Issue 3

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ONCOLOGY NURSING PROGRAM

Working collaboratively to Advance Cancer Control through Excellence in Oncology Nursing

Oncology Nursing Program Newsletter

cancer care ontario | action cancer ontario

Welcome to the third edition of the Oncology Nursing Program Newsletter. Our intent on writing these newsletters is to provide a summary of the work that has been completed or is in progress as a way to inform a broad audience. We need you to forward the newsletters to your colleagues, staff and others who might share common interests. We welcome your feedback or questions.

Since the last newsletter, several new members have been added to the Oncology Nursing Program Committee (ONPC): Heather Burden, Lakeridge Health; Maureen Watt-Smit, Grand River Regional Cancer Program; Barbara Fitzgerald, new Director of Nursing, Princess Margaret Hospital (replacing Karen Gayman); Camille Robinson, Humber River Regional Hospital; Dana Taylor, Royal Victoria Hospital (Barrie), and Kelly Bodie, South-Eastern Ontario Regional Cancer Program (Kingston). Please contact us for new membership.

There are a number of initiatives currently underway that we need to be aware of. For example, in Health Human Resource Planning (HHRP), the Consensus Report on Oncology Advanced Practice Nursing in Ontario has released; and there is work underway to consider the needs in systemic therapy programs for all related health human resources. We did a quick survey to assess the vacancy rates in nursing with respect to inpatient and ambulatory cancer care. Moreover, we need to consider new roles in the cancer system and the article written by Ingrid LeClaire outlines a pilot project to introduce Registered Nurses to perform flexible sigmoidoscopy, assess patients, teach them health behaviours and access follow up care, as needed. The project is a partnership with the MOHLTC, as well as 6 sites across the province. We need to consider innovation in relation to HHRP to maximize the HR to meet the needs of cancer populations in the future.

Finally, the Primary Care Launch (Oct 2008), represents a significant move to engage the primary care practitioners in the cancer system, beginning with prevention and screening initiatives. Dr. Cheryl Levitt, Provincial Lead, Primary Care, has worked with all the regional cancer programs to identify primary care leads for each program. http://www.cancercare.on.ca/english/home/about/newsroom/newsreleases/primcarestratrel/. Meet the lead in your program and find out more about this initiative.

Esther Green
Provincial Head - Nursing & Psychosocial Oncology
Cancer Care Ontario

Oncology Nursing Program Committee Update

The Oncology Nursing Program Committee will be having its face-to-face meeting on February 25, 2009. A working group will be struck to help organize the meeting as well as putting out a call for topics and speakers for the day. Current initiatives of the group include: creation of a document for IV Pumps in Radiation to further safety related mandates post incidents across the nation, collecting information on positions, vacancies and other HR indicators in oncology nursing to build a database of oncology nursing information for Health Human Resource planning, chemo education program to standardize a high quality program across the province, and the bi-annual release of this nursing newsletter to keep stakeholders informed and involved in happenings of the program. Monthly teleconference meetings will continue on the 4th Wednesday of the month. Next meeting is scheduled for Wed. January 28, 2009. For more information, please contact: Lena.Roccasalvo@cancercare.on.ca.

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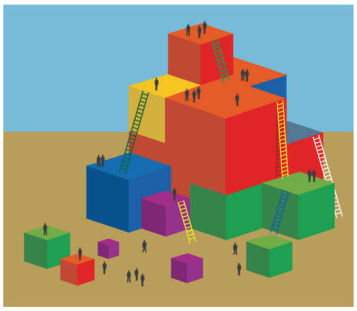


Ontario Cancer Symptom Management Collaborative - Susan King

The Ontario Cancer Symptom Management Collaborative (OCSMC) is an initiative by Cancer Care Ontario (CCO) to promote earlier identification, documentation, and communication of patient's symptoms, optimal symptom management and collaborative care planning for patients who require palliative care services. Provincial improvement aims have been developed to guide the work of the regional cancer centres, including aims for symptom screening and assessment, symptom control, functional status assessment and coordinated palliative care support.

A set of common tools is being implemented in each of the regions to promote a common language amongst patients and providers and across care settings. One of these tools is the Edmonton Symptom Assessment System (ESAS), a validated symptom screening tool. Patients are asked to rate the severity of 9 common cancer symptoms, e.g. pain, shortness of breath, nausea and anxiety. A patient's perception of how they feel is considered to be the gold standard. If a patient identifies a moderate to high score, clinicians are then guided to do further assessment. Clinicians are also provided with a symptom management tool to guide decisions leading to optimal symptom control for patients.

ESAS was initially available as a paper-based tool, but in order to improve communication of symptom scores across the circle of care (e.g. hospitals, home care) and enhance patient engagement in the process, CCO developed software known as ISAAC to allow patients to enter their symptom scores directly at a kiosk at the cancer centre clinic or from home via the internet. ESAS scores are reported as a histogram and include scores entered both at the cancer clinic and from home, enabling symptom severity tracking over time and across health care settings. The software also provides the capacity for clinicians to be notified by e-mail when the score is in the moderate to severe range, so that appropriate steps can be taken to improve symptom control, including referrals to specialized services. A user satisfaction conducted with over 400 patients in 2007 showed that 85% thought ESAS was important to complete as it helps providers know how they are feeling. Only 61% agreed that their providers took into consideration ESAS symptom ratings in developing a care plan, and 62% indicated that their pain and other symptoms have been controlled to a comfortable level, indicating that further work is needed to engage clinicians in actively responding to ESAS scores.

Other common tools that are being used are for functional status assessment and care planning for patients. Functional status is assessed using either the Palliative Performance Scale (PPS) or the Eastern Cooperative Oncology Group (ECOG) assessment tool. Scores on the functional assessment tool and certain identified patient symptoms then correspond with a set of Collaborative Care Plans (CCPs).

Reports on regional progress toward meeting the improvement aims and to help guide improvement activities can be generated through ISAAC. Progress toward achievement of the provincial improvement aim that 90% of lung cancer patients attending regional cancer centres will be screened for symptom severity using ESAS is being reported as part of Cancer Symptom Quality Index (CSQI) as of May 2008. In addition to meeting the 90% aim for lung cancer patients in 2008/09 regions have been provided with the target of achieving symptom screening for 30% of all other cancer patients.

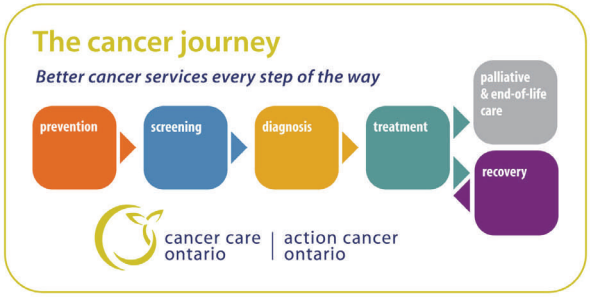
Funding is being provided to the regions over the next 3 years to support the ongoing work of the OCSMC. CCO is also exploring the potential of developing Tele-ISAAC to allow patients to call in their ESAS scores from home and is supporting further process improvement work related to use of the ISAAC kiosks and home internet use. Committees have been formed to review and update the existing Collaborative Care Plans and Symptom Management tools.

For more information about the OCSMC contact Susan King at: susan.king@cancercare.on.ca.

Disease Pathway Management

Cancer Care Ontario is introducing an approach called Disease Pathway Management (DPM) to guide the way we set priorities for cancer control, plan cancer services and improve the quality of care.

The objective is to examine the entire system for prevention, early diagnosis and care for specific types of cancer in an effort to ensure Ontario offers the best quality and most efficient services possible for patients, while improving the experience of those interacting with the system. This includes examination of the transitions between the different steps in the cancer journey to expose any quality gaps and bottlenecks along the way.



Our Disease Pathway Management Program will develop a framework for evaluating the performance of the cancer system across the cancer journey for specific cancers. Based on the results, the Program will advise on an integrated program of quality initiatives across all phases of the journey.

The key outcomes for the program will be:

- Greater focus on the patient's perspective
- Better collaboration and integration of programs
- New partnerships to leverage resources
- A more comprehensive view of the whole cancer journey
- A more explicit approach to planning and quality improvement.

The initiative will launch reviews of 1 or 2 cancer sites each year, starting with colorectal cancer and followed by lung cancer for 2008. Colorectal cancer is the first type of cancer for which we will be using this new approach. Looking across every phase of colorectal cancer will help us better understand the journey, and how best to provide resources and monitor cancer system performance each step of the way.

A province-wide multidisciplinary team spanning the cancer journey has been established. Their first job was to map out the entire patient journey, from prevention and screening, to survivorship and end-of-life care. The team examined what are doing in Ontario related to CRC, where there are gaps between knowledge and practice, and whether there are aspects of the system for which we are lacking the ability to measure our effectiveness. The team is currently developing recommendations for priorities for action to address the gaps identified. The actions will focus on improving quality, processes, and patient experience, three elements that are central to effective disease pathway management.

The team will promote continuous quality improvement by developing a comprehensive suite of indicators to assess and report on the current state and progress over time.

The team shared findings and recommendations with a broader group of stakeholders at a symposium on November 10, 2008, soliciting broad input before plans were finalized to move forward.

Chemotherapy Education - Raquel Shaw Moxam

An initiative is underway to develop a curriculum for chemotherapy education for nurses with an aim to advance the quality and standard of chemotherapy care delivery across the province. This initiative supports the establishment of standards within the Regional Systemic Treatment Program and will assist organizations at all levels (Satellite, Affiliate or Regional Cancer Centre) to comply with identified standards around nursing education/certification for delivery of systemic treatment. A provincial subgroup has been struck to define the required competencies and establish a means for certification. Draft content has been developed and the components of the curriculum have been identified and agreed upon by members of the subgroup as well at the Oncology Nursing Program Committee. Examination questions in support of certification have also been developed. Items are based on evaluation tools used by different organizations across the province; key questions have been chosen for the examination, which reflect common content among the various organization specific tools used. Please look for more details on this initiative as it rolls out. For more information contact Raquel Shaw Moxam at raquel.shawmoxam@cancercare.on.ca.

Regional Systemic Therapy Program - Sherrie Hertz

The Regional Systemic Treatment Program (RSTP) is designed to support the planning and implementation of regional models of care for systemic treatment to fit current and future predicted needs of the increasing burden of cancer on the health system. The 14 LHINs have submitted plans to CCO for their regional systemic treatment programs. Work that has gone into the development of the plans include: analysis of the current state, patient volumes, patient travel patterns and concordance with the Regional Models of Care for Systemic Treatment: Standards for the Organization and Delivery of Systemic Treatment (http://www.cancercare.on.ca/pdf/pebc12-10s.pdf). Groups looked at the current state and projected patient volumes into 2011/2012.

The RSTP, along with Regional Programs and Planning Departments at CCO have been working with the regions to further develop their plans where information is incomplete and then taking the regional plans, pulling out common themes and developing a provincial plan. The main provincial plan will have the 14 individual local plans appended as summaries. Common themes highlighted included the funding model, sufficient resources, health human resource (HHR) issues and innovations.

An Analytical Working Group that includes CCO staff, external partners and a Clinical Reference Panel has been struck to further look into the HHR issue.

The RSTP at CCO is now in the early stages of working on trying to identify indicators for success of the Regional Systemic Treatment Program.

The RSTP members are also working closely with Esther Green, Provincial Head of Oncology Nursing and Psychosocial Oncology, on ambulatory pump safety issues. A survey went out in October to look at a national approach to looking at IV chemo pump safety. In addition, others areas of pump safety being examined include: safe labeling guideline development; the appropriate use of medication pumps during radiation therapy.

For more information contact Sherrie Hertz at sherrie.hertz@cancercare.on.ca.

APN Community of Practice Update - Cathy Kiteley and Carolyn Dempsey

In the summer of 2008, a membership survey was conducted by the Ontario Oncology Advanced Practice Nursing Community of Practice (APN-COP). The purpose of the survey was to evaluate the current structure of the COP and assess progress toward achieving strategic goals. In addition, the survey will inform the group of further opportunities to enhance the work of the COP. Survey Monkey was used to collect information. The response rate for the survey was almost 60% of the total membership. Key findings from the survey resulted in four overarching themes that could assist with formulation of strategies for improvement.

Demographics of the group revealed that while almost equal numbers identified themselves as either a Nurse Practitioner (NP) (31.9%) or Clinical Nurse Specialist (CNS) (29.8%), 31.9% of respondents identified themselves as an Advanced Practice Nurse. This finding supports the work that is in the conclusionary phase by the COP's Role Clarity Working Group, which is creating a position statement targeted to administrators that articulates the contribution and difference between oncology and palliative care NPs and CNSs in cancer control.

Recruitment and orientation of new members were uncovered as a key area of improvement. Informal methods, such as word-of-mouth to recruit new members to the COP, is currently used, rather than targeted recruitment and marketing, therefore, the group does not know if all oncology/palliative care APNs are aware of the COP. Of those who joined the APN-COP in the last two years, 26.7% indicated that the orientation could have been better, whereas 20% revealed that they did not receive an adequate orientation. While we have created an online orientation package for new members, the survey results indicate one-to-one contact will improve the introduction and orientation of new members.

Communities of practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their understanding and knowledge of this area by interacting on an ongoing basis.

It was interesting to learn that while over 50% of the participants reported that most of the strategic goals outlined by the COP were being achieved, less reported achievement of the goals surrounding the development of evidence-based oncology advanced practice nursing through participation in research and knowledge transfer and translation (23.9% indicated well achieved vs. 50% somewhat well), and influencing and informing health policies that impact oncology APN roles (25% specified well achieved vs. 47.7% somewhat well).

Throughout the survey, there are references identifying the need to integrate practice-related professional development activities to support the APN role. All role dimensions were identified as a priority. Recommendations comprised providing opportunities to discuss role implementation challenges and generate solutions; inviting guest speakers; discussing trends, issues and positive APN uptake in organizations; and participating in local face-to-face meetings with APN-COP colleagues within their LHIN region.

For more information contact Carolyn Dempsey or Cathy Kiteley at carolyndempsey@rogers.com or ckiteley@cvh.on.ca.

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If there are topics or issues you would like us to address in the newsletter, let us know!
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Cancer Care Ontario is the provincial agency responsible for continually improving cancer services. As the government's cancer advisor, Cancer Care Ontario works to reduce the number of people diagnosed with cancer and make sure that patients receive better care every step of the way.

Health Human Resources: Oncology Nursing - Prabhjot Minhas

With the increasing burden of cancer in the health care system, the need for health human resources is increasing at an alarming rate. To examine this impending nursing shortage, data was needed to plan for nursing human resources in the cancer system. A database of information for oncology nursing in Ontario outlining total positions, role mix and vacancy rates is necessary. In order to fulfill this demand, a Nursing Vacancy Survey was conducted in June 2008. The survey was sent to all ONPC members as well as regional managers throughout the province. 33 total responses were received and 11/13 regions were represented. Majority of Oncology Nursing Positions are found in inpatient (dedicated or mixed units), systemic therapy or ambulatory clinics (92% FT and 85% PT). Approximately half of respondents (52%) had nursing vacancies (on average 3 positions). When vacancies were examined by regions, the oncology nursing vacancy was found to be prevalent throughout the region (82%). Lack of nurses, normal attrition and movement within the organization were seen as the top reasons for this vacancy, however, workload and work-life factors were also significant reasons. FT vacancies were predicted to triple over the next 3 years, while PT vacancies were predicted to remain approximately the same. Increased volumes, program expansion, increased complexity of protocols and retirements were given as reasons for this rising vacancy. Education incentives, leadership development and job flexibility were identified as key retention strategies. Student placements, internal/external advertising, and canvassing/networking were the most common recruitment strategies used. Although the survey had some limitations, this survey was a start to building the necessary database of nursing positions, mix and vacancy information. Next steps would include: refining survey questions, repeating the survey annually (updating data bases and tracking changes), creating a Health Human Resource plan for Oncology Nursing and comparing data gathered to other specialty areas and to the overall nursing picture in Ontario. For more information on this survey, please contact: prabhjot.minhas@cancercare.on.ca.

What's Happening in the Regions: Nurse Flexing Program—Flexible Sigmoidoscopy - Ingrid LeClaire

Cancer Care Ontario (CCO) and the Ontario Ministry of Health and Long-Term Care (MOHLTC) have a partnership to implement a two year innovative pilot program to enhance colorectal cancer screening under a new model which utilizes Registered Nurses (RNs). One of the key components of the HealthForceOntario strategy involves establishing innovative new health care professional roles in areas of high need. One of these new roles is utilizing Registered Nurses as endoscopists, specifically for flexible sigmoidoscopy.

This pilot project provides the clinical training and education experience required for RNs to perform flexible sigmoidoscopy procedures for screen-eligible patients aged 50-74 years and funds the operations of RN Performed Flexible-Sigmoidoscopy clinics in six pilot sites across Ontario. This interprofessional care model utilizes RNs and physicians working inter-dependently to provide a valuable and under-utilized screening method for colorectal cancer detection. The statistics show that colorectal cancer screening rates need to be improved significantly as only 20% of the average risk population in Ontario are currently being screened. The ultimate goal of this program is two-fold: to increase colorectal cancer screening rates for the Ontario population and to test the feasibility of RN-performed flexible sigmoidoscopy to enhance screening capacity.

The sites participating in this pilot program are:

- The Scarborough Hospital;
- Group Health Centre, Algoma District Medical Group and Sault Ste. Marie Group Association;
- Thunder Bay Regional Health Sciences Centre;
- Hamilton Health Sciences Centre,
- St. Joseph's Hospital,
- Toronto General Hospital (UHN).

For more information contact Ingrid LeClaire at ingrid.leclaire@cancercare.on.ca.