood cells – are they being used appropriately?</td>
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<td>1300 – 1320</td>
<td><strong>Evaluating the Effects of Aluminium Containing and Non-Aluminium Containing Deodorants on Axillary Skin Toxicity During Radiation Therapy for Breast Cancer: A 3-Armed Randomized Controlled Trial</strong></td>
<td>BelleVue Ballroom 5</td>
<td>Sharron Carson</td>
<td>A survey of unmet needs and self-efficacy in women diagnosed with breast cancer and the role of the breast care nurse</td>
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<td>1300 – 1320</td>
<td><strong>International IT Approaches to Survivorship Care: Suitability in the Australian Context</strong></td>
<td>BelleVue Ballroom 5</td>
<td>Margaret Hjorth</td>
<td>Intravesical treatments: We had to change mid-stream</td>
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<td>1300 – 1320</td>
<td><strong>Feasibility and acceptability of using the hand-held fan as a self-management strategy to increase physical activity in patients with refractory breathlessness:</strong></td>
<td>BelleVue Ballroom 5</td>
<td>Chris McKeon</td>
<td>Results from an international multisite pilot randomised control trial</td>
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### Additional Events

- **1320 – 1420** Lunch, Poster Viewing and Exhibition Networking
- **1420 – 1440** Awards Presentations
- **PLENARY SESSION 5 | Chair: Ray Chan**
- **1440 – 1520** Survivorship Care – Global Perspectives and Opportunities for Nurse Led-Care – Dr Carrie Tompkins Stricker
- **1520 – 1600** Cancer nursing diversity: how our profession is evolving – An Australian Context – Professor Mei Krishnasamy
- **1600 – 1615** Welcome to Congress 2016 and Closing Address
Please review approved Product Information before prescribing.

Product Information is available upon request from Merck Serono or via the TGA website https://www.ebs.tga.gov.au

Erbitux® Minimum PI: Indications: For the treatment of patients with epidermal growth factor receptor (EGFR)-expressing, RAS wild-type metastatic colorectal cancer (mCRC)*: 1) in combination with: infusional 5-fluorouracil/folinic acid plus irinotecan*, irinotecan in patients who are refractory to first-line chemotherapy* or in first-line with FOLFOX*, 2) as a single agent in patients who have failed or are intolerant to oxaliplatin-based therapy and irinotecan-based therapy. Also for the treatment of patients with squamous cell cancer of the head and neck (SCCHN): 1) in combination with radiation therapy for locally advanced disease, 2) in combination with platinum-based chemotherapy for recurrent and/or metastatic disease. Contraindications: Known severe (grade 3 or 4) hypersensitivity reaction to cetuximab, mutant or unknown RAS mCRC status*. Contraindications for concomitant therapy must be considered.

Precautions: Infusion-related reactions; respiratory disorders; skin reactions; electrolyte disturbances; cardiovascular disorders; eye disorders; mCRC patients with RAS mutations or for whom RAS status is unknown*; resectable liver metastases*; combination with capecitabine + irinotecan*; pregnancy Category D; no breast-feeding. Interactions: Increased incidence of specific adverse reactions in combination with chemo- or radiotherapy (see below).

Adverse effects: Very Common: skin reactions, hypomagnesaemia, mild to moderate infusion-related reactions, mucositis, increased liver enzyme levels. Common: headache, conjunctivitis, diarrhoea, nausea, vomiting, dehydration, hypocalcaemia, anorexia, severe infusion-related reactions, fatigue. The risk of adverse events due to chemotherapy or radiotherapy may be higher when combined with Erbitux: severe leukopenia/neutropenia, infections and infectious complications (with platinum-based agents); cardiac ischaemia, hand-foot syndrome (with fluoropyrimidines); severe diarrhoea (with capecitabine and oxaliplatin); hypokalaemia (with irinotecan or platinum/fluorouracil); radiation-related effects (with radiotherapy).

Dosage: Initial dose 400 mg/m2; subsequent weekly doses 250 mg/m2. Administer intravenously over 120 min for initial dose; 60 min for subsequent doses. Premedicate with antihistamine and corticosteroid for first infusion; recommended for subsequent infusions. Monitor closely during and for at least 1 hour after the end of the infusion. Do not administer chemotherapy agents until at least 1 hour after cetuximab infusion. For mCRC: RAS status must be determined prior to first infusion*; in combination with chemotherapy or as monotherapy, continue until disease progression. For locally advanced SCCHN: start one week prior to and then use concomitantly with radiation therapy. For recurrent/metastatic SCCHN: in combination with platinum-based chemotherapy agent then as monotherapy until disease progression. Based on PI dated 2 December 2014

* Please note change in Product Information

* Erbitux is a registered Trade Mark of ImClone LLC used under licence by Merck KGaA, Germany. Sponsor: Merck Serono Australia Pty Ltd, Units 3-4, 25 Frenchs Forest Road East, Frenchs Forest NSW 2086 Australia. PA: ONC-FEB-15-AU-0002

PBS Information: Authority required. Refer to PBS Schedule for full authority information.
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<td>A national cancer nursing survey: survivorship care provision for patients with haematological malignancy</td>
<td>Raymond Chan</td>
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<td>Does parenteral nutrition increase the risk of catheter-related infection? Does the evidence reflect current practice guidelines?</td>
<td>Nicole Gavin</td>
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<td>Does parenteral nutrition promote microbial growth? A review of clinical and laboratory findings.</td>
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<td>Peripheral Intravenous Access - Patients’ understanding of potential complications post cannula removal</td>
<td>Gillian Blanchard</td>
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<td>Survivorship care plans and treatment summaries in adult patients with haematological cancer: an integrative literature review.</td>
<td>Karen Taylor</td>
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<td>Chemotherapy induced nausea and vomiting – a better assessment tool – involving patients in their own care and gauging antiemetic effectiveness including early intervention when necessary.</td>
<td>Wendy Spencer</td>
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<td>7</td>
<td>Developing a cancer survivorship model of care through consumer engagement</td>
<td>David Larkin</td>
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<td>Comparing an active versus passive decontamination of the needle-less connectors on a central venous access device: An in vitro study.</td>
<td>Julie Flynn</td>
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<td>Implementation of a scalp cooling service- A Victorian private hospital experience</td>
<td>Gail Wilmot</td>
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<td>Aiming for consistency of practice: a whole-of-region approach to establishing a nursing and allied health network to support coordination of cancer care</td>
<td>Lea Marshall</td>
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<td>Measuring up against an oral hygiene protocol</td>
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<td>Meeting the needs of rural breast care nurses: Our experience of creating and using guidelines that support newer and relieving breast care nurses in rural NSW</td>
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<td>Patient treatment summary letters - improving communication within the multidisciplinary team.</td>
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<td>Cancer Council Nurses providing telephone-based support to those who care for people with cancer: lessons learned in a research context</td>
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<td>Review of the neuro-oncology service in a tertiary hospital in Western Australia</td>
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<td>‘Are you ready to accept accountability?’ Improving patient safety and satisfaction in an acute oncology/haematology unit using a uniform clinical handover tool</td>
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<td>The incidence of chemotherapy induced nausea and vomiting (CINV) in patients receiving moderately emetogenic chemotherapy (MEC) and the role of nurses in providing effective management</td>
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<td>Neuroendocrine tumor (NET) Australian and New Zealand patient experience: results from the first global NET patient survey - A collaboration between the International Neuroendocrine Cancer Alliance (INCA) and Novartis</td>
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<td>Rebecca Galvin</td>
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<td>Justifying your existence in specialist cancer nursing roles</td>
<td>Julie Sykes</td>
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WE MEASURE our SUCCESS IN MDS BY your SUCCESS
Sunday 14 June 2015

BMS Educational Dinner

Optimising supportive care in Immuno-Oncology (I-O): The VOYCE nurses network

Supported by:

Speakers

Professor Michael Millward
Winthrop Professor
Cancer Council Professor of Clinical Cancer Research
University of WA
Consultant Medical Oncologist
Sir Charles Gairdner Hospital

Julie Teraci
Clinical Nurse Consultant
Coordinator, Western Australian Melanoma Advisory Service

Description

YERVOY® (ipilimumab) is an Immuno-Oncology (I-O) agent that harnesses the body’s own immune system to fight cancer.1,2 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 and other IO agents. Nurse VOYCE (yerVOY Clinical nEtwork) is designed to aid cancer nurses in supporting patients on YERVOY. Using peer-to-peer engagement and sharing of clinical practice, the program can assist nurses in educating patients on YERVOY therapy and in supporting the safe and appropriate use of YERVOY.

The Nurse VOYCE dinner meeting will feature a discussion about the mechanism of action of IO agents including how these therapies differ from chemotherapy agents as well as case studies from a nursing perspective discussing the management of patients with advanced melanoma on YERVOY treatment. Attendees will have the opportunity to participate in case study discussion, to make new connections and to register for the VOYCE Nurse Program. More information on the VOYCE Nurse Program can be found on the VOYCE Nurse Website at http://www.yervoy.com.au/hcp/voyce/nurse/

References


Monday 15 June 2015

Breakfast Session 1

Experience of two major hospital oncology units, Royal Melbourne Hospital and Sydney Adventist Hospital, with the Neutron™ Catheter Patency Device on PICCs/CVCs, and learnings from a Clave Oncology™ closed system implementation

Supported by:

Presenters

Peter Haywood
Nurse Coordinator – Acute Leukaemia / Adolescent and Young Adult at the Royal Melbourne Hospital

Agnes Esak
Clinical Nurse Educator at the Sydney Adventist Hospital

Description

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

Peter Haywood and Elyse Harley, Department of Haematology, Oncology, Bone Marrow Transplantation, Royal Melbourne Hospital

A nurse-led project undertaken at the Royal Melbourne Hospital, investigated the impact of needleless connector type on the incidence of coagulase negative staphylococcus in blood cultures drawn from peripherally inserted central catheters in haematology/oncology inpatients. Peter Haywood, Nurse Coordinator - Acute Leukaemia / Adolescent and Young Adult, at the Royal Melbourne Hospital, will be presenting the results of this study, and the measures they took to reduce the incidence of such infections. These measures included the introduction of the Clave system.

Untangling the lines; reducing cytotoxic exposure risk via the implementation of a closed intravenous cytotoxic administration system

The experience of implementing the Clave system for chemo administration at the Sydney Adventist Hospital will be presented by Agnes Esak, Clinical Nurse Educator there. As one of the key participants of the action research project, Agnes will discuss how the implementation of a closed intravenous cytotoxic administration system can assist in reducing cytotoxic exposure risk for both patients and nurses.
Breakfast Session 2
Importance of the nurse and patient perspective on administration methods of anti-cancer drugs

Supported by: Roche

Presenter
Professor Lesley Fallowfield – Director, Sussex Health Outcomes Research & Education in Cancer (SHORE-C), Brighton & Sussex Medical School, University of Sussex

Description
Data from patient reported outcomes (PROs) enables better opportunities for more informed decision-making offering a broader assessment of the impact that different treatments exert on patients’ physical, functional, emotional and social well-being. PROs such as patient preferences, using study specific interview schedules, may refine and influence decision-making further, but up until recently few studies have such measures as their primary outcome.

Anti-cancer drugs can now be given orally, parentally, intravenously and subcutaneously and all have clinical and practical advantages and disadvantages; several of these may also have considerable impact upon patients’ QoL including convenience, pain and discomfort. Some treatments demand frequent, lengthy hospital visits, and issues such as out of pocket expenses, disruptions to social, occupational, or family responsibilities are frequently over-looked. If drugs or methods for administering them have similar efficacy, then patient preferences could be important.

Plenary Session 1
Cancer nursing opportunities beyond the bedside
Dr Carrie Tompkins Stricker

Cancer care is undergoing a time of great transformation. As demographic trends (e.g., a rapidly aging population), treatment advances, workforce shortages, and shifts in care delivery and reimbursement models all converge, cancer care delivery systems are struggling to keep up with demand and provide quality care across the cancer continuum. Cancer care is becoming increasingly complex and personalized, and rapidly evolving evidence is inconsistently applied to practice. But with these challenges come even more opportunities, and oncology nurses are well-positioned to envision and lead solutions by innovating both within and beyond traditional nursing roles. This lecture will provide a brief overview of cancer epidemiology, therapeutic, workforce, and care delivery trends that provide context for the rapidly evolving opportunities for oncology nurses. Opportunities beyond traditional clinical roles will be highlighted, illustrated by brief vignettes from interviews with cancer nurses in innovative roles within advanced practice, academia, non-traditional research settings, the corporate enterprise, and telehealth and technology. The speaker will highlight her own professional journey through traditional and non-traditional roles in clinical practice, academia, and most recently as nurse entrepreneur and health technology company executive, sharing experiences and insights on innovating both within and beyond traditional nursing roles so as to maximize both professional impact and personal reward. With growing emphasis on personalized, patient-centered, quality cancer care, there is no better time than now for nurses to own their place at the table in envisioning and enacting change for themselves, their teams, and the patients and families whose care their work can transform!

The changing cancer nursing workforce
Mr Jim McGinty

Jim McGinty will look at the major issues facing Australia’s health workforce.

He will bring the unique perspective of being both a former Health Minister and subsequently, Chair of Health Workforce Australia.

He will look at the political environment, being less than 18 months until the next federal election, with the coalition government not confident of re-election, and ask the question "what should the next Health Minister prioritise for health workforce?"

Nurses must be the central focus of any health workforce policy. The reason for this is quite simple. If we continue as we are, Australia will be facing an unprecedented shortage of nurses and we will not be able to provide the level of care the community expects.

This will impact every area of health care delivery. Nurses will find that they cannot provide the care they were trained to give to their patients.

Mr McGinty will discuss the causes of this impending shortfall and what can be done to alleviate the problem – all in the context that it is impossible for supply and demand for nurses to be in balance in the medium term.

Plenary Session 2
Symptom awareness and help-seeking in rural Australia: Is there a problem and can we change it?
Professor Jon Emery

Internationally a major focus on understanding variations in cancer outcomes has been later presentation to healthcare and later diagnosis. Approaches to reducing time to diagnosis of symptomatic cancer include public symptom awareness campaigns and interventions in primary care to improve early cancer detection.
This plenary will discuss research on symptom appraisal and help-seeking by people with cancer from rural Western Australian. I will describe our initial exploratory research which identified core Australian characteristics of stoicism, optimism and machismo that may contribute to later presentation to healthcare. This research informed the Improving Rural Cancer Outcomes (IRCO) Trial, a factorial trial of community and general practice level interventions aimed at raising community symptom awareness, promoting earlier presentation to healthcare, and early identification and referral of patients with suspected cancer by GPs. The IRCO Trial community intervention was a symptom awareness campaign tailored for rural Australians delivered through a community engagement model by Cancer Council WA rural educators. The GP intervention included a resource card with symptom risk assessment charts and local referral pathways implemented through multiple academic detailing visits and case studies. We recruited 1,351 people recently diagnosed with breast, colorectal, lung or prostate cancer from specific regions of rural WA. I will present preliminary results of the IRCO Trial and the impact of these interventions on time to diagnosis, and discuss implications for future research and policy.

**Strengthening the relationship between acute cancer care and palliative care**

*Professor Patsy Yates*

There is a growing momentum in many western countries to see reform to current models for delivering care for people with cancer. This agenda for reform is driven by many factors, some of which include the inadequate coordination of health services, unacceptable variations in access to quality evidence based care and treatment at all stages of disease, and poor integration of palliative services into the care journey for many people with cancer.

The future of palliative care services for people with cancer has the potential to be substantially influenced by this current agenda for service reform. This influence is likely to affect both the way in which palliative care is practised on a day to day basis, as well as to the systems for providing palliative care. Palliative care practice and delivery systems are likely to be increasingly characterised by more tangible examples of greater accountability for the quality and outcomes of care provided, further blurring of boundaries between knowledge systems and the practices of cancer and palliative care, as well as a continued mainstreaming of supportive care initiatives. These changes have important implications for practice, education, research and policy in cancer care.

**Why patient reported outcomes matter (PROs) when assessing new breast cancer treatments**

*Professor Lesley Fallowfield*

Women’s reactions to breast cancer and its treatment vary enormously; for some the diagnosis itself is a catastrophe, threatening irreparably their physical, functional, social, psychological, sexual and occupational well-being. For others it represents yet one more of life’s hurdles to overcome together with other socio-educational and financial iniquities they face.

However during the past 3 decades we have seen much greater attention paid to optimal delivery of cancer care. Most patients now have access to specialist nurses, counsellors, support groups or services provided by breast cancer charities which can alleviate some of the psychosocial trauma. Importantly some extraordinary advances have also been made in breast cancer treatment meaning that many more women now have greater prospects of cure or lengthier, good quality survival. These advances include: - improved diagnostic and staging procedures, sophisticated onco-plastic surgery and reconstruction, enhanced less-damaging radiotherapy techniques and more targeted systemic therapies. However we still require more patient-centred assessments of these improvements to establish whether or not they have led to comparable, measurable changes in patients’ psychosocial, physical, functional and sexual well-being. Determining the impact that the non-life threatening, iatrogenic harms of otherwise efficacious anti-cancer treatments has on overall well-being, is too often over-looked. There is a concentration on clinician reported safety data in clinical trials rather than PROs. Systematic monitoring of side-effects via PRO measures would encourage more research into ameliorative interventions and permit early implementation of any found to be effective.

PROs are not only quality of life questionnaires or symptom checklists; they also include semi-structured interview schedules and evaluation of patients’ preferences. In this talk I will outline some of these PROs and show recent examples of their importance for women with breast cancer.

**Concurrent Session 1 – Advanced Practice**

**Infusion related reactions: Differentiating and managing hypersensitivities, anaphylaxis and tumour lysis**

*Michael Cain*

Infusion related reactions (IRR) associated with contemporary anticancer drugs are frequent, and present significant challenges in patient management and the daily operations and resource utilisation of cancer treatment centres. Though most IRR are mild or moderate, with a lesser number potentially life threatening. All are disruptive, complicating treatment delivery, adding substantially to toxicity burden, and potentially precipitating treatment change. Given the generally unpredictable nature of
these reactions preparedness within treatment centres is paramount. The pathophysiology behind IRR is complex and remains incompletely characterised. As a generalisation reactions may categorised as; a “learnt” response mediated by IgE (and possibly IgG); a direct triggering of complement in susceptible individuals; as a consequence of cytokine release triggered by the biological activity of particular monoclonal antibodies. The natural history of these reactions differs with practical implications for how IRR are managed and the implications for ongoing therapy.

Corticosteroids: The highs and the lows
Julie Wilkes

Corticosteroids form the backbone of many haematological chemotherapy regimens, symptom management algorithms and oncological emergency management plans. They can be given in high doses, low doses, for prolonged periods or in short bursts. Swallowed, inhaled, instilled, inserted and injected, they are truly the most versatile of medications in our armamentaria.

But how well do we understand the highs and lows of using corticosteroids?

This presentation will focus on the:
• clinical use;
 • mode of action;
 • comparison of corticosteroids;
 • adverse effects; and
 • clinical strategies to detect and minimise the adverse effects of corticosteroids.

Concurrent Session 2 – Rural and Remote

Antineoplastic drug administration competency for rural cancer nurses: Expanding the possibilities
Christine Henneker¹, Lucy Patton², Catherine Seddon³, Peggy Briggs³
1. Western Australian Country Health Service, Goldfields, Kalgoorlie, WA, Australia
2. Centre for Nursing Excellence, Sir Charles Gairdner Hospital, Perth, WA, Australia
3. Western Australian Country Health Service, Head Office, Perth, WA, Australia

Introduction
Professional development of the rural cancer nursing workforce is required to: enable clinical service planning, provide best care for patients, promote patient and staff safety and ensure chemotherapy competency in rural Western Australia (WA). A standardised, evidence based online course for nurses administering chemotherapy in hospitals was piloted to underpin chemotherapy competency for rural nurses.

Objectives/Aims
To develop the skills, knowledge and attributes of nurses in rural chemotherapy units across WA by:

• enabling access to the EviQ Antineoplastic Drug Administration Course (ADAC)
• training facilitators
• promoting a state-wide approach to professional development in cancer nursing

Description/Methodology
Each WA region with a chemotherapy unit nominated two nurses to participate in the pilot program. Evaluation was conducted using level one to three of Kirkpatrick’s learning evaluation model. Participant satisfaction, knowledge and behavioural change were measured.

Results/Outcomes
Seven Registered Nurses enrolled, six attended the workshop, five completed the online modules and obtained a 100% pass. All participants agreed or strongly agreed the workshop was well prepared and applicable to practice. Four participants completed the behavioural change survey and agreed or strongly agreed knowledge, behaviour and leadership skills had changed. WA Country Health Service endorsed the ADAC as a service wide approach to underpin chemotherapy competency and have released the course for all nurses.

Conclusions
Standardisation of education and assessment of competency of nurses administering chemotherapy using EviQ ADAC is an effective method to underpin chemotherapy competency. Additional measurement of clinical practice would add to the knowledge of rural chemotherapy competency.
**Abstracts Monday 15 June**

**Description/Methodology**
The role was developed using the position description for the regional CSCs and in consultation with the WA Cancer and Palliative Care Network and the CCWA Manager, Accommodation. Because of the large volume of guests, the CSC assessed new clients using priority criteria in a face-to-face interview aided by an assessment and referral form and the NCCN Distress Thermometer and Problem List.

**Results/Outcomes**
Key responsibilities of the new CSC role include: (i) client management which involves screening and assessment of clients and referral to support services and (ii) Liaison with key stakeholders in delivering psychosocial support. Since September 2014, the CSC has assessed and supported 265 clients, has distress screened 62% of new clients, and has provided 359 occasions of service.

**Conclusions**
A new CSC role developed for a cancer nurse provides screening, assessment and psychosocial support for a substantial proportion of priority regional clients staying at CCWA Perth accommodation facilities.

**Improving patient experience across multiple sites and disciplines**

*Rose Cook*, *Eve Eynon*, *Carmen Churruca*

1. Ambulatory Oncology, Townsville Cancer Centre, Douglas, Queensland, Australia

**Introduction**
Geographical remoteness and associated travel for cancer patients to obtain comprehensive cancer care presents an array of issues. Not least is perceived need of health practitioners at each site wanting to undertake their own assessment using their facilities tool. In North Queensland we addressed this issue by developing an assessment tool in partnership between three cancer centres.

**Objectives/Aims**
Our initial aim was to develop a comprehensive tool for patients accessing the Townsville Cancer Centre. Early in its development though it became evident that a tool used within and across our related centres could improve quality and relevance of communication between cancer centres, ultimately improving the patient experience across all sites.

**Description/Methodology**
The development of an electronic assessment tool in partnership between Townsville, Cairns and Mackay, enabling the sharing of relevant clinical information using set criteria uniformly understood by all. This has enhanced the care and experience of patients at each of the sites. In addition to this we have developed easily accessible data for the analysis of the patient experience and quality of care outcomes.

**Results/Outcomes**
The tool is based on the CTCAE, but inclusive of other relevant information to the oncology day unit team, including an outline suitable interventions relevant to each assessment point. The benefits of having a current and comprehensive understanding of the patients care and experience throughout their cancer journey cannot be underestimated.

**Conclusions**
Through partnership North Queensland has improved patient care delivery across multiple disciplines and sites using a common assessment tool.

**Doing what I need to do: A qualitative research study of experiences of colorectal cancer in rural NSW**

*Rachel Pitt*

1. Manning Hospital, Oxley Island, NSW, Australia

**Introduction**
It is known that colorectal cancer is a leading burden of disease in Australia and that rural people with cancer have poorer outcomes.

**Objectives/Aims**
Little is currently known about rural people in NSW undergoing surgery for colorectal cancer. The study aimed to understand this experience, to inform and shape future practice.

**Description/Methodology**
Interpretive description was used to guide the study. Semi-structured interviews were conducted with nine rural people in NSW. Thematic analysis was used to develop the themes arising from the data.

**Results/Outcomes**
Control was the overarching theme with trust, interconnectedness, embodiment and transformation the sub themes. The participants lost control over their normal lives at diagnosis. They placed their trust in the doctors and largely did as advised, feeling that this was the right thing to do. Trust was diminished when recovery was different to expectations. Family support was important. The level of informational and emotional support required varied. Some had recovered fully, but others were left with significant changes as a result of surgery, including bowel disturbance, fatigue, pain and depression.

**Conclusions**
Not all people having surgery for colorectal cancer in rural NSW have their emotional, informational and physical needs met. To redress this inequity and provide the support needed for them to maintain control of their lives, it is essential to develop effective systems to identify needs early and as they arise, and ensure they have an understanding of their expected recovery, changes that may occur and their own plan of follow up care.
Professional challenges and support mechanisms for Breast Care Nurses in rural and regional Queensland.

Pammie Ellem¹
1. Central Queensland University, Bundaberg, QLD, Australia

Introduction
Breast Cancer Nurses (BCNs) are well recognised for their role in the treatment of women experiencing breast cancer. However little research has been undertaken to contribute to the support of the BCNs who often work in professional and geographical isolation. This research will contribute to the professional support of BCNs beyond further education.

Objectives/Aims
The objective of this study is to reduce the isolation of practice and increase professional support for BCNs across Australia. It is proposed that a model of support be developed that could then be transferrable to other isolated nursing modalities.

Description/Methodology
Eleven BCNs voluntarily agreed to participate in this research project which is based on Participatory Action Research methodology. The first action cycle has been conducted which consisted of a collection of minutes from monthly BCN meetings, individual BCN reflections and a series of one to one interviews with the nominated BCNs. The data has been thematically analysed and will be presented at conference.

Results/Outcomes
The data from the first cycle has indicated that the BCNs participating in the study are comfortable with the monthly meeting process and they value regular contact with their peers in the same field.

Conclusions
Taking the data analysis into consideration, the second action cycle will now be undertaken to further refine the support system for BCNs that is currently being utilised by the research cohort of 11 BCNs.

Reducing the impact on rural breast cancer patients by improving the knowledge, confidence and competence of community nurses

Michelle T Hamblin¹
1. Colac Area Health, Colac, VIC, Australia

Introduction
Colac is a rural town in South West Victoria. Breast surgery is carried out at major hospitals in the region and local patients were either staying in hospital longer or returning to the hospital to have their drain tubes removed as there was minimal community nursing support available.

Objectives/Aims
The aim of this quality improvement project was to reduce the impact on rural breast cancer patients by developing a combined education program for community nurses to increase their knowledge of breast cancer and competency in axillary drain tube care.

Description/Methodology
A combined online/ practical education package was developed by the McGrath Breast Care Nurse. The online component included basic anatomy and physiology, breast surgery and axillary drain tube removal. This was followed by an online questionnaire and supervised competency by the BCN to ensure that nurses were skilled effectively and felt competent to perform the procedure.

An evaluation measuring knowledge and perceived competence using Likert scale was distributed by Survey Monkey.

Results/Outcomes
16 community nurses were approached with 80% completing the package.
100% of respondents demonstrated increased knowledge in breast cancer, types of surgery and increased perceived confidence with removal of axillary drains tubes. Competence was assessed at completion of package by the BCN with a 100% success rate.

Conclusions
Early discharge of patients in Colac following breast surgery is now able to be implemented with improved knowledge, confidence and competence of community nurses following the completion of the combined package.

Concurrent Session 3: Breast Cancer Update

Air expander reconstruction

Mr Tony Connell

The use of tissue expansion in breast reconstruction has been undertaken for the past forty years. The sequential expansion of a saline device in a submuscular space to enlarge the space sufficient to place a permanent prosthesis has been one of the most common forms of breast reconstruction. The use of saline expanders which require sequential injections by the Surgeon in their office has proven to be painful, time consuming and difficult for patients who have to travel on a weekly basis to see their Surgeon.

In 2007 the patient controlled AirXpander device was developed and underwent the initial three trials in Perth and last month the randomised Xpand Trial in the United States was completed. The patient controlled AirXpander device allows the patient to tissue expand themselves at their own level of comfort whilst at home at a rate three times faster
than was previously permitted when using the standard saline device.

It has now been used in more than 450 breast reconstruction patients worldwide and it is about to be released to the Australian market in May and into the US market later in 2015. The patient-controlled tissue expansion technology will have applications in both paediatric and lower limb tissue expansion which currently is a painful and traumatic experience for these patients.

**Nursing implications with the use of air expanders**

*Miss Melissa Hegarty*

Nursing implications with the use of air expanders will cover the immediate postoperative care following reconstruction, follow up nursing care, the ease of use of expansion and the process leading up to exchange of expanders to implants.

**Managing breast oedema**

*Mrs Catherine Hunt*

Breast oedema is a potential side effect of breast conserving surgery. It is described as a side effect of breast cancer treatment with increasing frequency in recent years. Literature reports an incidence of up to 70% after Axillary Clearance surgery, and 28% after Sentinel Node Biopsy associated with breast cancer surgery and radiotherapy. Despite this, women are often not educated regarding the risk of breast oedema or the problems that it can cause for them.

The breast swelling can be painful and this discomfort can impede activity and disrupt sleep. The effect of visibly asymmetrical breasts is cosmetically displeasing, and a neat fit of clothing can be problematic.

Breast oedema is associated with increased risk of breast cellulitis.

The combined effect of the above, can impact on social activities and reduce quality of life. There is a significant health cost to treat oedema-related cellulitis, and the condition can be slow to improve.

Patients with symptomatic breast oedema benefit from conservative treatment and management strategies to reduce oedema, increase vascular circulation and improve comfort.

This presentation will review some of the evidence regarding incidence and treatment of breast oedema. A case study of a woman who had breast cancer surgery including Radiation Therapy, then experienced chronic breast oedema and recurrent cellulitis will be presented. Strategies that have been found helpful in managing the oedema will be discussed.

**Managing Neuropathy following surgery for breast cancer**

*Professor Eric Visser*

Chronic pain following breast cancer surgery is an under-recognised problem, affecting 20-50% of patients, with 5-10% reporting severe life-impacting pain. Causes include ‘neuropathic pain’ (nerve damage due to surgery or chemoradiotherapy (CRT)), phantom pain (5-10%), arm pain (eg lymphoedema, CRPS), also neck and shoulder pain (eg ‘frozen shoulder’). Intercostobrachial nerve injury (axilla) and scar neuromas are often-missed causes of pain. Occasionally, pain may is due to local or metastatic cancer recurrence (bone pain).

Risk factors for chronic pain after breast cancer surgery include; younger age; increased BMI; extensive surgery (mastectomy, axillary clearance, reconstruction); CRT; severe acute postoperative pain; perioperative anxiety and ‘catastrophizing’ (‘a doomsday state of mind’) —in other words, chronic pain is more frequent in very anxious young women who’ve had extensive surgery and CRT.

Managing chronic pain after breast cancer surgery requires a whole-person, biopsychosocial approach. Strategies include; prevention of breast cancer and the need for extensive surgery/CRT; excluding ‘red flags’ (cancer recurrence, treatment complications); screening and monitoring high-risk patients; pain education; minimally invasive surgery (avoiding nerve injury); effective acute pain management; ‘preventive analgesia techniques’, using multimodal analgesia (tramadol, tapentadol, pregabalin, NSRI antidepressants), nerve blocks (paravertebral) and topical anaesthesia (EMLA™ cream), which reduce nervous system pain sensitization or ‘wind up’. Cortical retraining techniques such as mirror therapy may be used to treat phantom breast pain. Last but not least, management of anxiety and depression, and the provision of social and spiritual support are very important.

**Concurrent Session 4: Education and Research**

**Chemotherapy Credentialing: The way forward.**

*Catherine Barratt¹, Rachel Jenkin¹, Violet Platt¹*

¹. WA Cancer & Palliative Care Network, Nedlands, WA, Australia

**Introduction**

Credentialing nurses involved in chemotherapy administration is a key initiative of the WA Health Cancer Services Framework 2005 to promote equitable access to safe, evidence-based practice.

**Objectives/Aims**

Credentialing of nurses administering cancer chemotherapy supports the aim of the WA Cancer Plan 2012-2017 to:

- Increase the number of patients receiving chemotherapy closer to home.
• Establish safety and quality in chemotherapy administration as a priority over convenience.
• Determine a minimum standard for chemotherapy education and competency assessment irrespective of the clinical setting.
• Reduce variation in practice ensuring clinicians with experience and expertise deliver chemotherapy.

Description/Methodology
The WA Cancer and Palliative Care Network convened the Chemotherapy Credentialing Governance and Steering Committee in June 2010. Stakeholders from a broad sector of health and consumers were represented. Terms of Reference were addressed and recommendations developed to support safer chemotherapy delivery.

Results/Outcomes
The development of the WA Cancer Chemotherapy Credentialing Framework 2011 determines:
• Standards of practice in chemotherapy delivery.
• Requirements for state wide education programs and continuous professional development.
• Chemotherapy competency assessment and pathways for credentialing the workforce.
• Scope of practice.

Also addressed is the impact of challenges faced with implementation of the Cancer Chemotherapy Credentialing Framework.

Implementation is underway with further consultation of key stakeholders planned to address additional detail and challenges presented in this process.

Conclusions
Chemotherapy credentialing will ensure nurses delivering cancer chemotherapy care develop and maintain the knowledge, clinical skills and practice behaviour critical to delivering safe, high quality, evidence based care to patients.

Nurses as trainers: delivering training, knowledge and skills to cancer support group leaders

Sally Carveth¹, Kim Pearce², Angela Pearce²
1. Cancer Council NSW, Sydney, NSW, Australia
2. Cancer Council NSW, Waverton, NSW, Australia

Introduction
Cancer Council NSW is uniquely placed to support and educate community and health professional Cancer Support Group Leaders (CSGLs) through development and delivery of evidence-based training

Objectives/Aims
Training for peer support group leaders aimed to increase confidence, knowledge, and acquisition of skills across a range of topics: Training is delivered by the program coordinators who have an oncology nursing background.

Description/Methodology
Four one day training sessions were delivered from June-October 2014 with 65 leaders attending. At the conclusion of training a survey 6-point Likert scale survey was used to conduct a retrospective post-then-pre evaluation.

Results/Outcomes
Statistically significant gains were recorded in each of the assessed outcomes. GPA: confidence developing a group agreement/purpose $[MT_1 = 1.95; MT_2 = 3.68, t(18) = 9.40, p = .000]$; and use of GPA to benefit the group $[MT_1 = 1.63; MT_2 = 3.79, t(18) = 13.67, p = .000]$. Skill acquisition was evident across the following: welcoming new members (WNM) $[MT_1 = 2.79; MT_2 = 3.63, t(18) = 4.80, p = .000]$; managing challenging behaviours (MCB) $[MT_1 = 1.94; MT_2 = 3.22, t(17) = 6.56, p = .000]$. Attendees gained a greater understanding of self-care practices $[MT_1 = 3.11; MT_2 = 3.83, t(17) = 3.20, p = .005]$.

Conclusions
Delivery of this evidence-based training had a significant impact on CSGLs who gained knowledge and skills in leading a cancer support group. Training such as this provides best practice principles for leaders and has flow-on benefits for support group members and health professionals who refer to the support groups.

Community and Cancer Care RN Rotation Project

Louise Maher¹, Linda Ora¹
1. Nepean Blue Mountains LHD, Penrith, NSW, Australia

Introduction
The Community and Cancer Care Rotation Project (CCCRP) was a result of recognising the Registered Nurse (RN) working in either an outpatient chemotherapy unit, a 24 bed inpatient Haematology Oncology ward and a community based RN working in the home setting requires ‘like’ knowledge, language and skills focusing on the continuity of care of a patient who transitions between these various cancer care settings.

Objectives/Aims
The CCCRP aim to promote professional development, educate and invigorate RNs using experiential learning and critical reflection into their own practice. To enhance their cancer care knowledge and clinical skills in a 2 week supernumerary clinical placement outside their ‘clinical comfort zone’.

Description/Methodology
RN were provided with evidenced-based resources whilst several written activities including pre and post-rotation surveys, a case study, a reflective workbook and a networking log were electronically submitted within one week of completing their 2 week rotation.
Results/Outcomes
RNs self-directed their learning experiences focusing on understanding the treatment trajectory, the patient journey, the patient's symptom experience and the fluidity of decision-making across clinical settings whilst transitioning of complex patients and their care needs between different service delivery models was recognised resulting in increased awareness of ‘like’ challenges faced by RNs.

Conclusions
Recognition of these ‘like’ challenges associated with the complex care of patients regardless of the care setting has generated various service delivery reviews with the focus on the flow of meaningful, current information as well as building respectful awareness and appreciation of the ‘other’ RNs roles involved in the patient's care.

Progression of the enrolled nurse in an oncology day unit
Corrie Miles1
1. The Townsville Hospital, Annandale, QLD, Australia

Introduction
An appropriate skill mix within the cancer workforce is essential to provide effective, high quality care to cancer patients and their families. A quality improvement activity was undertaken to identify how the skills and experiences of Enrolled Nurses (ENs) could be better utilised to improve patient care, and team cohesiveness within a busy oncology day unit.

Objectives/Aims
To identify the barriers and enablers for expanded opportunities for ENs to actively contribute to improved patient care and effective team work within the oncology day unit.

Description/Methodology
Twenty three nurses working in the ambulatory setting of a tertiary oncology day unit completed an anonymous, paper-based survey. Of these, twenty were Registered Nurses and three Enrolled Nurses. Areas explored in the survey included: strengths and weaknesses ENs bring to the unit and barriers and enablers for expanded opportunities for practice. Open ended responses were analysed thematically

Results/Outcomes
Thematic analysis identified five major themes: (i) team work, (ii) general nursing care, (iii) scope of practice, (iv) staff attitudes and (v) educational opportunities. Results clearly identified wide support for expansion of the EN role; however, a number of barriers to this expansion were also documented.

Conclusions
Based on the results, a new model of care is currently being developed in consultation with the Nurse Unit Manager and Clinical Nurse Consultant to prioritise competencies for development for the EN in the oncology day unit

Developing research capacity to achieve clinical excellence: The Cancer Nursing Professorial Precinct Initiative
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1. Metro North Hospital & Health Service, Herson, Queensland, Australia
2. School of Nursing & Institute of Health and Biomedical innovation, Queensland University of Technology, Brisbane, Queensland, Australia

Introduction
This increasing demand of cancer care has presented a challenge for nursing services to provide innovative, evidence-based and cost-effective care. Cancer nurse leaders have the responsibility to build capacity for research and practice development at all levels, in order to overcome this challenge.

Objectives/Aims
To build capacity to enable research excellence in cancer nursing at a service level

Description/Methodology
The Cancer Nursing Professorial Precinct, a strategic collaboration between cancer nurses at the Royal Brisbane and Women’s Hospital and Queensland University of Technology, was established in 2013. The Precinct aimed to enable (i) an open channel for collaboration and communication between the managers, clinicians and academics, (ii) regular on-site research consultation clinics with cancer nurse researchers, and (iii) effective strategies for the dissemination and uptake of latest knowledge generated by the Precinct. The Precinct is guided by eight principles, which are essential for ensuring all initiatives within the Precinct are truly consumer-centred, and enhancing cost-effective clinical practice.

Results/Outcomes
During 2013-2014, outcomes of the Precinct included: (i) over 3 million AUD of research competitive funding, (ii) 17 peer-reviewed articles in cancer care journals, (iii) over 20 research-focussed conference presentations, (iv) six staff enrolling into a research higher degree (three for PhD and two for Masters), and (v) a positive change in culture with stronger commitment to innovation and evidence-based care.

Conclusions
The Cancer Nursing Professorial Precinct is a feasible and effective means to build research capacity, which leads to optimising patient outcomes. Appropriate guiding principles and infrastructure were essential to the success of this initiative.
Patient access to high cost, non-PBS listed drugs

Kathy Wells1
1. Breast Cancer Network Australia, Camberwell, VIC, Australia

Introduction
Breast Cancer Network Australia is the peak national consumer organisation supporting Australians affected by breast cancer. Advocacy for better treatment and care of women diagnosed with breast cancer is a key aspect of BCNA's work.

Objectives/Aims
BCNA often hears from women living with secondary (metastatic) breast cancer about difficulties in accessing new expensive drugs not listed under the Pharmaceutical Benefits Scheme (PBS).

Results/Outcomes
In a 2014 BCNA survey of 582 people with secondary breast cancer, 25% (133) reported 'quite a bit' or 'very much' financial difficulty in the previous week. Non-PBS drugs accounted for the highest out-of-pocket costs.

Conclusions
BCNA will outline the processes for new drugs to be listed on the PBS and options for accessing non-PBS drugs. PBS listing can take several years from the time new drugs are approved for use in Australia by the Therapeutic Goods Administration. In this interim period, women may be required to pay exorbitant amounts to access the drugs. For women who cannot afford this, there is the distressing knowledge that there is a treatment that may help them but they cannot afford. Some pharmaceutical companies offer patient access programs prior to PBS-listing, under which the company subsidises the drugs for eligible patients. Nurses can play an important role in educating patients about such schemes. BCNA will continue to advocate for improved and equitable access to cancer drugs for Australian women with breast cancer, and work with oncology health professionals to ensure patients feel supported where access is not possible.

Concurrent Session 5: Cancer Nursing Education – Where do I start?

Facilitated by Kylie Ash

This interactive workshop will provide practical information on educational options for cancer nurses in Australia. A panel of education experts will highlight the range of pathways for extending the cancer nurse role. Attendees are encouraged to submit comments and questions for the panel members who will offer hints and tips for successful professional development.

Concurrent Session 6: AYA
Sub Specialisation in Cancer Nursing: Youth Cancer Specialist Nurse Role Contribution and Collaboration

Janine McDonald1, C O'Dwyer2, L Moore3, M Jones4, Kate White5
1. National Service Development Manager, Youth Cancer Services, Youth Cancer Services / CanTeen, Sydney, NSW, Australia
2. Sydney Youth Cancer Service, Youth Cancer Servcies / CanTeen, Sydney, NSW, Australia
3. Hunter & Northern NSW Youth Cancer Service, Youth Cancer Services / CanTeen, NewCastle, NSW, Australia
4. SA/NT Youth Cancer Service, Youth Cancer Services / CanTeen, Adelaide, SA/NT, Australia
5. Cancer Nursing Research Unit, SLHD? University of Sydney, Sydney, NSW, Australia

Introduction
The Youth Cancer Services Program was established in 2009 after funding from Commonwealth Department of Health, bringing together a national AYA program that had beginnings in Victoria, WA & SA. The Youth Cancer Services program aims to address the needs of this vulnerable age group (15-25yrs), with a focus on improving treatment and survival, and addressing the physical and supportive care needs of this age group. The Youth Cancer Services cross both adult and paediatric settings. Central to the program are Youth Cancer Nurse positions (YCN) who provide day to day care, support, navigation and triage to the young person and their family. These positions require collaboration across health sectors, disciplines and within cancer. Education preparation and ongoing professional development is a critical aspect.

Objectives/Aims
The aim of this presentation is three-fold: to provide an overview of the Youth Cancer Service Program, present the findings from a brief survey of YCNs' perception of education preparation and professional development needs; describe the facilitators and barriers to establishing cross service positions within a national program.

Description
Drawing on the YCN as a model, this paper will explore the evolving sub-speciality practice within cancer nursing, contemporary drivers for subspecialisation, associated challenges and benefits. The critical need for cancer nurses from all sub specialities to be able to collaborate on development of a shared evidence base for cancer nursing practice, how to achieve this, remains a challenge that cannot be ignored. The authors will describe opportunities for working towards this goal.
Piloting an Individual Psychosocial Support Model for young people impacted by cancer

**Pandora Patterson1, Fiona E.J. McDonald1, Elizabeth Kelly-Dalgety1, Liz L King1**
1. CanTeen, Sydney, NSW, Australia

**Introduction**
Every year around 23,000 young people are confronted with a cancer diagnosis; their own or that of a parent, brother or sister. These young people are at a significantly heightened risk of developing serious and sustained mental health difficulties.

**Objectives/Aims**
The identification of psychosocial issues followed by targeted intervention can positively impact young people’s lifestyles and behaviours. To address this, CanTeen (the Australian organisation for young people living with cancer) developed and implemented an Individual Support Model.

**Description/Methodology**
The Model involves individual psychosocial assessment of wellbeing and needs related to young peoples’ cancer experience. Working with CanTeen staff, young people develop an individual plan, set goals and identify strengths, to assist them in meeting their identified needs. This is followed by periodic progress assessments and individual plan reviews.

**Results/Outcomes**
Piloting of CanTeen’s Individual Support Model has recently been completed. Results of the pilot which focus on the implementation process will be presented, along with the initial development of the Model. Wellbeing and needs baseline and review data will also be discussed.

**Conclusions**
It is intended that the introduction of this Model will enable CanTeen to provide more targeted psychosocial support to young people consistent with their individual cancer journeys. The desired outcome is the optimal care and wellbeing for young people living with cancer. The information collected will also enhance CanTeen’s ability to provide responsive evidence-based support in line with young people’s needs.

**Process evaluation of the Young People Living with Cancer (YPLWC) E-mental Health Service**

**Meg Achilles1, Erin Griffiths, Mel Miller1, Pandora Patterson2, Liz King2**
1. Siggins Miller Consultants, Brisbane, Qld, Australia
2. CanTeen, Sydney, NSW, Australia

**Introduction**
YPLWC are at a significantly heightened risk of developing serious and sustained mental health difficulties. Internet related technology provides unprecedented opportunities to deliver online information, peer support, and mental health services for YPLWC. To address this, CanTeen developed the YPLWC E-Mental Health Service.

**Objectives/Aims**
The purpose of the YPLWC E-Mental Health Service is to meet the unique psychosocial needs of YPLWC (aged 12-24 years) in Australia. The Service provides daily extended-hours access to professional counsellors and 24/7 access to youth-specific information and an online peer-to-peer community. This paper will report on the process evaluation conducted of the E-Mental Health Service.

**Description/Methodology**
An evaluation framework and program logic guided this process evaluation. The process evaluation reviewed the reach, recruitment, implementation, and fidelity of the program components with a focus on the complex technical components of the service development. Strong governance supported by iterative project management processes guided Service development.

**Results/Outcomes**
The process evaluation reviewed the reach, recruitment, implementation, and program fidelity. Qualitative research identified the enablers and barriers to Service implementation and areas of focus for future refinement.

**Conclusions**
The Service was implemented as intended with well designed clinical content and technical online features developed.
Description/Methodology
Semi-structured interviews with YPLWC, their friends, health and education professionals, were conducted.

Results/Outcomes
Participants valued the accurate account of YPLWC’s experiences and examples of effective support. Issues with passing the resource to friends were highlighted as were strategies to address this, including the role of health and educational professionals as key facilitators in supporting friends’ access to the resource.

Conclusions
The *Wait…“Did you Say Cancer?!?”* resource is effective in providing information for friends of YPLWC to better understand and support them throughout their cancer journey. By helping to promote the resource nurses can play a key role in reducing the information gap for friends of YPLWC and paving the way for improved support to YPLWC.

Development of a simple adherence assessment tool for clinical use for anti-infective prophylaxis in adolescent and young adults with a haematological malignancy.

*Peter Haywood*  
1. Youth Cancer Service (VIC/TAS), Melbourne  
2. Royal Melbourne Hospital, Melbourne

Introduction
Anti-infective prophylaxis is routine in patients treated with high dose chemotherapy or bone marrow transplantation for haematological malignancies. It has been shown to significantly reduce the incidence of life-threatening infections. There are often periods where patients will self-administer anti-infective prophylaxis at home, and adherence is often presumed and not assessed.

Adolescent and young adults (AYA) with cancer are regarded as a vulnerable group within the cancer population. Of particular concern is that adherence to treatment in AYA cancer patients may be lower when compared with both younger and older cancer patients. Existing formal adherence assessments are often academic in nature, or are aimed at chronic conditions and impractical in this patient population.

Objectives/Aims
To develop an assessment tool for use by clinical nurses to promote adherence in AYA patients requiring anti-infective prophylaxis treatment.

Description/Methodology
A literature review identified three areas for potential assessment; simple self-report of adherence using Likert-style scales, open-ended questions that ask the patient to reflect on how they adhere to treatment and an assessment of family assistance in adherence.

Results/Outcomes
A six question tool was developed; two open ended questions to invite discussion and thought of how the patient may increase adherence, two auditable scale questions assessing current adherence, and two questions assessing family/social support in adherence.

Conclusions
In lieu of any alternative or validated assessment tools, this series of semi-structured questions may be a useful in clinical practice where nurses care for AYA cancer patients at high risk of infection.

Nurses and midwives: at the front-line of cervical cancer prevention

*Natalie Williams*  
1. King Edward Memorial Hospital, Women & Newborn Health Service, Subiaco, WA, Australia  
2. WA Cervical Cancer Prevention Program, Women & Newborn Health Service, Perth, WA, Australia

Introduction
The Pap smear is a screening tool, key in preventing cervical cancer; however in 2009-2010 only 57% of eligible Australian women participated in cervical screening (AIHW, 2012). Nurses and midwives at King Edward Memorial Hospital (KEMH) are well placed to provide cervical screening to women attending maternity and gynaecological care. Training to become a credentialed Pap Smear Provider (PSP) was previously not available at the hospital, having been limited to external education providers.

Objectives/Aims
This initiative aimed to provide a training program to assist nurses and midwives to become credentialed PSPs and thereby improve women’s access to cervical screening.

Description/Methodology
The Department of Nursing and Midwifery Education and Research, KEMH, designed and facilitated a PSP course in 2013 and 2014, with the support of nursing, midwifery and medical colleagues. The course comprised of online self-directed learning, an eight hour face-to-face workshop and a clinical component.

Results/Outcomes
Of the 15 nurses and midwives enrolled to date, ten completed all required learning components, with the remaining five (33%) completing their clinical requirements. The course resulted in five (33%) becoming credentialed PSPs and four (27%) being ready to submit their application. One (7%) has ceased to work in the clinical setting.

Conclusion
The success of the KEMH PSP course resulted in an increased number of available credentialed practitioners in this tertiary setting and offers an example for other health services to similarly improve access to cervical screening. An expansion of this course to include nurses and midwives throughout Western Australia is now being explored.
**Plenary Session 3**

**Personalised medicine, an unravelling era of treatment**

**Dr Nik Zeps**

In the last 2 decades since the sequencing of the human genome there has been a huge leap forward in our biological understanding of cancer. We can now sequence tumour genes in a matter of days and with a large pipeline of treatments specifically developed to target pathways that are altered in cancers we are closer to personalized approaches to treatment than ever before. In this presentation the current state of play will be reviewed and both the triumphs and the challenges will be presented. For all their promise Targeted therapies still remain just one part of the management of cancer and their utility will be discussed in the context of global cancer care.

**Abstracts Monday 15 June**

**Genetics and the changing world of cancer care**

**Professor Christobel Saunders**

Although gene alterations underlie the development of all cancers, this paper will concentrate on inherited gene mutations which predispose to cancer. We will look at how we can identify gene carriers both in the unaffected population and in a patient when they present with a cancer. Prevention and surveillance strategies in high risk patients – especially those at high risk of breast and ovarian cancer, will be explored, and guidelines on advice to those at risk outlined. We will then discuss how a patient with cancer and a known genetic predisposing mutation may have altered treatment pathways and how this affects both therapies used and cancer outcomes.

**Abstracts Tuesday 16 June**

**Breakfast Session 3**

**A key to redefining the management of patients with advanced melanoma**

**Supported by:**

**Panel**

**Julie Teraci** – Chair and facilitator

Julie Teraci has held the position of Clinical Nurse Consultant / Coordinator for WAMAS at St John of God Hospital Subiaco since 2004. She graduated from Sir Charles Gairdner Hospital in 1982 and prior to her appointment at WAMAS primarily worked in the area of general medicine and oncology. In 2007, in addition to her role with WAMAS, she commenced working as the Skin Cancer and Melanoma Cancer Nurse Coordinator for the WA Cancer and Palliative Care Network, linking services and working closely with other health professionals to facilitate a smoother pathway for patients to navigate the health care system in WA. Julie is involved with and is a current board member of melanoma WA.

**Dr Matteo Carlino** – Speaker: The evolving role of immunotherapy in advanced melanoma

Matt Carlino is a Medical Oncologist at Westmead and Blacktown Hospitals. He has recently completed his PhD examining melanoma predictors of response and mechanisms of resistance. He continues to be involved in the translational research program based at the Melanoma Institute Australia and the Westmead Institute for Cancer Research. He is an investigator on multiple phase I,II and III clinical trials in melanoma targeted and immunotherapy.

**Donna Milne R.N., PhD** – Speaker: Practical insights into the role of the nurse in optimising immunotherapy

Donna Milne is a registered nurse and has a dual role at Peter MacCallum Cancer Centre in Melbourne. She is an advanced practice nurse with the skin and melanoma service and a clinician researcher in the Department of Cancer Experiences Research. Donna's PhD investigated the perceptions of palliative care services held by people with advanced cancer. Her other research interests include understanding the needs of patients with melanoma and measuring care complexity. Donna is on the Executive of the Australian and New Zealand Melanoma Trials Group, and is an active member of the Cancer Nurses Society of Australia, Clinical Oncology Society of Australia, Psycho-Oncology Co-operative Research Group and the International Society of Nurses in Cancer Care.

**Description**

Join us for an interactive and practical session where a panel of experts will share their specialised experience focused on the management of patients with advanced melanoma. With cancer nurses on the panel and plenty of time for Q&A, this session will provide an opportunity to enhance your skills - all in an environment conducive to optimal learning.
Objectives of the session

• To understand the role of immunotherapy in advanced melanoma, and to discuss this in relation to chemotherapy
• To share learnings from both doctor and nurse perspectives on the practical management of Keytruda (pembrolizumab) in advanced melanoma patients

Breakfast Session 4
Addressing the patient adherence challenges of new oncology treatments

Supported by:

Presenters
Dr Rohit Joshi
Medical Oncologist at Lyell McEwin Hospital & Calvary Central Districts Hospital, South Australia
Vicki McLeod
Nurse Practitioner at Monash Health, Victoria
Richard Grainger
Pharmacist at SJOG Murdoch, Western Australia

Description
Advances in cancer therapy have brought about numerous changes, both to the treatments available, as well as to the way that drugs are administered. Adherence to treatment remains an important factor for patient outcomes – taking the medication as prescribed as well as staying on treatment over the course of the treatment cycle.

This talk will provide a Multidisciplinary approach to addressing some of the common adherence challenges that patients and Health Care Professionals face. A Medical Oncologist, Nurse Practitioner, and Pharmacist will highlight techniques and interventions used to improve medication adherence rates in Australian practice.

Concurrent Session 7: Radiation Oncology Nursing
Best practice guidelines for caring for patients undergoing radiotherapy

Professor Alex Molasiotis

This session aims to stimulate a debate about the pros and cons of advanced nursing practice and extended roles in oncology. It will discuss how nurses’ titles, roles and responsibilities are changing and what the key aspects of advanced practice. Results will be presented from a survey of senior UK oncology nurses about their scope of practice and the issues identified during a series of advanced practice observations that highlight realities, conflicts, expectations and disillusion of advance nurse practitioners in oncology. The presentation will also cover the potential impact of developing roles on patients, staff and service delivery.

Exercises Medicine and Cancer Survivorship: From Symptom to Survival
Professor Daniel Galvão

Physical exercise is essential to maintaining human health and is now recognised by the American College of Sports Medicine and the American Heart Association as an essential component for both the prevention and management of chronic disease, injury and other illnesses. Previously, the recommendation for cancer treatment-related adverse effects had been rest; however, emerging research on exercise has challenged this recommendation. It has become increasingly clear that exercise plays a vital role in cancer prevention and control. We have demonstrated clinical benefits of resistance training for improving physical and muscle function in prostate cancer survivors undergoing androgen deprivation therapy with significant improvements in muscle strength, physical function, balance, and cardiorespiratory fitness. We have also reported the rapid loss of bone and lean mass and increased total body fat due to androgen deprivation for prostate cancer and established the efficacy of exercise as medicine to reverse muscle loss, improve physical function and quality of life including general health, and reduce fatigue and low-grade systemic inflammation. This work has been further expanded in older prostate cancer survivors who had completed primary therapy and in those with advanced bone disease. Exercise has also been shown to have numerous positive effects in breast cancer survivors during and following treatment. Evidence from large observational studies also suggests that regular exercise post-diagnosis is associated with increased survival in patients with breast, colorectal and prostate cancer. Published Position Stands and exercise recommendations from the American College of Sports Medicine and American Cancer Society provides updated information in this field for clinicians, nurses and exercise physiologists.

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The purpose of this research study was to develop a set of best practice guidelines that promote a consistent approach to delivery of care, irrespective of service delivery environment.

Objectives/Aims

- Identify and describe key elements of best practice for patients undergoing radiotherapy.
- Develop best practice guidelines to support healthcare professionals to deliver optimal care.

Description/Methodology

- A review of current literature.
- Analysis of qualitative data obtained from focus groups comprised of expert clinicians.
- A modified Delphi process to gain consensus from a panel of expert clinicians.

Results/Outcomes

A guideline that consists of:

- Six best practice principles that provide overarching statements for care of patients undergoing radiotherapy.
- A series of best practice elements for each principle articulating specific aspects of service delivery required to achieve the principles.
- A series of supporting guidelines to provide clinicians with guidance on the operationalization of the best practice principles.

Conclusions

Across Australia there are substantial differences in the structure of radiation oncology centres; delivery of service, models of care, working environments and patient demographics. These guidelines provide the framework which allows for local adaptation, recognising that implementation will vary based on local resources.

Implementing a Model of Care into a Radiation Therapy Nursing Department

Michelle Roach

Introduction

Historically our nursing department only saw patients who were being treated for Head and Neck, Breast or Skin cancers, as these disease sites are the most likely to experience skin reactions requiring nursing intervention.

With the appointment of a Clinical Nurse Consultant (CNC) Radiation Oncology, the existing Model of Care was scrutinised, and subsequently it was decided to create a new model which provides nursing support to every patient receiving radiotherapy.

Objectives/Aims

The objective of the Model of Care is to provide comprehensive care to the patient and family who are receiving radiation therapy in a cohesive collaborative environment where each patient will be educated and cared for throughout their radiation therapy journey.

Description/Methodology

A Model of Care was formulated in consultation with the Nursing Unit Manager, Nurse Educator and Radiation Therapy Nurses. Education sessions were held to present the model to the Radiation Therapy Nurses, Radiation Therapists and Radiation Oncologists.

Resources available to assist in the successful implementation included the CNC Radiation Oncology and Clinical Nurse Educator along with on-line resource materials such as eviQ guidelines. Education sessions pertaining to site specific treatment reactions, radiobiology and how ionising radiation works were presented by Radiation Therapists, Physicists and Doctors.

Results/Outcomes

The implementation of this model has not been without its challenges. Due to nursing feedback the model has been adapted a number of times. However, the biggest obstacle to overcome has been staff resistance to change. Exploring the reasons for this resistance to embrace the model is an ongoing project.

Radiation induced skin toxicities, experiences of patients and effectiveness of interventions.

Gabrielle N Vigar

Introduction

Radiation treatment can cause a number of skin reactions contributing to pain, discomfort, skin damage, and reduced quality of life. Symptomatic and preventative treatment for radiation induced skin toxicities is important for treatment adherence, to minimize skin damage, and improve patients' quality of life.

Objectives

To examine both the experiences of patients and the effectiveness of interventions for patients with radiation induced skin toxicities.
Results
Twenty four studies were included in the review. Studies covered seven different types of tumour and 18 interventions. Eight grading and assessment scales were used to assess skin toxicity. Findings were categorized into three groups based upon whether the intervention was delivered topically, as a dressing or as an oral intervention.

Conclusion
The review revealed significant variation in the interventions used to prevent and treat radiation induced skin toxicities, a lack of consistency around how skin toxicity is assessed and a notable lack of studies of patients’ experiences. In terms of the interventions, existing recommendations for skin care are largely based on anecdotal experiences, institutional preferences, product availability, tradition, and cost.

Cancer Nursing in Denmark and Australia – A comparison between two hospitals.

Noeline Rozanc
1. Crown Princess Mary Cancer Centre, Westmead Hospital, Sydney, NSW, Australia

Introduction
A formal exchange program between The Crown Princess Mary Cancer Centre (CPMCC) at Westmead Hospital, Sydney and Aarhus University Hospital (AUH) in Denmark has afforded cancer nurses from both hospitals the opportunity to broaden clinical perspectives and experience different models of care.

Objectives/Aims
Program objectives are to progress the strategic relationship between the two hospitals and develop productive partnerships, promoting innovation in cancer care.

Description/Methodology
The 2014 exchange compared and contrasted the Danish and Australian models of cancer care. Differences in the Danish model included an expanded role for nurses delivering radiation treatment, greater resource availability, Government mandated care packages including obligatory timeframes for commencement of radiation and chemotherapy, psychological support for staff with compulsory clinical supervision, and clinical involvement of medical physics in partnership with nursing and medical staff. This model provides greater opportunities for patient centred care. Highlights of the Australian model include nurses’ responsibilities in relation to comprehensive patient assessment prior to proceeding with chemotherapy, specialist medical and radiation oncology training compared to general oncology physicians prescribing both radiation and chemotherapy, designated medical specialists for each patient, availability of sub-specialised allied health staff and better national cancer outcomes.

Results/Outcomes
The exchange program between CPMCC and AUH offers nursing, medical and allied health staff opportunities to build professional networks, explore different models of care, and facilitate exchange of ideas to improve practice and develop collaboration between educational institutions.

Conclusions
Exchange programs can afford cancer health professionals opportunities for reflective practice and improvements in patient care.

Nurse led review clinics, a positive impact on patient care.

Gabrielle N Vigar
1. Radiation Oncology Department, Royal Adelaide Hospital, Adelaide, SOUTH AUSTRALIA, Australia

Introduction
Patients receiving radiotherapy are reviewed weekly by a Consultant or Registrar for toxicity assessment and management and determination of patients’ fitness to continue treatment. There is strong evidence to suggest that nurse led weekly review clinics can have a positive impact on patients care. A nurse led weekly review initiative was implemented for all patients receiving radiotherapy.

Aims
To provide holistic patient care, assess toxicities earlier, decrease the severity of toxicities, nurses using skills, knowledge and expertise to enhance patients cancer journey, decrease clinic waiting times, allow Consultants to commit time to other areas and to develop and implement evidence based assessment tools that ensures nursing documentation is both appropriate and consistent.

Description
Current review clinic practice was audited for 10 weeks. These audits included waiting times, documentation and “drop ins” to the nurses station with patients that had new or unresolved toxicities. Nurse led clinics were implemented in the Radiation Oncology Outpatients Department in December 2014. Nurse led clinics are for all patients who require weekly review across all tumour streams. Nurses are using an evidence based assessment tool.

Results
Post nurse led clinic implementation audits showed that patients waiting times have decreased, the documentation of toxicities and other issues has improved significantly and the “drop ins” to the nurses station with new or unresolved toxicities has decreased.

Conclusion
The implementation of nurse led weekly review clinics is an effective strategy for improving patient care and has a positive impact on the patients’ journey.
Evaluating the effects of aluminium containing and non-aluminium containing deodorants on axillary skin toxicity during radiation therapy for breast cancer: a 3-armed randomized controlled trial.

Sharron Carson¹, Lucy Lewis², Sean Bydder¹, Mariyam Athifa², Anne Williams³, Alexandra Bremner⁴
1. Radiation Oncology, Sir Charles Gairdner Hospital, Perth, WA, Australia
2. School of Nursing and Midwifery, Curtin University, Perth, WA, Australia
3. School of Health Professions, Murdoch University, Murdoch, WA, Australia
4. School of Population Health, The University of WA, Perth, WA, Australia

Introduction
Nurses caring for women having radiation treatment to the breast commonly recommend avoidance of deodorants due to concern that it may exacerbate axillary skin toxicity. As nurses we like to safely advise patients on best evidence. A 3-arm randomized study was undertaken to compare the following groups: aluminium deodorant and soap, non-aluminium deodorant and soap, soap only (control).

Objectives/Aims
The hypothesis was that women receiving postoperative radiation would experience the same skin reaction regardless of whether or not they used deodorant.

Description/Methodology
333 patients were recruited from a single institution and randomly allocated to either aluminium deodorant, non-aluminium deodorant or soap only (control) groups. A research nurse assessed the patient weekly using the RTOG Skin Toxicity Scale, the Hyperhydrosis Disease Severity Scale and an inhouse scale of axillary itch, pain and burning. Details of radiation therapy treatment, age, smoking status, brassiere cup size and BMI were documented. The trial was double blinded with neither the research nurse nor patient being aware of whether the deodorant supplied contained aluminium.

Results/Outcomes
Patients in all three groups did not report significantly different ratings for axillary itch, pain or burning. The patients in the aluminium-containing deodorant group were less likely to experience axillary sweating. There was no increased skin toxicity in the deodorant groups when compared to the control group.

Conclusions
Aluminium deodorant significantly reduces sweating without increased symptoms of axillary radiation skin toxicity. This evidence can be used to inform women during radiation treatment for breast cancer about underarm skin management.

Concurrent Session 8: Hot Topics
A survey of Australian Cancer Nurses: The prevention and control of non-communicable diseases- CaNPaC study

Gillian Blanchard¹, Catherine Johnson¹, Yolande Cox¹
1. Calvary Mater Newcastle, Waratah, NSW, Australia

Introduction
In 2010 the World Health Organisation (WHO) established a goal of reducing of premature mortality from Non-Communicable Diseases (NCD’s) by 25% in 2025 through lifestyle modification of unhealthy diets, physical inactivity, tobacco and alcohol consumption. In 2014, WHO estimated NCD’s accounted for 43% of disease burden globally, and 73% of all deaths in 2020.

The International Council of Nurses identified that nurses are ideally placed to contribute to the prevention and control of NCD’s via implementation of evidenced based strategies (EBS).

Objectives/Aims
To explore the Australian cancer nurses role including role, knowledge and skills in the prevention and control of NCD’s.

Description/Methodology
An online survey was distributed to 899 members of the Cancer Nurses Society of Australia to collect data using non-probability snowball sampling.

Results/Outcomes
257 respondents; > 90% believed it’s within their scope of practice to contribute to prevention and control, >70% assess for modifiable risk factors, >85% refer to support services for prevention and control and 70% interested in spending more time addressing NCD prevention. >60% indicated they had adequate resources, skills and knowledge; however more than 73% felt they had inadequate time to incorporate strategies within their existing workload, 56% believed their physical environment was inadequate, and 48% felt a lack of culturally appropriate resources were a barrier to contributing and prevention of NCDs.

Conclusions
Australian cancer nurses want to contribute to the prevention and control of NCD’s although workload, physical environment and culturally inappropriate resources hinder the implementation of EBS.
Process mapping the patient’s journey: Enhancing the quality of care across the colorectal cancer pathway

Melissa A Warren¹
1. Capital and Coast District Health Board, Wellington, New Zealand

Introduction
For the patient entering the colorectal cancer service can be a complex encounter, coming into contact with multiple care providers. For health service providers care and management can be multifaceted. In order to understand processes across the colorectal cancer patient journey, process mapping was applied to “see” and understand the patient’s experience in a series of consecutive steps.

Objectives/Aims
The aim of the clinical project was to elucidate the current diagnostic and treatment pathway for colorectal cancer and identify areas where variation and delay in services may occur.

Description/Methodology
The clinical project consisted of:
1. Retrospective process mapping of 15 patients (random sample) diagnosed and treated for colorectal cancer within the last 12 months.
2. Interviews with key stakeholders within the colorectal multi disciplinary team (MDT).

Results/Outcomes
Process mapping has proved a valuable tool in making all the steps within the colorectal cancer pathway visible: engaging MDT members in owning any service problems that have emerged. Process mapping identified a number of areas where there is variability and delays within the colorectal cancer pathway; referrals, triage prioritisation, cross departmental systems, lack of pathway and supportive care.

Conclusions
Process mapping identified potential areas where improvements may be made to improve patient experience, reduce inequalities and achieve efficiencies. This has served as a useful starting point from which to develop clinical pathways collaboratively with the MDT; from GP referral to diagnostics and treatments and can be applied by cancer nurses to enhance the quality of care across the care continuum in their own cancer services.

Cancer Survivorship 101: findings from the Victorian pilot projects of post-treatment survivorship care

Nicole Kinnane¹, Linda Nolte¹, Paula Howell¹, Kathryn Whitfield², Spiridoula Galetakis³, Michael Jefford¹, 4, 5
1. Australian Cancer Survivorship Centre, A Richard Pratt Legacy, Peter MacCallum Cancer Centre, Melbourne, Victoria, Australia
2. North Eastern Melbourne Integrated Cancer Service, Melbourne, Victoria, Australia
3. Department of Health, Melbourne, Victoria, Australia
4. Department of Cancer Experiences Research, Peter MacCallum Cancer Centre, Melbourne, Victoria, Australia
5. Sir Peter MacCallum Department of Oncology, The University of Melbourne, Melbourne, Victoria, Australia

Introduction
Patient-centred models are required to assist cancer survivors transition to community based care. From 2011-2013 the Victorian Cancer Survivorship Program (VCSP) funded six 2.5-year pilot projects to develop, implement, evaluate post-treatment models of care. Projects were conceptualised in acute care, targeted different population groups and utilised partnerships with community organisations.

Objectives/Aims
To identify key learnings, enablers and challenges to inform future development of effective, sustainable, transferable models of survivorship care.

Description/Methodology
A thematic approach was used to identify common implementation learnings, enablers and challenges across the projects. Outcomes were considered individually in absence of shared evaluation frameworks.

Results/Outcomes
Outcomes included:
- increased receptivity to survivorship care;
- improved understanding of different populations;
- developing partnerships with primary care;
- transition to shared care for risk stratified survivors;
- resource development; utilisation of chronic disease models and self-management support approaches.

Absence of control groups / dissimilar interventions precluded comparison of interventions. Limited time-frames /outcome measure selection impacted strength of some findings.

Common enablers included:
- clinical leadership;
- partnerships with consumers, primary care and community organisations;
- risk stratification pathways with rapid re-access to specialist care;
- early preparation for survivorship, self-management and shared care;
- workforce education and infrastructure/resources to support models.

Shared challenges identified:
- reorienting to a culture of shared care; primary care engagement; diverse survivorship populations and needs. limited resources (information technology / staffing). Lack of sensitive, valid outcome measures impacted program evaluation.
**Conclusions**
Projects highlighted key learnings for implementing and evaluating survivorship interventions. Extended timeframes were required to embed new models and evaluate outcomes. Future projects should consider identified critical enablers / challenges.

**Broadening our horizons: clinical nurses and their role in the successful adoption of information technology systems**

*Linda LM McGinn*, *Margaret MH Hjorth*  
1. Epworth Healthcare, Richmond, VIC, Australia

**Introduction**
A leading private healthcare group recently implemented an electronic Medical Oncology Information System (MOIS) to deliver chemotherapy prescribing. Three senior oncology nurses were seconded to the project team to assist in a streamlined transition to the new system and support its uptake by clinical staff. This presentation explores the role of nurses in developing and implementing electronic information systems.

**Objectives/Aims**
Explore the role of nurses in developing and successfully implementing a MOIS into multiple oncology sites across the healthcare group to ensure consistent service delivery.

**Description/Methodology**
- Review local policies & protocols.
- Ensure chemotherapy protocols within the MOIS aligned with eviQ guidelines.
- Workflow analysis & testing across several sites.
- Engage internal and external stakeholders.
- Create training documents and materials.
- Provide ongoing consultation and support for clinical staff.

**Results/Outcomes**
The nurses proved pivotal in the successful implementation of the MOIS. Their key role was in development and delivery of the training model and materials, communicating the required changes to clinical staff and collaboratively driving the standardization across the multiple oncology sites. Having experienced clinical nurses in the project team provided the necessary interface between the IT components of the system and the clinical requirements of a day oncology unit.

**Conclusions**
It is crucial for nurses to be involved in the development and implementation of electronic information systems. Nurse’s knowledge, clinical experience and understanding of workflow practices promote the engagement of clinical staff and minimises challenges associated with the implementation of a new system.

**The Palliative Approach within the Acute Hospital Setting**

*Christina M Searle*, *Fran McInerney*  
1. The Queen Elizabeth Hospital, Adelaide, SA, Australia  
2. University of Tasmania, TAS, Australia

**Introduction**
Traditionally palliative care has been seen as relevant only to those approaching the terminal phase of their life. More recently this concept has been broadened to recognize that the palliative approach, that takes a holistic view to enhance the quality of life of those diagnosed with a life-limiting or life-threatening illness. Inpatient units are primarily populated by those with a life-limiting or life-threatening illness, and would arguably benefit from an incorporation of the principles of palliative care.

**Objectives/Aims**
The aim of this study is to explore how care within an acute hospital setting could be constructed to incorporate a palliative approach. In this process patients are actively involved in planning their care, taking into account their needs for comfort and dignity, especially when they are no longer able to express their wishes and discomfort.

**Description/Methodology**
The method used is ethnographic in orientation using data collection methods of semi-structured interviews, patient medical audits, and document reviews. As this project is in the early stages of data collection the paper will present descriptive results obtained from 100 patient medical audits.

**Results/Outcomes**
Patient medical records were explored for patient descriptive characteristics, referrals to palliative care, evidence of end of life decision making, circumstances of death and family supports.

**Conclusions**
The preliminary results suggest documentation in areas of advance care planning, the timing of referrals to palliative care and the management of distressing symptoms is often left to the patients’ end of life care, rather than at the time of diagnosis of their life limiting illness.
International IT Approaches to Survivorship Care: Suitability in the Australian Context

Margaret Hjorth
1. Radiation Oncology, Epworth Healthcare, Richmond, Victoria, Australia

Introduction
Survivorship can be defined as the process of living with, through and beyond cancer and incorporates physical, psychosocial and economic issues from diagnosis until the end of life. The challenge for healthcare providers is to find a sustainable model of care that meets the needs of cancer survivors in a resource poor environment. Internationally, the use of information technology (IT) systems has shown to be a viable approach to survivorship care. A study tour of several health services across the USA was conducted in mid 2015 to explore a range of IT based approaches to survivorship models of care.

Objectives/Aims
• Experience the usability and effectiveness of IT approaches to survivorship models of care.
• Explore the potential effectiveness and suitability of IT based survivorship care in the Australian context.

Description/Methodology
• Site visits were conducted to four leading healthcare providers across the USA.

Results/Outcomes
Key learning’s and discussion from the study tour regarding IT approaches to cancer survivorship will be presented at Congress. IT based systems allow health professionals to create structured, long-term survivorship care plan, enable population based research and measure long-term clinical outcomes. These resources also provide a portal for communication between the patient and the health care team.

Conclusions
Ongoing management of cancer survivors poses a significant challenge for health services and government bodies. Exploring the application of IT systems currently in use internationally provides information on approaches to management that are appropriate and sustainable in the Australian healthcare context.

Concurrent Session 9: Breast Cancer Care
Seroma Aspiration: An Australian Rural Study

Nancy Scott
1. Cancer Care Support Service - Bundaberg, Wide Bay Hospital Health Service, Bundaberg, Queensland, Australia

Introduction
Breast seroma’s are a common occurrence, especially in women having mastectomy and /or axillary clearance surgery for Breast Cancer. Despite CNSA seroma aspiration guidelines being available, their remains a disparity in follow up care in rural / remote breast cancer care, with patients often having to travel several hours to visit a health professional for a seroma aspiration. Anecdotal evidence suggests that many rural / remote Breast Care Nurses do not feel confident or competent to perform seroma aspiration.

Objectives/Aims
As the majority of adult learners prefer ‘visual’ learning, the aim was to develop a visual learning tool for rural remote Breast Care Nurses, which would compliment the current CNSA breast seroma aspiration guidelines and enhance learning the seroma aspiration technique.

Description/Methodology
Nationally, a small cohort of 20 rural McGrath Breast Care Nurses consented to taking part in this research. A DVD on seroma aspiration, along with an instruction letter, was posted to each of the cohort. Using Survey Monkey, each candidate was emailed a link to complete the survey after watching the DVD.

Results/Outcomes
90% response rate. 100% of the cohort believed that the DVD complimented the current CNSA seroma guidelines. Confidence and perceived competence to perform seroma aspiration greatly increased following watching the visual learning tool, in rural / remote regions.

Conclusions
It was suggested that the DVD was a powerful visual learning tool which complimented the CNSA seroma aspiration guidelines and increased confidence and perceived competence to perform seroma aspiration in rural / remote regions in Australia.
Liposuction for advanced lymphoedema – Impact of liposuction on limb volumes. Surgical treatment results from Australia.

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**Introduction**

Although liposuction has been established as a treatment for advanced lymphoedema in Europe and Scandinavia, determining its effectiveness in a hotter country like Australia is important.

**Objectives/Aims**

A prospective analysis on patients with unilateral, non-pitting, primary or secondary advanced (ISL stage II or III) lymphoedema, with a calculated limb volume difference greater than 25%, and for whom conservative therapies were no longer effective, was carried out.

**Description/Methodology**

Liposuction was performed under general anaesthesia. Compression garments or Ready Wraps were applied intra-operatively. Following surgery, patients were monitored at 6 weeks, 3, 6, 9, 12, 18 and 24 months with bioimpedance spectroscopy (L-Dex), volume differences using circumferential measurements, Magnetic Resonance Imaging (MRI) and functional assessments.

**Results/Outcomes**

Between May 2012 and January 2015, twenty-nine patients who were eligible for liposuction surgery have undergone surgery (of whom 69% had a previous diagnosis of breast cancer) had a mean pre-surgical percentage limb volume difference of 42.4% (range, 23-83). With continued compression at 6-month post-surgery, mean limb volume reduced to 3.8%, an 89.6% reduction of pre-surgical volume (t(18)=9.17, p<.001). By 12-month post-surgery with a reduction of 97.2% (t(9) 6.54, p<.001), equal volume was nearly obtained. These results demonstrate that by 12-month post-surgery, affected limb was nearly the same size as the un-affected, showing a near complete reduction as a result of liposuction-surgery. There have been no major complications from the surgery.

**Conclusions**

Liposuction is a safe and effective option for carefully selected Australian patients with advanced lymphoedema assessed and treated by a multidisciplinary team.

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Meeting the information needs of women from culturally and linguistically diverse backgrounds diagnosed with breast cancer

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**Introduction**

There are challenges in providing appropriate information about diagnosis, treatment and supportive care, to patients diagnosed with cancer, from culturally and linguistically diverse (CALD) backgrounds. Breast Care Nurses (BCN’s) working in culturally diverse settings face many barriers in meeting the needs of patients and their families where English language proficiency is low.

Breast Cancer Network Australia (BCNA) consulted with women from CALD backgrounds affected by breast cancer, BCN’s and the cancer and multicultural sectors to develop a series of bilingual resources to address these challenges.

**Objectives/Aims**

Improve access to culturally appropriate information and resources for women from CALD backgrounds diagnosed with breast cancer.

**Description/Methodology**

BCNs at Western Health provide care to a highly diverse population and are faced with language and cultural communication challenges daily. BCNA consulted with Western Health to develop and implement a series of bilingual resources for women from CALD backgrounds. BCN’s use these resources to provide diagnosis, treatment and supportive care information to women from CALD backgrounds.

**Results/Outcomes**

The bilingual resources allow BCN’s to guide patients to relevant, reliable and appropriate information in the patients’ own language. This helps build confidence and trust within the nurse / patient supportive care relationship and reduces patient anxiety when trying to understand their diagnosis and make informed decisions about treatment and care.

**Conclusions**

The Western Health / BCNA collaboration has resulted in a series of high quality bilingual resources that assist BCNs to provide care and support to women from CALD backgrounds diagnosed with breast cancer.
The Breast Care Nurse Supportive Care Model

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Introduction

The Breast Care Nurse (BCN) Supportive Care Model is a conceptual model that has been developed at the culmination of a doctoral research project exploring the role of the Australian BCN in the provision of information and supportive care. The conceptual model builds upon the Professional Navigation Framework offering a model applicable to the Australian context.

Aim

To develop a patient-centred BCN supportive care conceptual model.

Description

Three Australia-wide quantitative studies were conducted, forming a multi-perspective descriptive study investigating the information and support available to women in Australia with breast cancer, focussing particularly on the involvement of the BCN and the differences experienced according to geographical location. Findings from all three studies have contributed to the development and design of the BCN Supportive Care Model.

Outcomes

The themes of continuity of care and promoting patient and family empowerment documented in the Professional Navigation Framework are explored in the Australian context using findings from the doctoral research. New elements are introduced which are intended to support and guide the professional practice of Australian BCNs. For example, new elements such as collaboration and workable caseloads are presented and explored in the conceptual model.

Conclusions

The BCN Supportive Care Model provides educators, employing organisations and individual BCNs a conceptual model illustrating elements essential to supporting BCN professional practice in facilitating continuity of care and promoting patient and family empowerment within a patient-centred approach to nursing care.

The development of a model of care and nursing role to address the supportive care (SC) gap of metastatic breast cancer (MBC) patients

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Introduction

Breast cancer is the most commonly diagnosed cancer in Australian women and remains one of the leading causes of death from cancer in women in developed countries. In 2011-2012 Southern Melbourne hospitals treated the largest number of MBC patients in Victoria (956 patients had 6023 separations). Women with MBC have complex SC needs that vary over time, however it is recognized both internationally and nationally that a SC gap exists. This gap was also identified by a local consumer, who proposed that MBC nursing roles be created for the Southern Melbourne region.

Objectives/Aims

To develop a specialized MBC nursing role and model of care (MOC) that will guide best practice for meeting the SC needs of MBC patients.

Description/Methodology

A travel grant was awarded to two breast care nurses (BCN) to expand their knowledge of a MBC nursing role and to identify SC gaps by:

• attending a metastatic BCN practicum
• conducting interviews and comparing the roles of existing MBC nurses
• conducting a literature review

Results/Outcomes

A MBC nurse MOC was developed and presented to regional BCN’s to share knowledge of the role. This MOC was adapted to fit a nurse practitioner (NP) role and funding was obtained to create a new MBC NP role at Monash Health.

Conclusions

In response to a recognized SC gap for those with MBC, a MOC was developed that led to the initiation of a new MBC NP role at Monash Health. Further research into the value of this role will be conducted.
A survey of unmet needs and self-efficacy in women diagnosed with breast cancer and the role of the breast care nurse

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Introduction
The care and support that women with breast cancer receive from their Breast Care Nurse (BCN) is highly valued. However, little quantitative research has been done to investigate the BCN role in Australia.

Aim
To compare the unmet needs and self-efficacy of women diagnosed with breast cancer who have the support of a BCN with those who do not have a BCN.

Methodology
Participants were Australian women who had completed treatment for breast cancer between 6 months and 5 years ago, recruited through two national databases of women diagnosed with breast cancer. The cross-sectional online survey consisted of two well validated measures. Statistical data were analysed using SPSS software.

Results
Nine hundred and two participants responded to the survey. Of the top 15 unmet needs reported, eight were within the psychological domain. Those with a BCN were significantly less likely to report unmet needs in eleven of the 34 areas measured. Scores of self-efficacy demonstrated that those with a BCN had significantly higher self-efficacy when understanding and participating in care (p=0.0315), and seeking and obtaining information (p=0.0001).

Discussion and conclusions
Women with breast cancer have unmet needs regardless of time since diagnosis, particularly psychological unmet needs. Those with BCN support report decreased unmet needs and higher self-efficacy. High self-efficacy is an important factor in adapting to altered health states and has been associated with decreased psychological distress. Therefore, the ongoing presence of a BCN is pivotal to assessing and responding to unmet needs as well as working to improve patient self-efficacy.

Concurrent Session 10: Clinical Practice
Collaborative review of evidence-based guidelines in central venous access device (CVAD) management

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8. Cancer Council Western Australia, Perth, Western Australia, Australia
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10. Queensland Childrens Cancer Centre, Lady Cilento Childrens Hospital, South Brisbane, Queensland, Australia
11. Division of Cancer Services, Princess Alexandra Hospital, Woolloongabba, Queensland, Australia
12. Infection Management Services, Princess Alexandra Hospital, Brisbane, Queensland, Australia

Introduction
The majority of cancer nurses manage central venous access devices (CVADs) on a daily basis. While a number of clinical guidelines are available, clinicians are often uncertain of their quality and relevance to cancer care. The Cancer Nurses Society of Australia (CNSA) and eviQ Standard Cancer Treatments Online endeavour to direct cancer nurses to easily accessible and relevant evidence based clinical guidelines for CVAD management.

Objectives/Aims
To develop a reference tool that outlines the quality of existing clinical guidelines for CVAD management and their relevance to cancer care.

Description/Methodology
This is a collaborative initiative of CNSA and eviQ. The review group consisted of nurse researchers, infection control experts, CVAD specialist nurses, paediatric cancer nurses and eviQ content authors. Twelve infection control and CVAD guidelines were identified and assessed for quality of evidence and relevance, using a standardised assessment tool which evaluated the process of literature review, funding sources, plans for updating and the inclusion of the following clinical content: complications and trouble shooting, dressings and securement, patient education, device selection and accessing, flushing and locking. The reviewers independently assessed the guidelines and created recommendations to endorse, partially endorse or not endorse by consensus.
Results/Outcomes
At the time of abstract submission, six guidelines have been reviewed. One guideline had been endorsed, three partially endorsed for specific sections and two not endorsed. The full recommendation report and reference tool will be presented at Congress.

Conclusions
This collaborative initiative will provide a reference tool that can guide clinicians to cancer specific, highest quality, evidence based guidelines for CVAD management.

The challenges of conducting clinical research on central venous access devices
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Introduction
A single centre pilot study tested the feasibility of four dressings for central venous access devices (CVADs) to assess device failure. Unexpected difficulties were encountered during the recruitment phase, which highlighted the importance in conducting a pilot study.

Objectives/Aims
To describe the challenges experienced in a hospital wide nurse-led randomised control trial (RCT) of four CVAD dressings and the strategies employed to enhance recruitment.

Description/Methodology
This case study describes the valuable knowledge gained by the research team whilst conducting a CVAD dressing trial. The main challenges faced included: 1) recruitment; 2) clinical challenges with the trial products and; 3) integrating the trial with standard clinical practice.

Results/Outcomes
Strategies for managing these challenges included 1) extending the timeframe in which patients could be recruited; 2) discontinuing one dressing arm; 3) engaging the interest of clinical staff in study products to secure CVADs, therefore enhancing the relationship between clinical and research staff. This aided recruitment as many CVAD insertions are booked last-minute which made it essential to ensure the clinical staff felt valued by the research team, in order to encourage timely communication.

Conclusions
The recruitment phase of any pilot study can encounter unexpected difficulties that ultimately impact on the likelihood of achieving the proposed sample size within a specified time period. The strategies employed in this trial are readily applicable to other CVAD-related research projects. The knowledge gained during the recruitment phase of this trial provided essential information on the feasibility of conducting a larger RCT to test the effectiveness of CVAD dressings.

Hickman vs PICC: a comparison of central venous access device complications in patients undergoing intensive chemotherapy for acute myeloid leukaemia.
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Introduction
Central venous access devices (CVADs) are necessary to treat patients with acute myeloid leukaemia (AML). Serious complications such as central line associated blood stream infection (CLABSI) and venous thrombosis (VT) are not unusual. In our institution, choice between Hickman catheter and peripherally inserted central catheter (PICC) partly depends on staff preference.

Objectives/Aims
To compare the rates of complications between Hickman catheters and PICCs in patients with newly diagnosed AML undergoing intensive chemotherapy in our haematology unit.

Description/Methodology
The medical records of all patients who commenced induction chemotherapy for AML from Jan 2013 to Dec 2014 were reviewed. Date of insertion and removal, type of CVAD, and reason for removal were assessed. CLABSI was determined using the definition described by the National Healthcare Safety Network. VT was determined by diagnosis on ultrasound report. Statistical significance was determined using Fisher’s exact test.

Results/Outcomes
There were 57 patients with 95 CVADs (26 Hickman, 69 PICC) with 4341 line days included in the analysis. Rates of CLABSI and VT were broadly similar. For Hickman catheters: CLABSI 27% or 4.1 per 1,000 line days, VT 3.8%. For PICC: CLABSI 13% or 3.4 per 1,000 line days, VT 7.2%. Hickman catheters incurred significantly fewer non-infectious complications requiring removal; 0.58 per 1,000 line days vs 4.2 for PICCs (p = 0.03).

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Conclusions

Hickman catheters are more durable in patients with AML in our institution, though there were no significant differences in rates of CLASBI or VT; a finding consistent with other published data.

Sterile v aseptic non-touch technique for needle-less connector care on central venous access devices in a bone marrow transplant population: A comparative study

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Introduction

Central Venous Access Devices (CVAD) are routinely used in the Bone Marrow Transplant (BMT) population for the administration of various medications. However, they come with side effects such as infections associated with their use. BMT patients also have an increased risk of infection due to neutropenia as a result of their treatment.

Objectives/Aims

This study aimed to assess whether a change in practice from an aseptic non-touch technique (ANTT) to a sterile technique when changing the needle-less connector on a CVAD had any impact on infection rates in the BMT population.

Description/Methodology

A two group comparative study without concurrent controls using a retrospective cohort was conducted in a large metropolitan hospital in Brisbane, Australia. Inclusion criteria: haematological malignancy, Hickman catheter inserted, age ≥18. A data collection tool was developed to extract historical data from medical records and pathology results. Primary outcome: CRBSI.

Results/Outcomes

One hundred and fifty patients were assessed, 73/150 (49%) in the ANTT group. No difference in CRBSI rates between groups was observed (ANTT n=3 (4%) vs Sterile n=1 (2.7%), p=0.357 Fishers Exact Test). Infection by skin contaminants were identified in a similar number of cases across both groups (ANTT n=9 (12.3%) vs Sterile n=6 (7.8%).

Conclusions

No causal effect can be deduced from this small study; nevertheless results imply that an ANTT was not associated with increased CRBSI. Poor hand hygiene and ANTT were apparent across both groups. Education and awareness of pathogen transfer from healthcare worker and patient to their device is required.

Red blood cells – are they being used appropriately?

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Introduction

A recent Blood Matters audit examined elective red blood cell (RBC) transfusion and patient blood management (PBM) practices in adult patients (≥ 16 years of age). Exploring if:

• practice aligned with National Blood Authority’s PBM Guidelines (Modules 2, 3 & 4)
• transfusion triggers included assessment of the patient’s clinical status and not based on haemoglobin (Hb) alone
• in stable patients a single unit of RBC is followed by clinical reassessment, determining the need for further transfusion.

Description/Methodology

Health services were invited to audit up to 30 patients receiving an elective RBC transfusion during 2013. Audit instructions included definitions, inclusion and exclusion criteria.

Data were collected on a formatted EXCEL workbook, emailed to Blood Matters and imported into ACCESS database. A combination of programmed algorithms and medical review determined appropriateness.

Results/Outcomes

Ninety-three of 147 invited health services responded, submitting data on 2072 RBC transfusions. For the medical module (3) 1315 transfusion episodes were reported. Module 3 includes oncology/haematology patients. For this module, 1028 (78%) were considered aligned to guidelines. Reason for transfusion reported in 1031 episodes (78%), and recent/ongoing blood loss for 379 (29%). Documentation of haematological disorder or marrow failure reported in 429 (33%) episodes. Approximately 190 (14 %) followed single unit transfusion guidelines, and 332 (25%) reported documentation of iron deficiency.

Conclusions

Practice improvement is required to align with PBM guidelines. Areas for improvement specifically relate to addressing all causes of anaemia e.g. iron deficiency, assessment of patients between units (single unit policy), and documentation of indications for transfusion.
Intravesical treatments: We had to change mid-stream

Crossman, C.1, Maher, L.1, Sibbald, T.1, Kendall, A.1, Muhango, T.1, Crosdale, C.1, Brown, T.1, MacDonald, K.1, Duff, A.1, Rice, C.1, McMurray, J.1

1. Nepean Cancer Care DayWard, Nepean Hospital. NSW

Introduction
In the last 15 years, an outpatient chemotherapy DayWard in a Comprehensive Cancer Care Centre in Sydney NSW, has performed approximately 18 – 20 intravesical Bacillus Calmette-Guerin (BCG) treatments per month. The worldwide shortage of BCG used to treat early stage Bladder cancer intravesically has seen in October 2014, Gemcitabine or Mitomycin C replace BCG treatment.

Objectives/Aims
A number of clinical challenges occurred in quick succession once treatment was changed, which resulted in activating a ‘Critical Incident Log’ (CIL) to capture the evidence indicating

1. patients were unable to tolerate the required ‘hour’ of intravesical treatment due to increasing bladder spasms with or without intense abdominal discomfort

2. increase in episodes of leakage around the Indwelling Catheter (IDC) and Cytotoxic Spill procedures being initiated.

As a result, the DayWard RN’s were struggling and losing confidence in a procedure they previously considered ‘routine’.

Description/Methodology
A review of the literature using The Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, Ovid, PubMed, Scopus, Cochrane Database of Systematic Reviews and Google Scholar databases using Medical Subject Headings (MeSH headings) failed to enlighten or guide the clinical practice nursing issues being experienced.

Results/Outcomes
In consultation with the Medical Oncology Specialist a number of changes such as the concentration and volume of Gemcitabine were adjusted; trialling an increased French Gauge IDC size and patients being prescribed a urine Alkalising product for the duration of their treatment. The CIL is continuing to be used to document clinical practice challenges and to review this monthly with the various key stakeholders.

Concurrent Session 11: Advanced Research Workshop

Building research programmes using the Medical Research Council (MRC) Framework for developing complex interventions that lead to attracting funding

Professor Alex Molasiotis
This session will highlight how the MRC framework for complex interventions has been used in two real examples to build programmes of research. Carefully building theory, modelling of interventions, exploring the feasibility of trials before moving to large randomized trials is the model to be presented. How these different parts link together to make a successful programme of research and how to develop junior researchers to internationally-recognised faculty through this framework will be discussed.

Publication workshop: International publication opportunities, increasing your publication outputs

Professor Alex Molasiotis
This session will take people through the publication process, from identifying the reasons for writing to having an article published, and highlight some major mistakes people often make, particularly those less experienced researchers, in their attempt to disseminate their piece of work. Some ‘tips’ for preparing papers for submission for publication, based on editorial experiences of many years, will also be shared.

Concurrent Session 12: Practice Implications

Streamlining care practices: An example from the field

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Introduction
Patients with a diagnosis of cancer have complex care needs. To provide quality care it is critical that there is a culture of inquiry at the point-of-care so that clinicians are better equipped to rationalise patient care.

Objectives/Aims
Evaluate care practices to identify ‘waste’ and create a culture of inquiry as a process of professional development for point-of-care clinicians in an acute oncology/haematology ward.
Description/Methodology
Our method for creating a culture of inquiry has been to engage nursing staff to rationalise and streamline care activities specific to the cancer patients in terms of: what and how each care practice influences treatment decision-making and patient outcomes.

Results/Outcomes
Since commencing our project staff have become increasingly engaged in rationalising care practices and in reviewing and developing protocols. While some of the care practices identified as ‘waste’ appeared to be relatively minor, their integration into daily care activities had significant consequences. Tangible consequences included time and cost while intangible consequences included distracting clinicians from care priorities. One care practice identified as ‘waste’ was performing routine urinalysis on neutropaenic patients. This care practice equated to 10 mins per patient per day, 9 hours per week and $3,000 worth of consumables per year.

Conclusions
Streamlining and reviewing care processes requires commitment from management through to point-of-care staff. This project is creating a clinical workforce that is more inquiring about care processes, less caught up in the minutiae of care activities and more focussed on care activities that inform treatment decisions and promote patient outcomes.

Assessment of health professionals’ perspectives of a program to implement routine screening for psychosocial distress into the admission and discharge process.

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Introduction
Alongside physical symptoms, cancer results in a wide range of challenges that can contribute to greater patient distress resulting in clinical levels of anxiety and depression. Early detection of distress requires a systematic process to assess patients and refer to appropriate services. Whilst patient opinion on routine screening has been tested, qualitative research on health professionals’ perspectives is lacking in current literature.

Objectives/Aims
1. To ascertain health professionals’ views of systemative screening for distress
2. To ascertain health professionals’ views of introducing a model of routine screening and referral pathways into the admission and discharge process of cancer patients.

Description/Methodology
1. A one day workshop was provided for health professionals including psycho-oncology education, routine screening for distress and referral pathways for supportive care.
2. Qualitative data was obtained via semi-structured interviews with 5 health professionals

Results/Outcomes
Participants deemed the workshop to be very informative and met their education needs. Interviews of health professionals identified several overarching themes: the benefits of screening; the challenges encountered; overcoming difficulties and making it work; resources needed; ways forward.

Conclusions
Benefits and challenges of introducing a model of routine screening and referral pathways into the admission and discharge process of cancer patients were identified and possible solutions noted. We propose this information can be used to improve the admission and discharge process of cancer patients.

Integrating supportive care screening and allied health referral into a day oncology setting: Mind Body Soul Pilot

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2. Icon Cancer Foundation, Brisbane, Queensland, Australia

Introduction
Barriers to integrating supportive care and referral to allied health in the day only private cancer care setting include under-recognition of patient needs, accessibility of appropriately trained health providers, out-of-pocket expenses and the stigma associated with psychological referral.

Objectives/Aims
The Mind Body Soul Pilot Project aimed to evaluate integration of screening for unmet needs and supportive care through coordination of referral to allied health professionals.
Description/Methodology
Phase I of the pilot was conducted over 6 months with the appointment of a Personalised Care Coordinator (PCC) and development of assessment/screening tools. In Phase II, eighty-three (83) new patients were screened by the PCC. A mixed-method approach was taken to assessing supportive care needs and patient experience with the service.

Results/Outcomes
Fifty-four (65%) patients were identified to have unmet needs for psychological support, diet and nutritional support, mobility and practical support. Thirty-eight patients utilised supportive care services following referral. Over 80% of patients were satisfied with the level of information they received regarding allied health services available during their treatment. Greater than 70% of patients reported that having contact with the PCC substantially decreased anxiety associated with the commencement of chemotherapy.

Conclusions
The results of this pilot project provide evidence for integrating screening for unmet need and referral pathways to community-based allied health in the day only cancer care setting is needed. Further evaluation for ease of access to allied services by patients and uptake of particular services will continue over the next 12 months.

Fever management and the role of evidence in nursing practice

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Introduction
Fever associated with neutropenia, blood transfusion and disease processes is common in cancer patients, however nursing knowledge and practice in addressing symptoms is often not consistent with best evidence.

Objectives/Aims
This study aimed to 1) investigate nurses’ fever knowledge, attitudes and practices in a specialist cancer service; and 2) determine the participants’ intentions to administer paracetamol as part of the nursing response to febrile cancer patients.

Description/Methodology
Specialist cancer nurses (n = 65) from a metropolitan tertiary-referral facility participated in the study. A cross-sectional survey underpinned by the Theory of Planned Behaviour (TPB) was undertaken using an adapted Paediatric Fever Management Survey.

Results/Outcomes
Participants’ overall knowledge score was 11 (21 items, ± 3, range 7-16, possible score 0-21), and overall attitude score 3.88 (25 items, ± 0.42, range 3.04–4.32, possible score 1-5). Respondents’ intentions to administer paracetamol had a median score of 2.0 (± 3.0) on a 7-point Likert ranging 1(extremely likely) to 7 (extremely unlikely). Participants’ knowledge was moderately and positively correlated with their attitudes (p = 0.001). The overall TPB-based model explained 26% of the variance in respondents’ intentions to administer paracetamol (p = 0.001), to which ‘Subjective Norms’ (p = 0.037) and ‘Indirect Perceived Control’ (p = 0.016) were significant contributors.

Conclusions
The findings indicate that while participants’ fever knowledge was consistent with evidence, it is likely that nursing cultural norms precluded the full translation of evidence to practice. Exploration of optimal learning environments and nursing culture are currently being undertaken to address this issue.

CINV CHECK AUDIT – Audit of our practice in relation to control and documentation of CINV for moderate emetogenic chemotherapy in the Mater Cancer Care Centre.

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Introduction
Chemotherapy-induced nausea and vomiting (CINV) is a distressing side effect that is still experienced by many cancer patients, and clinical studies show that the severity and frequency of delayed nausea and vomiting due to moderately emetogenic chemotherapy (MEC) is often underestimated by healthcare professionals.

The CINV Check audit programme has therefore been developed to highlight the continuing problem of delayed CINV among patients undergoing MEC.

Objectives/Aims
This will help us to encourage greater communication about CINV between patients, nurses, and oncologists; promote evidence-based practice in assessing and responding to CINV risk in MEC patients and improve patient quality of life during chemotherapy in our unit.

Description/Methodology
The audit has been given exemption by the HREC and patients will be consented. Patients will complete a daily diary for 5 days following chemotherapy, rating their level nausea and vomiting, impact on their life and any medication used. Patients will be treated as normal in the clinic and treatment area. The lead nurse will then assess the level of documentation of CINV in the patient notes and collect the patient diary following an assessment tool.
Results/Outcomes
Aim to recruit 50 patients and compare the data collected from the medical chart and the patients, currently have recruited 10.

Conclusions
To show the current standard of the unit for assessing and treating CINV in acceptable and identify practice and procedures which can be improved.

Feasibility and acceptability of using the hand-held fan as a self-management strategy to increase physical activity in patients with refractory breathlessness: Results from an international multisite pilot randomised control trial
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5. Breathlessness Intervention Service, Addenbrooke’s Hospital, CAMBRIDGE, United Kingdom

Introduction
Breathlessness is a common symptom experienced by many people living with many chronic illnesses including cancer. There is emerging evidence that encouraging patients to use a hand held battery operated fan (‘fan’) to manage their exertion and/or anxiety related breathlessness may be beneficial.

Objectives/Aims
To test the feasibility of conducting an adequately powered large, multi-centre, multi-national randomised controlled clinical trial comparing the efficacy of a fan and exercise advice with exercise alone in increasing activity levels in people with optimally treated breathlessness from any cause.

Description/Methodology
A phase II multi-site internationally parallel arm feasibility RCT non-blinded study. Participants were randomised in a 1:1:2 ratio: low flow rate (Fan A) versus high flow rate (Fan B) versus No Fan. All groups received standardised general advice regarding breathlessness self-management exercise only. Participants were followed-up weekly for four weeks. Physical activity was measured by several instruments, including the ActivPal Monitor and Six Minute Walk Test.

Results/Outcomes
49 participants were randomised, with 40 participants completing the study. The overall attrition rate was 18%. There was no difference in the age, gender or level of functioning or breathlessness severity between the two groups. At Day 28 there was no difference between the intervention or control groups in accordance with their physical activity levels or breathlessness severity.

Conclusions
This study has demonstrated feasibility and acceptability of the overall study design. Before undertaking an adequately powered phase III RCT further consideration needs to be given to the selection of the primary outcome measure.

Plenary Session 5
Survivorship Care – Global Perspectives and Opportunities for Nurse Led-Care
Dr Carrie Tompkins Stricker
The number of cancer survivors around the globe is rapidly growing, particularly in developed countries where contributing factors include aging populations, earlier diagnosis, and marked treatment advances. Unfortunately, a diverse body of research has documented widespread gaps in the coordination and delivery of quality survivorship care, including supportive care for cancer survivors. In 2006, a major report from the Institute of Medicine identified strategies for overcoming these gaps, including implementation of novel care models and delivery of survivorship care plans. Since that time, many care delivery models have been undertaken, and diverse clinical and research efforts have been directed at implementation of survivorship care plans, with efforts to determine best practices and outcomes underway across the globe. Nurses have played a pivotal role in these growing efforts to transform the delivery of survivorship care. The goal of this session is to describe, from an international perspective, the state of practice and science related to survivorship care delivery, including the state of the art in survivorship care plan implementation and outcome evaluation. Emphasis will be placed on maximizing opportunities for cancer nurses in transforming survivorship care delivery, and providing tools to evaluate the impact and value of nurse-led survivorship care.
Cancer nursing diversity: How our profession is evolving – An Australian Context

Professor Mei Krishnasamy

Australia, as much of the developed world, faces a crisis of health care affordability and capacity to deliver adequate health care. The number of Australians aged 65 and over is projected to more than double by 2054 with life expectancy at birth projected to be 95.1 years for men and 96.6 years for women. Health expenditure is projected to increase as a proportion of GDP from 4.2 per cent in 2014-15 to 5.7 per cent of GDP in 2054-55 ($260 billion in today’s dollars) and with the increase in our population, the incidence and prevalence of cancer across all groups in society will rise.

To assure quality, safe care for all Australian’s affected by cancer, cancer nurses will need to be able to respond to these demographic and economic challenges through innovative, efficient roles and models of care delivery that will ensure equity and efficiency of care delivery.

This paper will explore international evidence based models of care delivery and innovative roles, and propose areas for urgent role development if cancer nurses are to be critical to the delivery of effective cancer care into the future.

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Education for Health Professionals

We offer a range of free or low cost education and professional development opportunities, as well as scholarships and cancer related information and resources.

We are committed to developing the skills of health professionals in WA, in order to improve cancer patient care.

Our education events and resources are relevant to clinicians, GPs, nurses and allied health professionals. E.g Cancer Clinician Communication Program

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Palliative and Supportive Care Education

Our PaSCE program provides innovative and evidence based palliative care education for health care professionals, health care workers and volunteers across WA. PaSCE programs and education events aim to increase the knowledge and understanding of palliative care in all settings.
Poster 1
A national cancer nursing survey: Survivorship care provision for patients with haematological malignancy

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3. Cancer Care Services, Royal Brisbane and Women’s Hospital, Herston, QLD, Australia
4. Olivia Newton-John Cancer & Wellness Centre, Austin Hospital, Melbourne

Introduction
Many patients with haematological malignancies report long-term post-treatment physiological and psychosocial effects. This study reports cancer nurses’ reports of their role, confidence levels, practices and barriers in relation to survivorship care provision for patients with haematological malignancies.

Methods
A total of approximately 1300 cancer nurses caring for patients with haematological malignancies were invited to participate in a survey. The survey was distributed to all cancer nurses at a Queensland tertiary cancer care centre and through two national professional bodies for cancer nurses in Australia.

Results
In total, 423 cancer nurses (33%) completed the survey. Overall, the majority of participants agreed that all survivorship interventions included in the survey should be within their nursing role. Nurses were least confident in discussing fertility, employment and financial issues with patients and discussing information about identifying signs of cancer recurrence. The least frequently performed interventions included discussing fertility, intimacy and sexuality issues and communicating survivorship care with the patient’s primary care providers. The most significant barriers perceived by participants were lack of dedicated end-of-treatment consultation, time, an appropriate physical location, and educational resources for patients.

Conclusions
Cancer nurses have a key role in providing survivorship care. A model of care that addresses the barriers identified in this survey has the potential to improve survivorship care provision. More dedicated training opportunities are required to enable nurses to deliver quality survivorship care and improve outcomes for patients with haematological malignancies. Future research should examine the effectiveness of different models of care for this population.

Poster 2
Does parenteral nutrition increase the risk of catheter-related infection? Does the evidence reflect current practice guidelines?

Nicole Gavin², ¹, Samantha J Keogh³, David McMillan⁴, Claire Rickard³
1. Alliance of Vascular Access Training & Research, Griffith University, Nathan, Queensland, Australia
2. Royal Brisbane & Women’s Hospital, Herston, QUEENSLAND, Australia
3. Alliance of Vascular Access Training & Research, Griffith University, Nathan, Queensland, Australia
4. Alliance of Vascular Access Training & Research, University of the Sunshine Coast, Sippy Downs, Queensland, Australia

Introduction
Parenteral nutrition (PN) is associated with catheter-related infections (CRIs). Clinicians generally refer to clinical guidelines rather than original studies.

Objectives/Aims
Our aim was to critique current evidence and assess consistency with practice guidelines.

Description/Methodology
Journal articles that compared CRIs in (i) central venous access devices (CVADs) for PN and non-PN administration, (ii) single or multiple lumens CVADs, (iii) the configuration of intravenous administration sets (IVAS) and (iv) the frequency of IVAS changes for PN administration were reviewed using systematic methodology and compared to practice guidelines.

Results/Outcomes
Ten papers met the selection criteria and found (i) CRI was five times higher in groups receiving PN (PN 35/358; 9.8% vs without PN 34/1789; 1.9%), (ii) CRI was doubled higher in patients with a multiple lumen CVAD (RR 1.82; CI 95% 0.83-4.00), (iii) CRI was doubled in multiple use multiple lumen CVADs (multiple use multiple lumen CVAD 7/61; 11.5% vs multiple use single lumen CVAD 46/824; 5.6% vs dedicated lumen on multiple lumen CVAD 30/523; 5.7%) and (iv) there is no difference in CRI when IVAS were changed more frequently (RR 1.25; CI 95% 0.12-12.91).

Conclusions
The literature highlights PN infusion as a risk for CRI. The recommendation of using a designated single-lumen CVAD to administer PN containing lipids and changing the IVAS every 24 hours is based upon non-analytical studies and expert opinion. Well designed randomised controlled trials are needed to answer many questions regarding PN as a risk factor for CRI.
Poster 3

Does parenteral nutrition promote microbial growth? A review of clinical and laboratory findings.

Nicole C Gavin¹, David McMillan², Samantha J Keogh³, Claire Rickard³
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2. Alliance of Vascular Access Training & Research, University of the Sunshine Coast, Sippy Downs, Queensland, Australia
3. Alliance of Vascular Access Training & Research, Griffith University, Nathan, Queensland, Australia

Introduction

Parenteral nutrition (PN) is considered to be a good growth media for microbes and so clinical practice guidelines recommend replacing intravenous administration sets containing lipids every 24 hours.

Objectives/Aims

Our aim was to synthesize clinical research and laboratory studies comparing microbial growth in PN versus non-PN solutions.

Description/Methodology

A systematic review of journal articles reporting microbial colonisation of patients receiving PN and without PN, or laboratory papers reporting growth curves of microbes in any PN and control solutions.

Results/Outcomes

One paper reported findings of colonised PN and non-PN central venous access devices (CVADs) rather than combining the data. A total of 1140 CVADs were analysed: 23/237 (9.7%) PN and 13/903 (1.4%) non-PN CVADs were colonised. The majority of CVADs were colonised with aerobic Gram-positive cocci (12/23, 52% PN vs 8/13, 61% non-PN CVADs), followed by fungi (6/23, 26% PN vs 4/13, 31% non-PN CVADs) and aerobic Gram-negative rods (3/23, 13% PN vs 1/13, 8% non-PN CVADs).

Six papers presented microbial growth curves using a variety of PN and control solutions. A selection of microbes were grown in a range of PN and control solutions. Lipid solutions, broth and normal saline supported growth of the tested microbes. Candida grew in all test solutions.

Conclusions

There is no difference in the types of microbes colonising patients, but sample sizes were small and further research is needed. Microbes grow in clinically administered solutions although microbial growth in 0.9% NaCl was slower than in lipids.

Poster 4

Peripheral Intravenous Access – Patients’ understanding of potential complications post cannula removal

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Introduction

Peripheral venous access carries the risk of complications such as infection, phlebitis, emboli, pain, bruising and extravasation. One of the most frequently undertaken procedures in a day chemotherapy unit is peripheral intravenous cannulation (cannula insertion). It is important that with each procedure performed that patient safety is paramount before, during and after the procedure. Whilst much care is taken before and during the insertion process; we were unsure of patients’ understanding of post insertion care and complications.

Objectives/Aims

To ascertain patient understanding of potential complications post cannula removal.

Description/Methodology

A quality survey of 81 patients attending the Calvary Mater Newcastle Day Treatment Centre (DTC) was undertaken. Patients were asked if they had any problems with their cannula site after treatment; signs and symptoms to look out for; education they received on aftercare; provision of contact details and if they believed aftercare information was necessary.

Results/Outcomes

Our results indicated the majority of patients believe they did not receive written or verbal information on how to look after the cannula site. Interestingly, despite this, 60% of patients surveyed reported knowing what signs and symptoms to be aware of that may indicate a problem at the cannula site after removal. Most patients reported no problems with past cannula sites, knew who to contact if there were any problems and believed it was necessary to receive adequate information on post cannulation care.

Conclusions

The results of this activity showed that there was a need for patients to receive further post cannula care information.
Poster 5
Survivorship care plans and treatment summaries in adult patients with haematological cancer: an integrative literature review.

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3. St John of God Hospital, Murdoch, WA, Australia
4. Edith Cowan University, Joondalup, WA, Australia

Introduction
Survivorship care plans [SCPs] and treatment summaries [TS] have been recommended by the Institute of Medicine as facilitators to deliver holistic survivorship follow-up care. Nurses have established expertise in health promotion, information, support and resource provision, and therefore can develop and disseminate SCPs and TS to facilitate structured communication between the survivor, specialist and primary care. This will help to consolidate nurses as essential in survivorship care. Haematological cancers have distinctive and complex treatment regimens that commonly involve high dose chemotherapy agents, and/or targeted therapies, radiotherapy and hematopoietic stem cell transplants, often at different institutions. Unfortunately the outcome of these largely aggressive treatments is a number of long-term and late physical, practical and psychosocial effects.

Objectives/Aims
An integrative literature review was undertaken to identify current SCPs and TS to meet haematological cancer survivors’ needs.

Description/Methodology
A search of relevant electronic databases for eligible articles was executed. Included articles described SCP and/or TS use with haematological cancer survivors or haematologists.

Results/Outcomes
Four articles that reported on experience, dissemination or components of SCPs and/or TS were included. Haematology-specific literature was limited and no randomised controlled trials or literature reviews were found for the haematological cancer survivor cohort.

Conclusions
This review revealed a lack of high quality evidence evaluating the effectiveness of SCPs and/or TS on haematological survivorship follow-up care. SCPs and TS that provide information and practical assistance for guiding follow-up care to transition haematological cancer patients into the survivorship phase require further work.

Poster 6
Chemotherapy induced nausea and vomiting – a better assessment tool – involving patients in their own care and gauging antiemetic effectiveness including early intervention when necessary.

Wendy Spencer1, Kylie Stonestreet1, Corrina Cooney1, Jerry Varghese1
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Introduction
It is well recognised that Chemotherapy Induced Nausea and Vomiting (CINV) is one of the most common side effects occurring from treatment. A pilot assessment tool with a scale was developed and introduced into the outpatient setting. This tool was implemented from the patients’ first education.

Objectives/Aims
To better assess/treat CINV via education and early risk assessment.

Description/Methodology
Patients receiving education prior to cycle 1 were asked a series of questions on the tool for pre-assessment/risk giving a result out of 10. On day 1 of the first cycle, a pamphlet was given to the patient to score their emetogenicity for the five days post treatment. This would in turn give a score from 1 – 50 calculated over the five day period.

Results/Outcomes
The CINV tool has provided patients with an element of “hands on” and control in their own care. The tool has helped nurses quickly identify and assess CINV appropriately. It has allowed for proper medical review and the patient risk factors to be reduced. This tool was expanded and developed through a Quality Improvement Project and built on from the original MASSC CINV scale.

Conclusions
The CINV tool is part of patient education. Scores for every cycle are electronically and can be reviewed prior to following cycles. CINV has reduced, and experiences have improved quashing myths and expectations that are commonly spoken about by the patient before they enter our clinic.
**Poster 7**

**Developing a cancer survivorship model of care through consumer engagement**

*David Larkin*, *Megan Nutt*, *Toni Ashmore*, *Desmond Yip*, *Angela Rezo*, *Marian Currie*

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2. Research Centre for Nursing and Midwifery Practice, ACT Health, Garran, ACT, Australia
3. University of Canberra, Canberra, ACT, Australia

**Introduction**

Canberra Region Cancer Centre (CRCC) commenced operation in 2014 and is the primary adult tertiary referral hub for cancer diagnosis and treatment in ACT and South East New South Wales region, servicing over 500,000 people. A significant part of the vision to provide integrated and contextually appropriate cancer care involves implementing a Survivorship Model of Care for ACT Health Directorate’s Cancer Services.

**Objectives/Aims**

To define the term cancer survivorship within the local context; to inquire about the physical, emotional and practical support needs of cancer consumers; and to examine coordination of resources and support from a clinician perspective.

**Description/Methodology**

Survey tools were devised based on current issues in cancer survivorship research and widely distributed in both paper and electronic format to consumers and clinicians. Selection criteria reflected the unique population groups serviced by CRCC.

**Results/Outcomes**

Results indicate our cohort define survivorship as living with cancer from the time of diagnosis, through treatment and beyond. Other themes included managing the psychosocial impact, adjusting to altered roles and expectations, and living with an unknown future after treatment, with these needs able to be better met. Findings show that information on the disease, treatment and side effects is more helpful in early stages of the cancer trajectory, whereas there is a continual need for psychosocial information and support throughout.

**Conclusions**

Development of a Model of Care that enhances the wellbeing approaches important in survivorship provided to patients and carers has commenced, emphasising survivorship as living well with cancer, beyond diagnosis and treatment.

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**Poster 8**

**Comparing an active versus passive decontamination of the needle-less connectors on a central venous access device: An in vitro study.**

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1. RBWH, Herston, Queensland, Australia
2. Griffith University, Anstead, QLD, Australia
3. Griffith University, Nathan, Queensland, Australia

**Introduction**

Central venous access device (CVAD) needleless connectors (NC) have been implicated in the development of catheter related bloodstream infections (CRBSI). However, the specific degree to which connectors and connector care may contribute to CRBSI has not been quantified. Nonetheless decreasing the risk of microbial contamination of CVAD and attachments can reduce the risk of CRBSI and improved patient outcomes.

**Objectives/Aims**

To assess the rates of contamination on the internal surface of a needle-less connector (NC) after decontamination with three separate disinfection protocols.

**Description/Methodology**

Design: In vitro study

Three different types of needle-less connectors will be tested.

*Needle-less connector groups:*

1. –ve control – tested with no bacterial contamination
2. +ve control – contaminated and tested with no disinfection
3. 70% isopropyl alcohol swabs (IAS) – each NC scrubbed for: 5 seconds, 15 seconds, and 30 seconds, and allowed to air dry
4. Chlorhexidine (CHG) with alcohol swabs – each NC scrubbed for 5 seconds, 15 seconds, and 30 seconds, and allowed to air dry
5. 70% isopropyl alcohol impregnated caps (IC)

Needleless connectors were contaminated with 3 bacteria and 1 fungi:

- *S. aureus*
- *S. epidermis*
- *P. aerugonosa*
- *Candids sp.*

Fifty percent of the NC will be exposed to serum for 2 hours, then immediately exposed to the bacteria. NC pre-exposed to serum will be left to dry for 18 hours prior to testing.

**Results/Outcomes**

Study is currently in progress and results will be presented at the conference.

**Conclusions**

Presented at conference
Poster Abstracts

Poster 9

Implementation of a Scalp Cooling Service-A Victorian Private Hospital Experience

**Gail Wilmot**, **Evelyn Clowes**

1. Day Medical Unit-Oncology, Epworth Healthcare, Richmond, VIC, Australia

**Introduction**

Scalp cooling, a procedure to minimize chemotherapy-induced alopecia (CIA), is well established practice in Britain and parts of Europe and is gaining acceptance in Australia. The procedure allows nurses to expand the care available to patients, but presents many challenges. In November, 2013 Epworth Healthcare, Richmond was the first Victorian hospital to offer a scalp cooling service to patients.

**Objectives**

The aim of this presentation is to report one hospital’s experience of establishing a new service to minimize CIA in selected patients.

**Description**

Planning considered the structure, process and outcomes of the service from the perspective of patients, staff and the organization. Literature provided only limited guidance. Key considerations were resources such as staff, equipment and space; staff knowledge and skills; and policy and procedures.

During implementation key considerations related to: patient education, preparation and comfort; staff engagement, learning needs and workload; and scheduling, capacity management, resourcing, data collection and service monitoring.

**Results/Outcomes**

To date 61 patients have used/are using the service and 18 have completed treatment. Success with minimizing CIA is similar to reports in the literature. Strategies to improve staff engagement and skills have been successful.

Key learnings relate to effective planning, stakeholder involvement, managing patient expectations, data collection and service monitoring. Offering patient's the choice of this service is a point of difference for our organization.

**Conclusions**

The service continues to be offered to our patients. Learning from the challenges encountered during establishing this service can assist other organizations.

Poster 10

Aiming for consistency of practice: a whole-of-region approach to establishing a nursing and allied health network to support coordination of cancer care

**Lea Marshall**

1. Grampians Integrated Cancer Service, Ballarat, Victoria, Australia

**Introduction**

Nursing and allied health professionals occupy a high percentage of the cancer care workforce in the Grampians region of Victoria. However, their capacity to influence cancer care improvements at a strategic level is often overshadowed by existing models.

**Objectives/Aims**

The Grampians Integrated Cancer Service (GICS) is seeking to redress this issue by establishing a regional clinical network for nursing and allied health professionals. It will share an equal voice with three other established GICS working groups for consumers, cancer medical specialists and general practitioners.

**Description/Methodology**

The network focus aligns with the GICS mission: ‘To improve the experience and outcomes for those affected by cancer across the Grampians region by improving access to high quality, integrated, patient-centred care close to home.’

Network membership is self-regulated and returned via expression of interest. Clinical expertise extends from specialized oncology staff to generalist local cancer resource nurses. Membership extends from acute cancer services to community-based care. Executive level interest and buy-in is keen.

**Results/Outcomes**

Contemporary and emerging themes such as professional minimum cancer educational and skills requirements for the cancer, workforce, delivery and provision of optimal supportive care and cancer survivorship care will provide an initial framework to concentrate efforts. Terms of Reference have been completed. Formation of network membership is underway. Launch date is March 2015.

**Conclusions**

An appointed GICS Governance Group member will work with the network to deliver solutions and be a conduit for reporting to the Governance Group. The solutions identified are anticipated to contribute to an improved regional cancer system.
**Poster 11**

**Measuring up against an oral hygiene protocol**

*Trevor Saunders¹, Tracey Dryden*

1. Peter MacCallum Cancer Centre, Melbourne

**Introduction**

Oral hygiene protocols represent best practice for the management of oral mucositis. Cancer nurses have a central role in the implementation of such protocols. The adherence to oral hygiene best practice principles by nurses in our hospital had not previously been evaluated.

**Objective**

To evaluate the impact of an existing evidence-based oral hygiene protocol on the documentation of oral cavity assessment, oral hygiene patient education, pain and bleeding interventions and dental and nutrition referrals.

**Description**

A point prevalence study was conducted at our metropolitan tertiary hospital, collecting details of mucositis symptoms and assessing compliance with an oral hygiene protocol. Participants were inpatients on the day of data collection (n=35).

**Results**

The survey found that most participants were assessed as at risk but only two had documented evidence of oral mucositis. Reported symptoms included oral pain, difficulty eating and drinking and oral bleeding. Around one-third of participants reported receiving education about oral hygiene. None of the participants had documented evidence of a systematic oral assessment and documentation was generally sparse. Compliance with dental referral guidelines was extremely low but all participants meeting criteria for a nutrition review were referred.

**Conclusion**

This small study demonstrates that nursing interventions for oral mucositis in our hospital do not consistently align with best practice. Whilst the generalisability of the findings is limited, the study provides a better understanding of how oral mucositis affects our patients and sets the scene for future improvements to nursing management of this condition.

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**Poster 12**

**Meeting the needs of rural breast care nurses: Our experience of creating and using guidelines that support newer and relieving breast care nurses in rural NSW**

*Rachel Pitt¹, Annette Davis, Susan Wetton*

1. Manning Hospital, Oxley Island, NSW, Australia

**Introduction**

Rural breast care nurses (BCN’s) often have to work alone with little formal support which makes it harder for new and relieving nurses to function optimally.

**Objectives/Aims**

To support new and relieving BCN’s by developing a system that outlined specific and detailed interventions to patients with early breast cancer, together with a database to identify when these interventions were due. This also needed to address the role of the rural BCN in our area.

**Description/Methodology**

“Specialist breast care nurses: an evidenced-based model for Australian Practice”, is a document which outlines details of specific interventions for patients undergoing treatment for early breast cancer. Using this document as the foundation, a new guideline and database was developed that provided details about the information and support that the BCN needed to cover in their interventions with patients and approximate timings of initiated interventions by them.

**Results/Outcomes**

The guidelines and database provided structure and support for new and relieving BCN’s. This gave them confidence and assisted in their development. It ensured that clients were given optimal care and that interventions were not missed. Maintaining the database took time.

**Conclusions**

As rural BCN’s often work without the support of other BCN’s in their immediate team, developing this system provided support for new and relieving BCN’s although it took time to maintain the database. It assisted with providing people with breast cancer with optimal care. It may be replicable across other rural areas.
Poster 13
Evaluation of the “Brightways” Breast Cancer Service

Bronwyn Flanagan¹, Alison Murphy¹, Vicki Durston¹, Laura Connelly¹
¹. Cabrini Brightways, Brighton, VIC, Australia

Introduction
In 2013 a service known as Brightways was established at Cabrini private hospital, the purpose of which is to deliver multidisciplinary, comprehensive and coordinated care for patients with early breast cancer, along the disease trajectory. An evaluation strategy was embedded into the service model to ensure outcomes are measured using quantitative and qualitative data against best practice recommendations.

Objectives/Aims
To ensure 100% of Brightways patients have a minimum of 3 points of contact with Breast Care Nurses.
To evaluate, and where possible, improve the service model.

Description/Methodology
The method of evaluation is twofold:
• Monthly quantitative data is collected electronically and measured against established indicators.
• Patient surveys providing qualitative data.

Results/Outcomes
Both quantitative and qualitative results demonstrate Brightways is achieving best practice, care in a private hospital setting.

Since the launch of Brightways, quantitative results demonstrate increased numbers of points of contact (touch points) per patient.

Qualitative data demonstrates the usefulness of these touch points and suggests areas for improvement.

Conclusions
A successful evaluation strategy for measuring supportive care, for women with early breast cancer has been embedded within the Brightways service.

Two years following the inception, the evaluation highlights that Brightways is delivering a service in a private hospital setting, which is multidisciplinary, comprehensive and coordinated and is measurable against best practice.

Poster 14
Expanding the possibilities in Nursing Education for Central Venous Access Device (CVAD) Management: A cross speciality nursing approach in Southern NSW Local Health District (SNSWLHD)

Melissa Mudie¹
¹. CNC Cancer Services, Southern NSW LHD, Bega, NSW, Australia

Introduction
Increasing numbers of Cancer patients receiving outpatient chemotherapy treatment is trending towards larger numbers of patients presenting to emergency departments and inpatient facilities. Staff skill level in managing CVADs is varied across the 12 sites in our geographically large rural area. A new approach to training staff in CVAD management was developed so all patients can receive safe, evidenced based care.

Objectives/Aims
To support evidenced based care in the management of CVADs and to standardise that care across SNSWLHD.

Description/Methodology
Policy was adopted by SNSWLHD to endorse the NSW Cancer Institute, EviQ Nursing CVAD Information Area as standard clinical procedures. As part of the implementation of this policy a CVAD working party was established with a cross speciality approach and intensive care, renal, general hospital ward and oncology nurses were all represented. Guided also by the Cancer Nurses Society of Australia CVAD Principles for Nursing practice and Education, a package was developed including a PowerPoint presentation, knowledge quiz and set of nursing competency assessments. A train the trainer day was developed to launch this package to CNEs. The response from all sites has been overwhelming resulting in the need for an additional day to be planned.

Results/Outcomes
An evidence based, cross speciality educational package and competency assessments have been developed and over 30 participants are currently enrolled to attend the train the trainer day.

Conclusions
Collaboration across nursing specialties has already led to increased interest in CVAD education with hope for future improvements in patient care.
**Poster 15**

**Patient Treatment Summary Letters – improving communication within the multidisciplinary team.**

*Michelle Beringer*, Natasha Bell
1. Radiation Oncology Institute, Gosford, NSW, Australia

**Introduction**

General Practitioners (GP's) and other members of the multidisciplinary team (MDT) were often unaware that their patients had commenced radiotherapy and were experiencing radiation induced toxicities requiring further management.

It was identified that written communication from the Clinical Nurse Specialist (CNS) outlining Patient Treatment to the GP and MDT during the course of radiotherapy is vital for the ongoing management of radiation induced toxicities and overall improved patient care.

**Objectives/Aims**

To improve communication between the Clinical Nurse Specialist and radiotherapy team to GP's and MDT; subsequently improving patient care.

**Description/Methodology**

A treatment summary letter was developed to be completed by the CNS for each patient having active treatment. This letter was sent midway through treatment and a second letter was sent on completion of treatment. Both letters were sent to GP and MDT involved in the patient's care.

A questionnaire was created and sent to all patients GP's and MDT for the period of 1 Nov - 31 Nov 2014. This questionnaire requested specific feedback on the information provided within the letters and if the GP's/MDT supported the process of communication.

**Results/Outcomes**

86 questionnaires sent with a return rate of 56%. 100% positive feedback on the information provided with 26% requesting more detailed information on topics already discussed. 20% did not know patient was having active radiotherapy treatment without the letter.

**Conclusions**

The treatment Summary letters are an effective tool to improve communication within the multidisciplinary team and further enhance patient care through an integrated cancer care approach.

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**Poster 16**

**Cancer Council Nurses providing telephone-based support to those who care for people with cancer: lessons learned in a research context**

*Benita Heritage*, Chris Rivett, Katherine Lane
1. Cancer Council SA, Eastwood, SA, Australia
2. Cancer Council Victoria, St Kilda, Victoria, Australia

**Introduction**

Often carers of people with cancer provide unrecognised support; many reporting depression and or anxiety related to the burden of caring for someone with cancer. In partnership with Deakin University, SA Cancer Council Nurses provided a nurse-based led intervention to test the efficacy of a telephone intervention to reduce carer burden and depression among carers of individuals newly diagnosed with cancer (the PROTECT study).

**Objectives/Aims**

The purpose of this paper is to describe the experience of being involved in a large NHMRC funded, national randomised controlled trial (RCT), from the perspective of the Cancer Council nurses delivering the intervention.

**Description/Methodology**

This presentation will take the form of a reflective piece, covering impressions from the nurses delivering the intervention on; 1. being involved in a research study; 2. requirements learnt about record keeping; 3. working with researchers from other disciplines; 4. how nurses felt the intervention was received by participants; 5. lessons learned from this experience.

**Results/Outcomes**

Key learning's from Cancer Council nurses’ points of view are that a telephone-based intervention appears to provide carers with a welcomed gateway to Cancer Council support services.

**Conclusions**

Cancer Council nurses welcomed the opportunity to be involved in research. This reflective work describes key lessons learnt that are applicable to nurses interested in being involved in cancer related research projects that provides evidence based practice to support individuals caring for people with cancer.
Poster 17
Review of the neuro-oncology service in a tertiary hospital in Western Australia
Anne King
1. WA Cancer & Palliative Care Network, Perth, WA, Australia

Introduction
Glioblastoma (GBM) is the most common and aggressive primary brain tumour, with a median survival of 14.6 months. Studies suggest that timing of treatment modalities is essential to provide optimal care. This audit compares timeframes at a tertiary hospital in WA with national benchmarks.

Objectives/Aims
• Assess current treatment delivery timeframes in GBM patient care pathways and identify gaps
• Compare findings against recommended benchmark standards

Description/Methodology
Retrospective audit from January 1st to December 31st 2013. Data collated and descriptive statistics generated using Microsoft Excel.
• Inclusion criteria; 18 years or over, histological diagnosis of GBM and treatment at tertiary hospital.
• Timeframes analyses at key points in patient’s care pathway from admission until commencement of treatments. Recommendations developed and presented to stakeholders

For interest, survival was calculated using a Kaplan meier survival curve, final census date 2nd of January 2015.

Results/Outcomes
Total of 78 patients, aged 15-83 years, predominantly male (70%), majority undergoing tumour excision (83%). Treatment information on 75 patients, with 59 patients receiving concurrent chemo/radiation. Median time from surgery to start of radiation was 42 days. Analysis of timeframes showed variation between patients, with treatment delays occurring for some patients.

Final census date showed 45 patients’ now deceased. As expected patients who had tumour resection and concurrent chemo/radiation had an increased median survival (15 weeks versus 70 weeks).

Conclusions
Most patients received timely referrals and commenced concurrent treatment within the recommended six weeks. However some targets have not been achieved with delays occurring between treating specialties. Recommendations developed to improve service delivery.

Poster 18
‘Are you ready to accept accountability?’ Improving patient safety and satisfaction in an acute oncology/haematology unit using a uniform clinical handover tool
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1. Division of Cancer Services, Princess Alexandra Hospital, Woolloongabba, Queensland, Australia
2. Division of Cancer Services, Princess Alexandra Hospital, Woolloongabba, Queensland, Australia

Introduction
Transferring accountability of the care of a patient with cancer from one clinician to the next requires safe, accurate and concise exchanges of information. In Australia, clinical handover is a key domain evaluated by the Australian Council on Healthcare Standards (ACHS).

Objectives/Aims
Auditing data collected at the Princess Alexandra Hospital inpatient oncology unit showed approximately only 40% compliance with safe clinical handover practices according to the base national standard. Therefore, the division of cancer committed to a clinical handover project aiming to improve uniformity of clinical handover practices through engagement in planning and communication of care to increase patient safety and satisfaction.

Description/Methodology
The division of cancer services formed a working party to review the literature and develop an acronym that could be used within the division. The inpatient oncology unit recruited one direct care nurse to lead the project with leadership team support. The acronym ISBARS was developed comprising of; introduction, situation, background, assessment, recommendation and safety scan, with specific information required to be exchanged at each phase. Staff education was provided during December and the project implemented January 2015.

Results/Outcomes
Project evaluation began immediately through independent observational auditing and will continue weekly for up to 6 months. Early auditing results have shown greater than 80% compliance.

Conclusions
This project will be sustained through ongoing auditing and regular review of clinical incident reports to look for a decrease in incidents related to clinical handover. Finally increased satisfaction will be evaluated through Best Practice Australia surveys every 6 months.
Poster 19
The incidence of chemotherapy induced nausea and vomiting (CINV) in patients receiving moderately emetogenic chemotherapy (MEC) and the role of nurses in providing effective management.

Meagan Taylor1
1. St John of God Murdoch, Murdoch, WA, Australia

Introduction
An audit was conducted to measure the level of patients experiencing CINV in MEC regimes. The audit allowed the chemotherapy clinic to reflect on current practice and look at implementing better strategies for the nurses to manage CINV for patients receiving MEC.

Objectives/Aims
To measure the level of CINV experienced by patients having MEC regimes. To improve patients quality of life by measuring and improving nurses assessment practice to foster better communication and education between nurses and their patients.

Description/Methodology
Four oncology nurses working in the outpatient setting were involved in the trial. 29 patients were selected in this trial after fulfilling the strict criteria including; patients starting their first cycle of any MEC treatment and a diagnosis of colorectal, lung or ovarian cancers. Ethics approval was also granted, patients were given diaries to take home and were asked a series of questions, rating their experience and actions taken. Documentation was audited to measure education and actions taken by nursing staff.

Results/Outcomes
The results showed 56% of patients suffering from nausea only whilst having MEC. The audit also showed 69% not documented by nursing staff and 48% of patients reported a decrease in their quality of life. An anti-neoplastic toxicity assessment tool has since been implemented to assess nausea and all other potential side effects and an algorithm of management for the nursing staff to use.

Conclusions
This trial is an effective way of measuring CINV with patients having MEC and improving the assessment and management by the nursing staff.

Poster 20
Neuroendocrine tumor (NET) Australian and New Zealand patient experience: Results from the first global NET patient survey – A collaboration between the International Neuroendocrine Cancer Alliance (INCA) and Novartis

John Leyden1, Dale Long1
1. Unicorn Foundation, Mosman, NSW, Australia

Introduction
Quality of life (QoL) is important in patients diagnosed with cancer. Despite a rising incidence of Neuroendocrine Tumours (NET), few studies document the NET patient experience. We present data on quality of life (QoL) from an Australian and New Zealand NET patient perspective.

Objectives/Aims
To raise awareness of the NET-related burden and share patients perspectives on NET.

Description/Methodology
In 2014, 1928 NET patients from >12 countries (Americas, Asia, Europe, Oceania) participated in a survey, conducted by Hall & Partners on behalf of the International Neuroendocrine Cancer Alliance (INCA)/Novartis on the NET patient experience. Oceania (Australia and New Zealand) represented 8% (138/1928) of the survey population and will be presented in this abstract (comparisons significant at P<0.05)

Results/Outcomes
Most patient’s QoL was negatively affected by the diagnosis of NET with patients diagnosed > 5 years more than those diagnosed recently (65% vs 48%) and patients with a gastrointestinal NET more than pancreatic NET or lung NET (64%; 41%; 23%). Negative effects on energy levels and emotional health predominated; the majority of patients made disease imposed changes in lifestyle with increased time and money spent on medical care and travel.

Anxiety, stress and worries about an uncertain future were the most common feelings due to NETs and patients believed that better access to NET specific treatments and more general awareness of NET would help them live better.

Conclusions
Patients with NET suffer significant impairment to QoL due to misunderstandings in the medical and general community which represents an opportunities for improvement to enhance patient care.
Poster 21
Development of a geriatric online education resource for nurses to improve the care of older people with cancer.

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⁷. Western Central Melbourne Integrated Cancer Services (WCMICS), Melbourne, Victoria
⁸. Workforce Education Development Group (WEDG), Sydney Medical School, The University of Sydney, Sydney, New South Wales

Introduction
In Australia, it is estimated that 65% of all new cancers in women and 75% in males will be in people aged 60 and older (Australian Institute of Health and Welfare, 2014). Integration of geriatric oncology into the training programs of healthcare professionals is recognised as an urgent priority (Steer et al., 2009).

Objectives/Aims
To develop and pilot test an online geriatric oncology education resource for cancer nurses.

Description/Methodology
The online education resource will include four modules, covering:
1. Changes associated with ageing (including definitions of ageing and assessment)
2. Impact of cancer and treatment on older people
3. Communicating with older people about cancer and treatment
4. Professional issues associated with caring for older people with cancer

Modules are being developed and reviewed by nurse educators, a multi-disciplinary expert panel, and consumers.

A minimum sample of 40 registered cancer nurses will be recruited from the Royal Melbourne Hospital, Western Health, The Royal Women’s Hospital, Peter MacCallum Cancer Centre and Cancer Nurses Society of Australia to pilot test the resource. Consenting nurses will be asked to complete at least one of the four modules and corresponding evaluation form to assess module presentation, layout, length, content, clinical relevance and usefulness.

Results/Outcomes
Descriptive statistics and content analysis will be used to analyse evaluation data. Findings will be used to refine the education resource prior to its national release.

Conclusions
This Australian-first online education resource will provide Australian cancer nurses with the opportunity to expand their knowledge of patient-centred geriatric oncology care.

Poster 22
Palliative radiation therapy nursing role – An innovative multidisciplinary approach

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¹. Radiation Oncology Mater Centre, Princess Alexandra Hospital, Brisbane, Queensland, Australia

Introduction
Palliative radiotherapy is an integral part of palliative medicine that potentially improves quality of life for people with advanced cancer. Very few radiation oncology centres, nationally and internationally, have dedicated palliative radiation therapy programs. In 2005 the Radiation Oncology Mater Centre, Brisbane, became the first centre in Australia to introduce a Rapid Response Palliative Radiation Clinic (RRPRC). This multidisciplinary team consists of a Radiation Oncologist with specialist palliative care training, an Advanced Practice Radiation Therapist who facilitates treatment planning and delivery, and a radiation oncology nurse.

Objectives/Aims
The aim of this project is to evaluate the role of a radiation oncology nurse with palliative care expertise as a member of the RRPRC team will enhance patient care. The secondary aim of the project is to support institutional decision-making regarding the implementation of this particular nursing role in a sustainable manner for the future.

Description/Methodology
A project is currently underway to determine the efficacy of this nursing role using a mixed method realistic evaluation approach. This will be achieved through thematic analyses of interview data of patients, carers and staff, and collection of survey data pre and post radiation therapy.

Results/Outcomes
Currently the nursing position is staffed as part of the primary nursing model in the department and is not a recognised palliative radiation oncology nursing position. It therefore lacks identity and sustainability as part of this dynamic palliative radiation oncology team.

Conclusions
This project aims to formally establish the role of a palliative radiation oncology nurse as part of the RRPRC team.
Poster 23
NeuroEndocrine Tumour (NET) Support Nurse – Providing support to geographically dispersed patients affected by neuroendocrine cancer.

Dale Long¹, John Leyden¹, Simone Leyden¹
1. Unicorn Foundation, Blairgowrie, Victoria, Australia

Introduction
NETs are an uncommon, heterogeneous group of malignancies that are frequently diagnosed at an advanced stage. The chronic nature and unpredictable course of NET, associated with a widespread misunderstanding and lack of knowledge about disease management can result in a challenging and uncertain NET patient journey.

Objectives/Aims
To deliver accurate, NET disease specific information and support through a Specialist NET Cancer Nurse telephone and internet support service.

Description/Methodology
The Unicorn Foundation Australia employed the first NET Specialist Nurse in January 2014 to meet the demands of NET patients for NET specific information on management, treatments, research and referral processes to NET specialists and NET Multi Disciplinary Teams which were not generally available through other Australian cancer support services.

Results/Outcomes
Over the first year the service received an average of 5 contact points per day (range 3-12) with significant referrals from established organisations such as the Cancer Council. The service, independent of any hospital, received calls / enquiries via a 1300 number, the internet and via social media channels from both metropolitan (38%) and rural (62%) Australia.

Patient enquiries focused on the challenges of recent diagnosis; information about NET medical Specialists / MDTs; evidence-based information on NET management and treatment and general psychosocial support.

Analysis of results of the first year of the NET Nurse Specialist role revealed a positive impact on hundreds of Australian NET patients.

Conclusions
Patients with uncommon cancers such as NET need disease specific information and support to improve their emotional well-being and quality of life.

Poster 24
Developing and implementing a brachytherapy clinical pathway for locally advanced cervical cancer – a collaborative approach

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1. Radiation Oncology Institute, Gosford, NSW, Australia
2. Radiation Oncology Institute, Wahroonga, NSW

Introduction
This project explores the role of the radiation oncology nurse within the brachytherapy team at the Radiation Oncology Institute at Wahroonga. Brachytherapy is a highly specialised form of radiation that uses radioactive sources, Iridium-192, to deliver radiotherapy. Patients require general anesthetic to place intracavity +/- interstitial applicators, that must be kept stable for accurate dose delivery and optimal outcome to the treatment.

Objectives/Aims
The clinical pathway was developed and implemented during 2014 with the aim of setting, monitoring and improving the delivery of nursing care for patients undergoing cervical brachytherapy.

Description/Methodology
The clinical practice improvement model was used, Plan, Do, Study, Act.

There were patient safety issues identified early in 2014 stemming from a lack of a standardised systems based approach, inadequate clinical handover and workforce training issues.

The nursing literature identified pain, distress and nausea as priorities for nursing care, and a learning program was developed in consultation with the nurse educators.

Results/Outcomes
Between April to December 2014 a total of 15 patients received cervical brachytherapy, and adherence to the clinical pathway was maintained in 100% of cases. Clinical handovers were completed and documented every time the patient care was transferred between departments and shifts.

Conclusions
This project demonstrates the important role of radiation oncology nurses. Since the introduction of the clinical pathway there were no further incident reports, and there was greater nursing collaboration and communication between the departments.
**Poster Abstracts**

**Poster 25**  
**Does the role of evidence change nursing practice when handling antineoplastic medications and related waste?**  
*Michelle Weston¹, Leanne Stone¹, Doreen Tapsall¹, Jessica Scaife¹*  
1. Cancer Services, Princess Alexandra Hospital, Brisbane, QLD, Australia

**Introduction**  
Despite control measures introduced to provide optimum protection when handling or administering antineoplastic medications and related waste, evidence cannot demonstrate that these eliminate risk of exposure. National and International guidelines recommend, staff handling and, or administering antineoplastic medications and related waste must use full Personal Protective Equipment (PPE) including a particulate P2 (N95) mask.

**Objectives/Aims**  
Although strong compliance has been exhibited in the use of impermeable gowns, goggles and gloves, use of respiratory protective equipment (RPE) has not been routinely used within local practice. The objective of this paper serves to investigate the process of implementing a practice change through evidence and education.

**Description/Methodology**  
An International literature search on handling antineoplastic medications and related waste was undertaken. Proposed practice change was delivered through chemotherapy education workshops. Ensuring available supply of N95 masks, and that these were correctly fitted. Dissemination of Antineoplastic Drugs and PPE Fact sheet with attached fit testing advice throughout Cancer Services. Audits were undertaken on experienced Cancer nurses in a high flow oncology day therapy unit prior to implementation of practice change and for 2 months following to monitor compliance.

**Results/Outcomes**  
Preliminary results indicate that no staff utilized this practice. However with the implementation of the above strategies, results should indicate a positive practice change.

**Conclusions**  
Effective planning and implementation of a practice change based on evidence, is needed to support nursing staff to follow recommendations to wear full PPE during handling, administration, and spill and waste management of antineoplastic drugs.

**Poster 26**  
**A Multidisciplinary Nursing Approach to the Management of a Fungating Merkel Cell Carcinoma during Radiotherapy**  
*Roach Michelle¹*  
¹. Liverpool Hospital, Liverpool, NSW, Australia

**Introduction**  
Implementing a multidisciplinary nursing approach proved valuable in the care of a patient undergoing radiotherapy for a fungating Merkel Cell Carcinoma.

Involvement of Radiation Oncology, Palliative Care and Wound Care Clinical Nurse Consultants (CNCs) provided the patient with expert care to manage radiotherapy treatment reactions, increasing pain issues, tumour ooze and odour control problems.

**Objectives/Aims**  
To provide a care plan which enabled the patient to complete radiotherapy, whilst being able to manage treatment reactions and pain issues. A plan that encouraged patient involvement was critical. Patient acceptance and compliance of an analgesic regime which would improve his quality of life was also a main focus.

**Description/Methodology**  
Through multidisciplinary nursing consultation, a patient plan was developed. A critical factor in the success of this plan was continual involvement of the patient and his family. Regular review and reassessment throughout the patients’ radiotherapy treatment enabled the patient to complete radiotherapy with the expected treatment reactions being managed in an acceptable manner.

**Results/Outcomes**  
By the involvement of the Wound Care CNC, dressing materials and techniques that were unfamiliar to the radiation therapy nurses were able to be utilised. Involvement of the Palliative Care CNC enabled prompt and effective consultation with Palliative Care doctors to manage increasing opioid analgesia needs.

**Conclusions**  
The Radiation Oncology CNC was able to facilitate the coordination of the multidisciplinary nursing teams, initiate Allied Health referrals and communicate treatment goals and progress to the Radiation Oncology team, whilst also acting as the point of contact for the patient.
**Poster 27**

**Implementation of a Subcutaneous Immunoglobulin (SCIg) Program in a Regional Health Service**

*Tammy Lehn-Van Diem*, *Leanne Hollis*

1. Sunshine Coast Hospital and Health Services, Nambour General Hospital, Nambour, Qld, Australia

**Introduction**

Subcutaneous immunoglobulin (SCIg) was approved for use by the National Blood Authority in 2013. This approval would apply to specific patients with primary and secondary immunodeficiencies. The Sunshine Coast Hospital and Health Service’s Haematology and Immunology Departments identified a need to implement a SCIg program for adult patients.

**Objectives/Aims**

Previously, the only option patients were given is intravenous immunoglobulin requiring treatment every 3-6 weeks in the day unit. With regular weekly subcutaneous injections the objective was to improve the patient’s condition by keeping immunoglobulin levels stable. The stable levels would decrease the amount of infective episodes, thereby decreasing the episodes of inpatient admissions. Overall and most importantly, this would mean a better quality of life as the product would be administered by patients in the home at a time and day convenient to them.

**Description/Methodology**

The Transfusion Clinical Nurse Consultant co-ordinated the implementation of the SCIg program. A training day was undertaken by key medical, nursing and laboratory staff. Patients attend training at their choice of treatment units to learn how to self-administer SCIg safely, and are followed up monthly by trained nurses. A data base tracks and monitors the outcomes.

**Results/Outcomes**

Since the implementation of the SCIg program we have had 32 patients. Twenty six of those currently self administer SCIg. Patient satisfaction was the greatest outcome as 95 percent reported an improvement in their quality of life.

**Conclusions**

The implementation of the SCIg program has been a success for those who matter the most – our patients.

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**Poster 28**

**Developing a Nurse Led Clinic in a Non-Government Organisation to Improve Patient Outcomes.**

*Peggy A Briggs*

1. WA Country Health Service, Perth, WA, Australia

**Introduction**

Rural patients residing in Perth for cancer treatments do not have access to their usual health team. Access to patients by the Metro based Rural Cancer Nurse Coordinator (MRCNC) was ad hoc and time consuming when attending the Cancer Council Western Australia (CCWA) accommodation facilities. It was perceived that patient outcomes could be improved by streamlining access, assessment and intervention.

**Objectives/Aims**

To improve care coordination and outcomes for rural patients undergoing cancer treatments, specifically to:

- Facilitate referral to the MRCNC
- Facilitate coordination of care
- Improve efficiency of MRCNC service

**Description/Methodology**

- Liaison with CCWA management to establish a fortnightly clinic at Milroy Lodge.
- Development of a booking system to allocate time framed appointments.
- Negotiation for use of a private room for consultations.
- Use of the distress thermometer to assess patient’s distress.
- Coordination of care according to patient needs.

**Results/Outcomes**

Data were collected over a 12 month period between August 2013 and 2014. One hundred and thirty-seven occasions of service (94 patients) resulted in 128 onward referrals. Practical problems (47%) and symptom management (30%) were the main causes of distress. Twenty-two percent of episodes were considered complex and involved referrals to multiple health agencies.

**Conclusions**

A nurse led clinic, established to meet the needs of rural cancer patients undergoing cancer treatment, proved successful in facilitating coordination of care, increasing referral to the MRCNC and improving efficiency of service.
Poster Abstracts

Poster 29
Development of a brachytherapy pathway for locally advanced cervical cancer

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Introduction
Caring for cervical brachytherapy patients was a new clinical procedure for the hospital thus adding to the normal complexity of delivering cancer care. The majority of patients included in this project were from New Caledonia and did not speak English. There was cultural difference, communication issues, geographical and social isolation which all contributed to the significant vulnerability of the patient group.

Objectives/Aims
Ensuring patient safety by providing comprehensive nursing education through collaborative practice between departments and to improve nursing knowledge, confidence and skill when caring for patients having cervical brachytherapy pre and post-operatively.

Description/Methodology
The use of Plan-Do-Study-Act clinical practice improvement model was used during the quality process. A literature review was undertaken and identified common side effects and potential risks and analyses and priorities were addressed in the pathway development process.

In-servicing addressing cultural and linguistic aspects relating to this patient group were commenced by the Radiation Oncology department. Focused in-services were given to nurses in the ward as well as workshops.

Results/Outcomes
Nursing practices developed for the clinical pathway were founded upon best available evidence to ensure patients received the highest available care. Development of a clinical pathway was implemented which resulted in a positive outcome in cervical brachytherapy nursing.

Conclusions
The use of cultural diversity and collaborations between departments with education ensured safe practice including improved staff confidence and competence as per workforce surveys. Ultimately patient safety was obtained through proper implementation of a unique model of care tailored for cervical brachytherapy patients.

Poster 30
Justifying your existence in specialist cancer nursing roles

Julie Sykes¹
1. Prostate Cancer Foundation of Australia, ST LEONARDS, NSW, Australia

Introduction
The role of the Nurse in the provision of specialist psychosocial and coordinated supportive care to those affected by cancer is well documented. Additionally, there is a growing body of evidence demonstrating the positive impact of specialist roles on the patient care experience. Prostate Cancer Foundation of Australia (PCFA) has endeavoured to bridge this gap through the introduction of a Prostate Cancer Specialist Nursing Service. This program piloted 12 PCSN’s nationally for 3 years with the view to the positions becoming an embedded service in the host hospital. The Service operates from a structured framework which is based on best practice guidelines and PCFA support the role with a professional development framework. Evaluation of the role demonstrated a benefit to the patient group at both a clinical and strategic level. However, despite evidence to support the benefits of such roles, economic constraints dictate that funding for such positions still require a competitive tender for permanency. This requires the input of all key stakeholders, including the current post holder.

Objectives/Aims
The purpose of this presentation is to demonstrate to Nurses their role in influencing the outcomes in building a sustainable specialist nursing workforce. This has relevance across all specialist cancer nursing roles.

Results/Outcomes
Using the PCFA Prostate Cancer Specialist Nursing Service as an example, this presentation demonstrates the need for a robust operational model which includes effective program evaluation with active involvement from the Nurse to maximise the opportunity for continued growth and development of these essential roles.
Poster 31
Nursing presence as a nursing intervention for the dying child with cancer: A qualitative research using participatory method

Surasak Treenai
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Introduction
Nursing presence is an integral part of nursing intervention for the dying child with cancer but nurses expressed uncertainties about “How to create nursing presence as the nursing intervention?” Moreover, nursing presence is a complex concept that is vague and difficult to defined. The scope and detail of nursing presence as nursing intervention is necessary.

Objectives/Aims
To develop and define nursing presence as a nursing intervention

Description/Methodology
Research participants consisted of 20 nursing staff. The study was divided to three phases. The first phase was a situational analysis. The second phase involved working out for developing nursing presence as nursing intervention thought the application of Watson’s human caring theory. During this phase researcher was interview and observe the participants when they provide nursing care for dying child. In addition, the nursing care plan was analyzed. The last phase, nursing presence as nursing intervention was concluded and discuss with all participants by focus group.

Results/Outcomes
Four caring action of nursing presence as nursing intervention were emerged as; caring of spiritual, caring of family, caring therapeutic and caring for dying. Every caring action related with Watson’ human caring theory with the specific detail and can use as nursing intervention for the dying child with cancer.

Conclusions
These findings may help nurses recognize the importance of the link between nursing presence, nursing intervention and nursing theory. Additionally, the findings can be used as a direction to improve nursing care for the dying child with cancer.
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Interactions: co-administration with drugs that prolong QT interval and/or cause electrolyte abnormalities; apomorphine; potent inducers of CYP3A4 (i.e. phenytoin, carbamazepine, and rifampicin); tramadoli; others (see full PI). Adverse Effects: Headache; sensation of warmth or flushing; constipation; xerostomia; local anal/rectal burning sensation following insertion of suppositories; asymptomatic increases in liver function tests with cisplatin; local I.V. injection site reactions; others (see full PI).

Dosage and Administration:
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- Place wafers on top of tongue where it dissolves within seconds, and is swallowed.

Emetogenic chemotherapy and radiotherapy: Adults: 8 mg by slow I.V. injection in not less than 30 seconds, immediately before treatment or two oral doses of 8 mg each at 12 hourly intervals, the first dose given 2 hours before treatment or single 16 mg suppository, 2 hours before treatment. For prevention of delayed emesis after the first 24 hours: 8 mg oral twice daily, or 16 mg suppository rectal once daily, for up to 5 days after a course of treatment. Children: experience is limited. 4 years and older: Give I.V. at 5 mg/m² over 15 minutes, immediately before chemotherapy, followed by oral 4 mg twice daily for up to 5 days. Suppositories are not recommended. Highly emetogenic chemotherapy: Adults: 8 mg by slow I.V. injection in not less than 30 seconds, immediately before treatment. If required, higher additional I.V. doses may be given up to a maximum of 32 mg in 24 hours. Post-operative nausea and vomiting (injection only): Adults: give 4 mg by I.M. or slow I.V. injection. Up to 8 mg if necessary for treatment. Children: 2 to 12 years: slow I.V. injection at 0.1 mg/kg up to 4 mg. Hepatic impairment: Maximum total daily dose of 8 mg in moderate or severe dysfunction. See full PI. (PI last amended 24 Sept 2012). References: 1. TK Giri, et al. International Journal of Pharmacy and Pharmaceutical Sciences Vol 2, Suppl 3, 2010. 2. Zofran Product Information v5 24 Sep 2012. Prepared: Apr 2015. FD15347 ASP343.1

PBS Information: Zofran Zydis wafer. Authority required: Management of nausea and vomiting associated with radiotherapy used to treat malignancy. Restricted Benefit: management of nausea and vomiting associated with cytotoxic chemotherapy being used to treat malignancy which occurs within 48 hours of chemotherapy administration.
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