INTERNATIONAL PERSPECTIVES

Highlights from an International Panel on Cancer Nursing and Care

by Marg Fitch

The 8th World Cancer Congress was held in Beijing, China, in May 2015. The highlights presented below outline a series of presentations offered under the theme of Cancer Nursing and Care. Cancer nursing is beginning to emerge as a specialty in China and the World Cancer Congress offers an opportunity for nurses from Western and Eastern countries to exchange knowledge and explore possible collaborations. There are many similarities about the issues that cancer patients and their families experience around the world. However, the solutions for the care delivery challenges are dependent on the local setting and resource availability.

Dr. Fusun Terzioglu (Faculty of Nursing and Division of Obstetric and Gynecologic Nursing, Hacettepe University and Hacettepe University Hospitals, Turkey) presented study results on the effect of home care service on the sexual satisfaction of patients with gynecologic cancer. Sexual health and sexual satisfaction can be greatly influenced in women with gynecologic cancer depending on the disease and its treatment. A prospective randomized study was conducted to test the efficacy of nurse visits with women, in the hospital (three visits) and at home (five visits plus telephone access), 12 weeks post-discharge using specially developed nursing teaching and care plans. The control group was monitored without intervention using hospital routine care. Data were gathered using an interview questionnaire, a home visiting satisfaction questionnaire, and the Golombok Rust Inventory of Sexual Satisfaction. Within the 12-week post-discharge monitoring period, as compared with the time before treatment, women in the treatment group experienced fewer sexual problems, as compared to the control group.

Dr. Jun-E Liu (School of Nursing, Capital Medical University, China) presented data regarding the post-traumatic growth and psychological distress in hospitalized early-stage breast cancer survivors over a six-month period. The study utilized a longitudinal design and applied the Post-Traumatic Growth Inventory and the Distress Thermometer and Problem List at three, six, and nine months following diagnosis. At baseline, 155 individuals who were receiving chemotherapy were selected from four first class tertiary Beijing hospitals using a purposive sampling approach (eligibility criteria: over 18 years, stage I or II breast cancer, no metastases, no history of mental illness). In total, 120 individuals completed the follow-up measures. The total score of the post-traumatic growth was 62.72 ± 14.66 at baseline with a weak negative relationship between post-traumatic growth and distress (r=-0.282, p<0.001). Post-traumatic growth increased and psychological distress decreased from three to nine months. Final scores were 70.29 ± 16.07 for post-traumatic growth and 2.51 ± 1.00 for distress. It was concluded the breast cancer survivors had developed a low level of posttraumatic growth at three months while on chemotherapy, but this growth was enhanced by nine months.

Dr. Margaret Fitch (Bloomberg Faculty of Nursing, University of Toronto, Canada) summarized how the interest in patient reported outcomes has been growing in cancer care over the past decade as a way to gather insight into the patient perspectives about their health and illness. Improving patient experiences in cancer care will be strongly dependent on our capacity to measure patient reported outcomes and use those data in our day-to-day interactions and program planning. In Canada, efforts are underway to design and implement infrastructure to systematically measure, report, and act on patient reported outcome data, as well as patient experience and satisfaction feedback. The Canadian Partnership Against Cancer is providing leadership for this work with projects across the country. Nurses will be highly involved in capturing patient reported data at point of care. The advent of electronic health care records will enhance the ability to capture this information easily and track changes over time.

Dr. Leslie Waltke (Aurora Health Care, Global Cancer Rehabilitation Consulting, USA) emphasized how cancer rehabilitation is an area of care that has been somewhat overlooked, yet is being recognized as increasingly important given the growth in the number of cancer survivors. Cancer rehabilitation is the area of physical medicine responsible for addressing the musculoskeletal, cardiopulmonary, and functional impairments associated with cancer treatment, survivorship, advanced disease, and end-of-life care. Many of the common late and long-term adverse effects of cancer and its treatment (e.g., fatigue, pain, weakness, fibrosis, incontinence, lymphedema, edema, decreased mobility, impaired cardiopulmonary function, impaired balance, altered gait, safety issues, sexual dysfunction, impaired swallowing, and cognitive issues) are within the purview of cancer rehabilitation. The evidence base is growing to support interventions in this field and advocates are calling for rehabilitation to begin at the time of diagnosis. Survivors can gain strength, be more active, and enjoy improved quality of life through effective rehabilitation approaches.

Dr. Hanna Admi (Rambam Health Care Centre, Israel) focused on the transition experiences of cancer patients
and identifying barriers to effective transition. Participants were adult Hebrew, Arabic, and Russian-speaking patients and health care providers from hospital and community settings. Qualitative (focus groups and interviews with 37 patients and 40 health care providers) and quantitative (self-administered questionnaires with 422 respondents) were utilized to gather perspectives on hospital to community transactions or interactions. Qualitative findings showed that patients faced difficulties navigating what they found to be a complex and fragmented health care system. They had to become their own case managers in many instances. They used informal routes to overcome the barriers including personal relationships, and the coordinating roles of nurse coordinators and family physicians or general practitioners. The most significant factor that influenced the quality of the transition process was the general practitioner involvement (P < 0.001) in the community. The importance of the interpersonal role of oncology nurses in coordinating and facilitating care transitions was emphasized, as was the ongoing need for patient education and support during and after hospitalization.

Dr. Lisa Muirhead (Nell Hodgson Woodruff School of Nursing, Emory University, USA) summarized the complexities of cancer risk among individuals living with serious mental illness and highlighted implications for practice, policy, and public health. This population is a very vulnerable one and is often neglected. Living with a serious mental illness presents many challenges and poses higher risks of morbidity and mortality associated with acute and chronic conditions, certain cancers, and cancer-related deaths. Many of those living with a serious mental illness in the United States are uninsured, have dual diagnosis of substance abuse, and are least likely to access and use preventative health care services. Many of the factors influencing their health are modifiable, given the appropriate interventions: body weight, physical activity, diet, smoking, drug and alcohol use, and sexual practices. As many as 50% chance becoming homeless. Their voices are often silent ones in terms of advocating for their own care. Much research is required to understand what constitutes appropriate and effective models of care to reach this population.

Dr. Edith Ubogagu (London Northwest NHS Trust, United Kingdom) highlighted the results of an Advanced Care Planning pilot at a London teaching hospital focused on delivering the preferences and wishes of patients in the last 12 months of life. The study was started out of concern for the growing aging population and their vulnerability because of the increased health burden they experience. A literature review identified the most common risk factors and characteristics for the ‘vulnerable older patient’: age >75, ≥1 advanced end-stage long-term co-morbidity, ≥3 hospitalizations within the last six months, at risk of an acute event resulting in loss of capacity or causing sudden death, and a ‘do not attempt resuscitation’ decision on the patient’s current admission. The study involved offering advanced care planning to any patient who met at least two of the five criteria. Over a six-month period, 90 individuals had a documented discussion about advanced care plan discussion resulting in the creation of an actual plan. Seventy of these individuals were discharged from hospital and only five were readmitted within 30 days. Of the 129 patients in the same time period who were discharged (without an advanced care plan), 53 were readmitted within 30 days. There was a net result of 50% reduction in readmission rates from the national average of 15% to 7% for this hospital facility. The criteria were helpful in triggering the need for the advanced care planning conversation and subsequent creation of a plan.

Dr. Kellie Alleyne-Mike (National Radiation Centre, Trinidad and Tobago) presented the results of a study to identify the reasons for unscheduled visits to the oncology department as the basis for improving health care delivery. A prospective observational design was implemented to track the individuals who presented for an unplanned visit at the oncology department over a month-long period. In that timeframe, 3,573 individuals had a total of 34,045 scheduled and 169 unscheduled visits to the centre. Those who presented for an unplanned visit required clinical assessment in 59.8% of the visits and prescription refilling in 40.2%. Oncology-related problems were identified during the clinical assessment for 67.3% of the patients and admissions needed in 44.1% of these cases. Pain, respiratory, neurological, and gastro-intestinal problems were identified most frequently. Sixty per cent (60%) of those who required prescription renewal were not on active treatment. Recommendations were directed toward better integration of cancer care with primary care, especially for individuals who are no longer receiving active treatment for their cancer. This will require additional cancer education of care providers in the community setting.