

Montréal Comprehensive Cancer Care Centre

Integrating nurse navigators in Montréal's oncology teams: The Process. Part 2

by Anne Plante and Sonia Joannette

Abstract

Quebec's Oncology Nurse Navigators (or "IPOs" after their French acronym) have been integrated in the entire Montréal health care region. They have been agents of change mandated with implementing a philosophy of care that centres on the patients and their families, and is delivered by oncology teams. The goal of this second article is to describe the role of IPOs in practice, the problems encountered in the various contexts and the solutions brought forward to facilitate their integration. The training of IPOs, the support they receive from administrators, the deployment of interdisciplinary teams dedicated to oncology, the holding of regular structured interdisciplinary meetings and the training of professionals and development of standardized work instruments are discussed. The observed impacts of introducing IPOs will also be examined.

The Québec Cancer Control Program ("PQLC" after its official French acronym) was developed to meet the needs of cancer patients and their families. This re-engineering of oncology health services advocates for a global approach where the patients and their loved ones are perceived as "an entity." According to the program, patient- and family-centred care optimizes the quality of care, as well as the work performed within an integrated network and in interdisciplinary teams at all oncology points of service. This type of service planning includes prevention, systematizing clinical follow-up, standardizing practices for all disciplines and computerizing oncology patient records, acquiring a work and support structure, maintaining skills through continuing education, following up on the oncology population, preparing the transition to palliative care and, finally, doing oncology research. The PQLC promotes quality of life and longevity for the oncology population. Establishing IPOs as referral personnel is the first element in the introduction of this change from a biomedical care model to a patient-centred care model (Ministère de la santé et des services sociaux, 1998).

Montréal is the first among the Québec regions to have formally launched the implementation of an integrated network of services for people living with cancer and their families (Plante & Joannette, 2009). To achieve this, the integration of IPOs in each and every oncology outpatient clinic and development of interdisciplinary teams within this context were started in 2001. How did the IPOs manage to be agents of change during their integration? This second article aims to clarify the role of IPOs in Montréal, the problems encountered and the solutions brought forward to facilitate their integration, as well as the impacts that were observed.

Anne Plante, MScN, CON(C), CNCCP(C), Regional Nurse Consultant in Oncology Care, Centre intégré de cancérologie de la Montréal, Hôpital Charles LeMoine, Greenfield Park, Québec. Phone: (450) 466-5000 # 2667 ; E-mail: anne.plante@rrsss16.gouv.qc.ca

Sonia Joannette, BScN, Master's Candidate, CON(C), Oncology Nurse Navigator, Centre intégré de cancérologie de la Montréal, Hôpital Charles LeMoine, Greenfield Park, Québec.

The following four verbs are used to define the work of IPOs: evaluating, teaching, supporting and coordinating. These functions are reflected in the IPOs' interventions through meetings with the patients and their families both at oncology clinics and in-patient units and through phone calls initiated by the patients and/or their families or professionals from other disciplines. These nursing roles constitute a winning formula for the clients because they ensure the quality of their care and clinical follow-up in an interdisciplinary context (Ponte & Nies, 2003; de Serres & Beauchesne, 2000). As described in the Avis de la Direction de la lutte contre le cancer du Québec [Statement by the Québec Cancer Control Branch] (Ministère de la santé et des services sociaux, 2008), the IPO's role is essentially clinical and non-administrative. The IPO is not a case manager, nor a liaison nurse, nor a discharge nurse, nor a palliative care nurse. Instead, she is the patients' resource person throughout their cancer care continuum.

As one would expect, each of the nine hospital centres in Montréal has its own organizational culture. Integration of the IPO is achieved differently in each centre depending on its mechanisms for adapting to change and the existing support context (Roberge, Denis, Cazale, Comtois, Pinault, Touati & Tremblay, 2004). Each IPO conveys the new paradigm for oncology care. In 2001, a Montréal oncology team was mainly made up of an oncologist or hemato-oncologist, a pharmacist (specialized or multipurpose) in oncology and nurses assigned to chemotherapy administration. To these professionals, committed to their functions for years, the manner in which oncology care was delivered was being disrupted by the arrival of graduate-prepared IPOs. Tremblay (2008) explains that five years after her deployment with the teams, her role remains misunderstood by some managers and clinicians. The IPO's new role brings many changes to the operation of oncology clinics. The IPO becomes the first-line professional responsible for evaluating the needs and resources of patients with cancer and their families. She presents new cases to the team at interdisciplinary meetings. She requires the team members to engage in order to develop a concerted plan for interdisciplinary interventions in keeping with the patient's specific history.

The integration of IPOs brings change to the organization of care. In five of the nine hospital centres, IPOs are readily welcome. They fill a need for clinical follow-up, teaching, management of complex symptoms, as perceived by professionals, but left unmet to this day due to a lack of organization. In the four other centres, adaptation is more gradual. Some teams felt very relieved because no one had time to ensure adequate follow-up, but other teams felt pressured by the change to patient-centred care. Whitten and Cameron (2007) state that communication and collaboration among the various members of the oncology team guarantee the best results. Health professionals are called upon to change their routines and go beyond their comfort zone in their practice. Changes and their impacts give birth to resistance, which can be reasonable at times, but can be discouraging over the long run.

Encountered challenges

The integration of IPOs in Montréal is an experiment that comes with its share of challenges. According to the objective stated by the PQLC (de Serres & Beauchesne, 2000), the work of IPOs is to insure patient follow-up throughout the care continuum and this brings to the

fore needs that existed previously, but are now fully acknowledged. Existing clinical and organizational problems, listed below, had to be recognized:

- growing oncology population
- ageing of the population
- too few indicators to increase hours/care in the oncology clinics
- low percentage of patients having a family physician
- many patients with complex symptoms requiring expert palliative care
- symptom management done without any reassessment
- interdisciplinary teaching that is redundant and non-comprehensive
- contradictory statements on the part of health professionals
- lack of access to professionals (intra- and/or extramural psychologist, social worker, nutritionist)
- lack of facilities to meet with patients/families
- wait times for diagnostic tests
- resistance among the professionals to the idea that IPOs were going to be the frontline for the evaluation of patients' needs and resources.

Oncology patients have multiple needs: physical, psychological and emotional, material, financial, practical and spiritual, as well as informational needs about self-care, healthy lifestyles and the need to engage in their own wellness (Fitch, Porter, & Page, 2008). Soothill, Morris, Harman, Francis, Thomas and McIlmurray (2001) report similar findings where needs related to everyday life, psychological distress and social identity are still difficult to satisfy.

Viable solutions

The following solutions were selected to facilitate the integration of IPOs within Montérégie oncology teams: training of IPOs, support from administrators, training of professionals in the various disciplines and oncology work contexts, deployment of interdisciplinary teams specializing in oncology, interdisciplinary meetings and standardized work tools.

Training of IPOs

The basic training program and continuing education for IPOs (Comtois et al., 2003) prepares them for their commitments and reinforces their capacity to foster a culture where value is given to precise discussion of symptoms, developing hypotheses in order to better understand the causes of symptoms and actively participating in interdisciplinary exchanges and identifying therapeutic interventions that are both realistic and evidence-based. IPOs are strongly encouraged to join their provincial and national associations: Association Québécoise des infirmières en oncologie (AQIO) and the Canadian Association of Nurses in Oncology (CANO). The creation of a study and support network for preparing the Oncology Nursing Certification Examination in Canada (AIIC, 2008) encourages IPOs to take this exam. In Montérégie, the goal is that all IPOs hold the Canadian certification in oncology.

The clinical training provided to support IPOs in their new role was based on the recommendations of the PQLC, on evidence-based oncology nursing care and the CANO Standards of Care, Roles in Oncology Nursing, and Role Competencies. The CÉPIO [French acronym of the committee on the evolution of oncology nursing practice] (Bélanger, Bergeron, de Serres, & Saucier, 2005), Cancer Care Nova Scotia (CCNS, 2002) and CANO (2001) stressed the importance of the oncology nurses' training given the complexity of the care. Continuing education for the IPOs has been updated with new literature and clinical rounds in oncology care and adapted to the knowledge needs expressed by the IPOs.

The authors Otto (2001), Gates and Fink (2001, 2008) are guiding the basic training for IPOs in clinical oncology and nursing care in areas such as oncogenesis, tumour staging, oncology treatments, side effects, oncologic emergencies and best nursing interventions.

Authors like Ausloos (2002), Wright and Leahey (2001) and Duhamel (1995, 2007) underpinned the educational canvas for a family-based approach. D'Amour (2005), Dufour (2004), Farrell, Schmitt and Heinemann (2001), Carson, Carson, Yallapragada and Roe (2001), Degner and Davidson (1998) and Benner (1984) all contributed to anchoring the nurse's role in order to facilitate collaboration with all other team members through the development of a personalized intervention plan.

Regarding symptom assessment, the use of the Edmonton Symptom Assessment Scale (Bruera, Kuehn, & Miller, 1991), a multisymptom measurement instrument, was decided in 2001. This simple visual tool is practical, but did not prove sufficient to capture the overall symptoms of the patient between treatments (Watanabe, Nikolaichuk, Beaumont, & Mawani, 2009). Through the years, the assessment of biopsychosocial symptoms with the help of the PQRST model proved to be an efficient communication strategy with physicians and the other team members (Lacasse & Beck, 2007). Conceptual models for symptom management by Dodd, Janson and Facione (2001) and Larson, Carrieri-Kohlman, Dodd, Douglas, Faucett and Froelicher (1994) support the collaborative work with the patients and their loved ones to get efficient symptom management strategies and obtain satisfactory health outcomes for the patients. The guide Telephone Nursing Practice Manual (CCO, 2004) with its decision algorithms is used as a reference document for telephone calls.

Rando (1984) and Rosen (1998) set the groundwork for the development of courses on the concept of loss, the grieving process and the care to be provided to a population with a poor prognosis illness associated with many losses along the trajectory. All intervention-related courses included case histories and role-plays. To shift the philosophy of each and every team towards patient- and family-centred care, it can be said that the initial assessment tool—the data collection completed by the IPOs was decisive. Several studies in oncology conclude that health professionals know very little about the life experience of the patients and their families, and that this systemic approach proves to be more productive than the linear one where patients are seen as individuals in the absence of their network (Fitch, Porter, & Page, 2008).

The development of the initial assessment was based on oncology specificities while drawing on the Calgary model (Wright & Leahey, 2001, 2007) and the McGill model (Feeley & Gottlieb, 2000). The Calgary Family Systems Approach underlines how important it is for the care to lean on the forces and resources of both patients and families, not just on their deficits. The McGill model places the patient/family in constant relation with their environment. Care activities are delivered in collaboration according to the goals, capacity and potential of both the clients and their families. With its circular questions, the initial assessment is an intervention in itself. From the moment they use it, IPOs can perceive the impact of the family on the person with cancer and vice versa. From then on, the IPO is seen by the patients and their loved ones as a health professional who is interested in their lived experience and who relates to them as individuals with specific needs and resources.

The monthly continuing education sessions led by the regional nurse consultant in oncology care are generating a great deal of participation by the IPOs, promoting communication and fostering the understanding of theoretical concepts and their clinical application in the day-to-day practice. For example, in this networking context, how can one improve the working relationship between the hospital and home care contexts and reduce the number of calls from professionals because service requests are not explicit enough? A whole day was thus allocated to the writing of service requests so that IPOs could submit more precise and complete requests to home care and other health professionals, as in the following example: “20/12/07—47-year-old male, married with no

children diagnosed with a metastatic colon cancer T2N1M1 completed his oxaliplatin chemotherapy six weeks ago. Is losing his strength = fatigue 7/10. His symptoms, diarrhea 4/10 and neuropathic pain in the pelvis 3/10 are persistent. He requires assistance with symptom monitoring, understanding his medications and support with family communication. His wish is to go back to work..."

With the help of the nurse consultant, IPOs share new knowledge, experiences, work tools and case studies with a mind to standardizing practices. Nonetheless, IPOs can find their work to be very demanding and their work environment to be rather uncomfortable when it comes to interprofessional collaboration. These continuing education sessions result in uniting the nine IPOs into a homogeneous group aiming for the same goals and able to support one another in their understanding of the topics and learn from the organizational adaptation strategies used by their colleagues. Developing the IPOs' competencies requires the regular organization of continuing education and support activities within each facility, each region and the whole of Québec, all considered essential to reinforce the expertise and help maintain a personal balance in a very demanding role (Bélanger, Bergeron, de Serres, & Saucier, 2005; Whitten & Cameron, 2007).

Support by administrators

The support from administrators is a key factor in the successful integration of IPOs. To introduce their role to newly diagnosed patients, a fact sheet was produced. It is distributed in the region's hospital and community care network. The IPO's role was presented to the directors of nursing, head nurses, to the council of physicians, dentists and pharmacists, to cancer program heads in the region and to service coordinators in community care contexts in order to explain how the role fits in with the implementation of the PQLC in Montérégie. A high profile is achieved for the IPO's role by presenting it at a staff meeting of each oncology team. The emphasis placed on the definition of the role helps set boundaries in relation to the other disciplines.

The request for consultation addressed to the IPO by physicians (surgeons, oncologists, hemato-oncologists, etc.) helps her get the name and diagnosis of individuals with cancer. The time elapsing between the communication of diagnosis and the initial meeting with the IPO is of utmost importance. Individuals living with cancer and their families experience a great distress from the moment the diagnosis has been announced (Holland et al., 2007). Waiting without any support increases that distress on a daily basis. Administrators must act in each clinic to supply clerical support and add health professionals whose only duties are to the oncology team, both necessary elements for the IPO to fulfill her assigned role. In all oncology centres, administrators invariably supported the establishment of oncology interdisciplinary teams. Framing the common goals within a care philosophy played a decisive role in setting accountability for the results to be achieved (Roberge et al., 2004) (Appendix 1).

Deployment of oncology dedicated interdisciplinary teams

It was necessary to deploy interdisciplinary teams in the various contexts within the region. In oncology, interdisciplinary work is essential as many different specialists are involved in the care of individuals with cancer and their loved ones, as this population has numerous needs and as care is complex (Gendron, Gagnier, & Plante, 2005). The development of an oncology care philosophy upheld by each and every member of the local team helps to create a common vision. Health professionals were solicited to put together and present information sessions to patients/families such as cancer and sexuality, cancer and lymphedema, cancer survival,

etc. The development of task descriptions for all members of the oncology interdisciplinary team (chemotherapy nurse, secretary, nurse navigator, pharmacist, research nurse, social worker, physiotherapist, volunteer, nutritionist, psychologist, pastoral animator, etc.) leads to complementarity of skill sets without any duplication or inconsistencies (Fallowfield & Jenkins, 1999) and the careful use of resources.

Holding of regular interdisciplinary meetings

The establishment of a regular (weekly or bimonthly) structured interdisciplinary meeting in Montérégie clinics enables access to relevant information regarding the patients to ensure both joint action and care continuity. Oncology care is discussed and must be adapted to the individual with cancer, not the other way around (Gendron, Gagnier, & Plante, 2005). The IPO is not the only professional who presents patient cases at the interdisciplinary meetings, as the other care providers may present the cases of patients for which it is wise to discuss the best solutions to be implemented in order to stymie experienced symptoms (biopsychosocial difficulties). The meeting is organized according to the number of patient cases to be discussed and the type of request put forward by the requesting professional: new cases, complex symptoms, and patient record follow-up. The personalized interdisciplinary intervention plan brings to the fore the collective skill mix (Le Boterf, 2002) and the cooperation between professionals in light of the issues raised (D'Amour, Goulet, Labadie, San Martin-Rodriguez, & Pineault, 2008). Complex symptoms logic (Plante, Carrier, & Gendron, 2004) is used by the interdisciplinary team (Appendix 2).

Training for the professionals

The expansion of oncology knowledge must be achieved by all health care professionals so that they share a common discourse. The basic oncology nursing course is the one place where all nurses from community care contexts, oncology clinics and care units in the region converge. It consolidates their roles in the assessment and monitoring of the cancer patient's clinical status and goes over the theory of family systems nursing. As for new oncology nurses, their orientation plan includes a 21-hour course. A seven-hour/year continuing education program is offered focusing on an in-depth look at oncology nursing standards with the help of case histories (active teaching method). These teachings are developed and presented by the regional nurse consultant with the assistance of a clinical nurse educator. The establishment of regional practice committees encourages the various professionals to unite and move in the same direction; groups have thus been created for oncology head nurses, palliative care consultant nurses, psychosocial intervention professionals, pharmacists, and nutritionists.

Standardized work tools

Pooling efforts and using standardized tools throughout the Montérégie health network greatly facilitate exchanges between disciplines and minimize overlaps in services. The initial biopsychosocial assessment is used by all Montérégie IPOs. Referral requests to community care contexts have been improved upon collaboratively with a view to optimally describe clinical situations and reduce response times. Coordinating with pharmacists to meet new patients ensures that the education provided to them is both complementary and non-redundant. Implementation and usage of pocket guides on the family systems nursing are done with all nurses across the network (coping with a new diagnosis, role of a parent with cancer, and interventions in fatal prognosis situations).

A computer program (Fournier, Plante, & Roberge, 2001) has been installed in all IPOs' computer workstations in Montérégie. The

analysis of data thus collected helps determine links between their practice and their clients' needs. The following information is obtained at the end of each 28-day administrative period for each IPO in Montérégie: information on the patient and their support person, affected local community health centre, number of meetings with new patients, number and duration of phone calls and meetings, purpose of clinical activities, who their interlocutors were and the care interventions proposed. The Provincial Cancer Registry is located at the Centre intégré de lutte contre le cancer de la Montérégie [Montérégie's Integrated Cancer Control Centre], a regional hospital affiliated with the University of Sherbrooke. Complete datasets have been gathered since 2005 for breast, colorectal and lung cancer. At present, computer data are collated for all tumour sites. The registry includes a sociodemographic and diagnostic component and a pharmaceutical component; a symptom component is being developed. The registry will provide a comprehensive view of the population treated at this centre.

Various efforts are also been made to develop and offer support groups and other complementary medicine sessions such as mental imagery and art therapy in order to help the patients and their families to better deal with their situation and optimize their health. Welcoming volunteers help provide a better support for patients and their families when they visit the oncology clinic and in-patient units.

Observed impacts

A survey by Comtois and her colleagues (2003) helped to identify the positive impact IPOs have on patients. Below are some of the commentaries patients or their loved ones expressed about the care provided by IPOs:

- Someone I can confide in. "What you do is important!"
- Someone who asks the right questions. "I have never talked so much, it feels good."
- Someone who explains slowly and who repeats as necessary. "I understand better when you're the one explaining it."
- Someone who encourages my family to communicate more readily with me. "You have given me hope."
- Someone who recognizes me when I phone to ask for some information on my husband's behalf. "You helped me so much last week when my husband had a fever."
- Someone who helps me get involved in the success of my therapies. "I did not think I had any power over my quality of life."
- Someone who takes the time to understand what I dare not say. "You have been a good listener."

To complete this list of opinions, here is how department heads sum up the care benefits brought about by IPOs:

- The information imparted is much more complete.
- Better symptom management.
- Better patient follow-up.
- The number of crisis situations has dropped to almost zero thanks to the planning of care.
- Better usage of resources from all perspectives: family, professional, community.
- Support is much more personalized and seen as being a part of oncology care.
- Patients are relieved to have a resource person who knows them and answers their questions when they call the clinic.
- Oncological emergencies are detected more rapidly and often managed in collaboration with the oncologist without the patient having to visit the emergency room.
- All professionals are more aware of the quality of care to be provided and of the efficiency of team collaboration.
- Linkages with home care are improved and the IPO is available to answer questions from community care nurses.

Oncologists have noticed changes among their patients who are better informed on side effects and have more specific enquiries about treatment options. IPOs and interdisciplinary teams foster the optimal usage of health care system resources, prevent crisis situations and enable early monitoring of foreseeable problems.

Even to this day, the IPO's daily role remains extremely demanding. There is still difficulty in setting boundaries to the role and a need to remind the other care providers and even patients and family members about her frontline role. Walczak and Absolon (2001) report on this reality in their article on communication, conflict resolution, delegation and motivation. IPOs feel powerless when faced with the lack of human resources within the care system and the lack of physical resources for patients and with overtly long wait times for specific consultations or investigations. To this day, they must still negotiate referral requests to the second line of care. Some patients, families and health care professionals believe that the hospital is a place where individual patients are "managed" and the focus on empowerment is a culture change that requires both time and education. Due to insufficient resources, the growing volume of new cases and the number of patients/families in follow-up and palliative phases remain for a long time in the IPO's group of patients who can't get access to second-line professionals. Often, the coordination function ties up too much of the IPO's hours. As her workload is excessive and as she does not get replaced when away (holidays, training sessions, meetings...), accessibility to her services is limited.

Conclusion

In Montérégie, the implementation of the PQLC and integration of IPOs were achieved notably by training IPOs to their role, by training for interdisciplinary work and clearly describing each discipline's functions. Thanks to the support from the health and social services agency and its administrators and the introduction of standardized tools, oncology work activities were reengineered based on evidence. This has an impact on the quality and continuity of care. The successful integration of IPOs rests on successfully blending careful attention to the needs of patients and their families, practical application of theories and interdisciplinary collaboration.

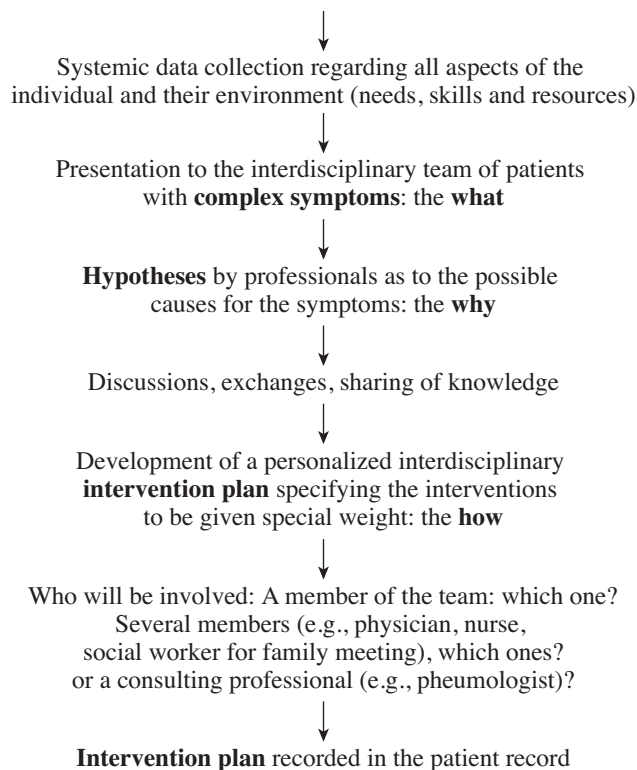
Known for their patience and their passion, IPOs are perceived by their clients as care providers who listen to their distress and offer them hope. As they evolved in their new role, they developed multiple qualities and have been able to cope with different organizational and clinical stressors. None of them realized the scope of the challenge waiting for them as they applied for this innovative position. Situations characterized by stress, change, adaptation and the use of coping strategies form an integral part of a nurse's life. Duquette, Kérouac and Beaudet (1992) establish that "hardiness" is the ultimate quality to be found in nurses who are able to live through the difficult years of the 21st century and introduce new perspectives. The nurses have also demonstrated the three important qualities seen as the key to success in administration: competence, perseverance and ability to form alliances (make and maintain contacts).

The PQLC was the catalyst for change, and the IPOs successfully fulfilled their role as agents of change. The goal to deliver integrated care within a network where interdisciplinary care is centred on the patients and their families in an evidence-based practice setting is now a reality in Montérégie. IPOs are integrated into the various levels of the Québec oncology health system. Multiple implementation initiatives of the IPO's role are conducted first in the large centres, then in the periphery. The integration of IPOs within oncology care teams has resolutely evolved over the years. In 2006, the provincial minister of Health and Social Services, Dr. Philippe Couillard, determined that the integration of IPOs would be carried out in the whole province. ♣

Appendix 1. Useful ingredients for interdisciplinary collaboration within a patient- and family-centred care philosophy

- Be equipped with a great dose of flexibility
- Accept compromises
- Experiment with new ideas
- Congratulate our colleagues as often as possible on their good work (recognition)
- Always maintain our clients' trust
- Assess situations accurately and report symptoms to colleagues with both facts and dates
- Take risks and innovate
- Seize opportunities
- Help one another
- Know how to lose (humility)
- Be open to others
- Always trust oneself and take a daily mega dose of vitamins called "I believe I am going to succeed"
- Capitalize on all alternative solutions
- Learn to communicate better
- Trust one's colleagues
- Take responsibility for updating one's knowledge
- Mention challenging situations to one's superior and do not take them as personal failures
- Choose the best words for the circumstance
- Always present a well thought-out intervention plan and have enough patience to wait for the moment when it will receive a fair "hearing" and assessment
- Use case histories to move one's audience toward change
- Listen to all individual opinions and stress the importance of a constructive decision for the patient and their loved ones.

Appendix 2. Interdisciplinary meeting framework



(Framework designed by A. Plante, C. Carrier and C. Gendron)

References

- Ausloos, G. (2002). *La compétence des familles*. Montréal : Édition Érés.
- Bélanger, S., Bergeron, C., de Serres, M., & Saucier, A. (2005). *Pour optimiser la contribution des infirmières à la lutte contre le cancer, avis du Comité de l'évolution de la pratique infirmière en oncologie (CEPIO)*. Direction de la lutte contre le cancer: Bibliothèque nationale du Québec.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Boston: A. Wesley.
- Bruera, E., Kuehn, N., & Miller, M.J. (1991). The Edmonton Symptom Assessment Scale (ESAS): A simple method for the assessment of palliative care patients. *Journal of Palliative Care*, 7, 6–9.
- Canadian Association of Nurses in Oncology. (2001). *Standards of Care, Roles in Oncology Nursing, and Role Competencies*. Ottawa: CANO.
- Canadian Nurses Association. (2008). *Oncology Nursing Certification*. Retrieved May 25, 2009, from http://www.cna-nurses.ca/cna/documents/pdf/publications/CERT_Oncology_e.pdf
- Cancer Care Nova Scotia. (2002). *Furthering cancer education in Nova Scotia, nurses needs assessment: Final report*. Halifax: CCNS. Récupéré le 25 mai 2009 à <http://www.cancercare.ns.ca/media/documents/NursesNeedsAssesFinalReport.pdf>
- Cancer Care Ontario. (2004). *Nursing telephone practice & symptom management guidelines*. Ontario: Nursing Professional Advisory Committee. Récupéré le 25 mai 2009 à <http://www.cancercare.on.ca/documents/NursingTelephonePracticeGuidelines.pdf>
- Carson, K.D., Carson, P.P., Yallapragada, R., & Roe, C.W. (2001). Teamwork or interdepartmental cooperation: Which is more important in the health care setting? *Health Care Manager*, 19(4), 39–46.
- Comtois, E., Roberge, D., Denis, J-L., Cazale, L., Pineault, R., Latreille, J., & Touati, N. (2003). *Bilan de l'expérience des infirmières pivots en oncologie de la Montérégie 2001–2003. Un nouveau rôle dans un réseau en émergence*. Centre de recherche Greenfield Park : Hôpital Charles LeMoine.
- D'Amour, D., Ferrada-Videla, M., San Martin Rodriguez, L., & Beaulieu, M.D. (2005). *The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks*. *Journal of Interprofessional Care*, 19(S1), 116–131.
- D'Amour, D., Goulet, L., Labadie, J-F., San Martin-Rodriguez, L., & Pineault, R. (2008). A model and typology of collaboration between professionals in health care organization. *BMC Health Services Research*, 8, 188.
- Degner L., & Davidson J. (1998). Promoting patient decision-making in life and death situations. *Seminars in Oncology Nursing*, 14(2), 129–136.
- de Serres, M., & Beauchesne, N. (2000). *L'intervenant pivot en oncologie : un rôle d'évaluation, d'information et de soutien pour le mieux-être des personnes atteintes de cancer*. Conseil québécois de lutte contre le cancer : Bibliothèque nationale du Québec.
- Dodd, M., Janson, S., & Facione, N. (2001) Advancing the science of symptom management. *Journal of Advanced Nursing*, 33(5), 668–676.

- Dufour, B. (2004). Approche interdisciplinaire et soins, les fondements de l'interdisciplinarité. **Recherche en soins infirmiers**, **79**, 4–11.
- Duhamel, F. (1995). **La santé et la famille. Une approche systémique en soins infirmiers**. Boucherville : Gaetan Morin Editeur.
- Duhamel, F. (2007). **La santé et la famille. Une approche systémique en soins infirmiers** (2^{ième} édition). Montréal : Gaetan Morin Éditeur.
- Duquette, A., Kérouac, S., & Beaudet, L. (1992). **L'épuisement professionnel du personnel infirmier : un bilan des connaissances. Synthèse d'un rapport de recherche présenté au Conseil québécois de la recherche sociale**. Montréal : Université de Montréal.
- Fallowfield, L., & Jenkins, V. (1999). Effective communication skills are the key to good cancer care. **European Journal of Cancer**, **35**(11), 1592–7.
- Farrell, M.P., Schmitt, M.H., & Heinemann, G.D. (2001). Informal roles and the stages of interdisciplinary team development. **Journal of Interprofessional Care**, **15**(3) 282–295.
- Feeley, N., & Gottlieb, L.N. (2000). Nursing approaches for working with family strengths and resources. **Journal of family nursing**, **6**(1), 9–24.
- Fitch, M.J., Porter, H.B., et Page, B.D. (2008). **Supportive Care framework: A foundation for person-centred care**. Pembroke, ON: Pappin Communications.
- Fournier, M., Plante, A., & Roberge, D. (2001). **Base de données infirmière pivot en oncologie**. Centre intégré de cancérologie de la Montérégie : Hôpital Charles LeMoine.
- Gates, R., & Fink, R. (2001). **Oncology nursing SECRETS**. Philadelphia: Hanley & Belfus.
- Gates, R. & Fink, R. (2008). **Oncology nursing SECRETS** (3rd ed.). St-Louis: Mosby Elsevier.
- Gendron, C., Gagnier, J-P., & Plante, A. (2005). **Les équipes interdisciplinaires en oncologie**. Comité des équipes interdisciplinaires de lutte contre le cancer : Bibliothèque Nationale du Québec.
- Holland, J.C., Breitbart, W.S., Foley, G.V., Greenberg, D.B., Handzo, G.F., Knight, S.J., et al. (2007). The NCCN Distress Management, clinical practice guidelines in oncology. **Journal of the National Comprehensive Cancer Network**, **5**(1), 65–98.
- Lacasse, C., & Beck, S. (2007). Clinical assessment of symptom clusters. **Seminars in Oncology Nursing**, **23**(2), 106–112.
- Larson, P.J., Carrieri-Kohlman, V., Dodd, M.J., Douglas, M., Faucett, J., & Froelicher, E. (1994). A model for symptom management. **Journal of Nursing Scholarship**, **26**(4), 272–276.
- Le Boterf, G. (2002). **Développer la compétence des professionnels. Construire les parcours de professionnalisation**. Paris: Éditions d'organisation.
- Ministère de la Santé et des Services Sociaux. (1998). **Programme québécois de lutte contre le cancer : pour lutter efficacement contre le cancer, formons équipe**. Québec: Direction de la lutte contre le cancer.
- Ministère de la Santé et des Services Sociaux. (2008). **Rôle de l'infirmière pivot en oncologie**. Québec : Direction de la lutte contre le cancer.
- Otto, S. (2001). **Oncology nursing**. New York: Mosby.
- Plante, A., Carrier, C., & Gendron, C. (2004). Logique des symptômes complexes (problèmes bio psychosociaux) utilisée par l'équipe interdisciplinaire. Schéma dans Gendron, C., Gagnier, J-P., Plante, A. (2005). **Les équipes interdisciplinaires en oncologie** (p. 50). Comité des équipes interdisciplinaires de lutte contre le cancer : Bibliothèque Nationale du Québec.
- Plante, A., & Joannette, S. (2009). Integrating nurse navigators in Montérégie's oncology teams: One aspect of implementing the Cancer Control Program. PART 1. **Canadian Oncology Nursing Journal**, **19**(1), 13–18.
- Ponte, P.R., & Nies, J. (2003). Making patient-centred care come alive. **Journal of Nursing Administration**, **33**(2) 82–90.
- Rando, T. (1984). **Grief, dying and death**. Illinois : Research Press Co.
- Roberge, D., Denis, J-C., Cazale, L., Comtois, E., Pinault, R., Touati, N., & Tremblay, D. (2004). **Évaluation du réseau intégré de soins et de services en oncologie, l'expérience de la Montérégie**. Fondation canadienne de la recherche sur les services de santé. Récupéré le 25 mai 2009 à http://www.chsrf.ca/final_research/ogc/pdf/roberge_2_f.pdf
- Rosen, E. (1998). **Families facing death**. San Francisco: Jossey-Bass Inc.
- Soothill, K., Morris, S.M., Harman, J.C., Francis, B., Thomas, C., & McIllmurray, M.B. (2001). Informal carers of cancer patients: What are their unmet psychosocial needs? **Health and Social Care in the Community**, **9**(6), 464–475.
- Tremblay, D. (2008). **La traduction d'une innovation organisationnelle dans les pratiques professionnelles de réseau: l'infirmière pivot en oncologie**. Montréal: Thèse Université de Montréal.
- Walczak, M.B., & Absolon, P.L. (2001). Essentials for effective communication in oncology nursing: Assertiveness, conflict management, delegation, and motivation. **Journal for Nurses in Staff Development**, **17**(2), 67–70.
- Watanabe, S., Nekolaichuk, C., Beaumont, S., & Mawani, A. (2009) The Edmonton symptom assessment system—What do patients think? **Support Care Cancer**, **17**, 675–683.
- Whitten, D., & Cameron, K. (2007). **Developing management skills**. New Jersey : Practice Hall.
- Wright, M., & Leahy, L.M. (2001). **L'infirmière et la famille: guide d'évaluation et d'intervention**. Adaptation française de Lyne Campagna. Saint-Laurent: Éditions du Renouveau pédagogique.