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# Oncology nursing supporting cancer survivorship from diagnosis to discharge: A case exemplar

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## ABSTRACT

*This paper provides an overview of the survivorship special interest group workshop conducted at the 2023 CANO/ACIO Annual Conference. Using a case exemplar, the workshop aimed to highlight patients' unique needs throughout the cancer trajectory and to enhance clinical oncology nurses' knowledge of self-management support strategies they can use to assist patients with survivorship concerns. A discussion with workshop attendees facilitated how the provision of self-management support strategies assists in meeting a patients' individual needs at three phases of the cancer trajectory: surgery, chemotherapy, and transition to primary care. Ninety-three percent of workshop attendees agreed that their understanding of survivorship evolved through their participation. Participants also reported that the workshop had a positive impact on their practice by providing them with new strategies to support patients during transitions and encouraging early integration of self-management support into their practice.*

**Keywords:** cancer survivorship, oncology nursing, self-management support, workshop, education

## INTRODUCTION

In Canada, two in five individuals will be diagnosed with cancer in their lifetime (Canadian Cancer Statistics, 2023). Moreover, the incidence of cancer in Canada is estimated to rise to 176,704 cases in 2042 (Poirier et al., 2019). However,

due to advancements in cancer treatment and faster diagnosis, 64% of people diagnosed with cancer are likely to live for at least five years beyond the diagnosis (Canadian Cancer Statistics, 2023). Cancer survivors experience long-lasting physical and psychological effects from the disease and its treatments, including fatigue, cognitive difficulties, depression, and anxiety (Fitch et al., 2019). These effects can persist for years after cancer treatment and impact survivors' ability to engage fully in work, personal, and social activities (Bilodeau et al., 2021; Fitch et al., 2019). Cancer survivors are often required to self-monitor and self-manage aspects of their care, treatment-related adverse effects, cancer-related symptoms, and emotional distress (Howell et al., 2021). Therefore, they seek to learn to live with the chronicity of cancer, take charge of certain aspects of their health management, and become independent while developing self-management expertise (Bilodeau et al., 2021; Bilodeau et al., 2022; Vinette & Bilodeau, 2021). However, learning self-management is challenging for cancer patients (Bilodeau et al., 2022; Vinette & Bilodeau, 2021). Generic education material and unreliable information on the internet are ineffective in helping cancer patients develop self-management expertise (Vinette & Bilodeau, 2021). Survivors require personalized support and instruction from healthcare professionals to develop self-management skills (van Dongen et al., 2020; Vinette & Bilodeau, 2021).

Self-management is defined as "an individual's ability to manage the symptoms, treatment, physical and psychosocial consequences, and lifestyle changes inherent in living with a chronic condition" (Barlow et al., 2002, p. 178). Nurses provide self-management support (SMS) strategies in the care pathway through the systematic provision of education and supportive interventions to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support (Adams et al., 2004; Howell et al., 2021; Lorig & Holman, 2003).

Considering the biopsychosocial impacts of cancer, spanning from diagnosis and treatment to post-treatment (Howell, 2018), and acknowledging the episodic nature of cancer care, it is crucial to provide SMS promptly upon diagnosis and sustain it throughout the entirety of cancer care trajectory (Howell et al., 2021; van Dongen et al., 2020). Every encounter at each phase of the cancer trajectory should be considered a teachable moment and an opportunity to incorporate assessment and self-management support to meet the individual needs of cancer survivors to self-manage their care (Howell et al., 2021). Nurses are ideally situated to provide SMS due to their extended interactions with patients (Hassankhani et al., 2023), and their esteemed status as trusted healthcare providers (Budge et al., 2021; Tharani et al., 2021). The nurse's role

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in SMS extends beyond traditional education and information provision; it involves empowering patients and equipping them with core skills (e.g., problem-solving and decision-making) to integrate the management of the chronic condition into their daily lives (Coates, 2017). Unfortunately, nurses often lack confidence in providing SMS for cancer patients (Jongerden et al., 2019), and nurse-led SMS is rarely integrated in routine clinical cancer care practice (Charalambous et al., 2018). Nurses educated and skilled in facilitating patient engagement can improve physical and emotional symptom severity and quality of life (Chan et al., 2023). However, there is uncertainty and a lack of knowledge regarding the most important components and what constitutes SMS for cancer patients (Boland et al., 2018). Therefore, an increased awareness and more training is required among nurses about tailored SMS for patients affected by cancer (Chan et al., 2020; Chan et al., 2023; Hassankhani et al., 2023; Vinette & Bilodeau, 2021).

### Context of this Paper

To assist in addressing this gap, the co-chairs (CML,KB) of the survivorship Special Interest Group (SIG) conducted a workshop at the 2023 CANO/ACIO Annual Conference to enhance the knowledge of oncology nurses about the unique needs of cancer patients and the SMS strategies they can employ to empower patients in coping with their concerns at different phases of the cancer trajectory (MacDonald-Liska et al., 2024). This 90-minute workshop presented a case exemplar of a cancer patient with unique needs at three phases of the cancer trajectory (surgery, chemotherapy, transition to primary care provider). Due to the 90-minute time constraint, three cancer trajectory touchpoints were selected for review and discussion.

In this paper, we provide an overview of our survivorship SIG workshop presentation. We provide the case exemplar employed and highlight the SMS strategies that oncology nurses may use at the three phases of the cancer trajectory. Evaluations from the workshop participants are also reported.

## EVIDENCE SOURCES OF THE CASE EXEMPLAR

### Frameworks

The workshop was guided by two frameworks. First, the Otero-Sabogal et al. (2008) framework is based on the Health First self-management program in California, which defines SMS as the actions taken by healthcare providers to empower patients and caregivers, enabling them to actively participate in their care and play a central role in managing their chronic illness. Otero-Sabogal et al. (2008) identify seven key characteristics for self-management support:

1. Assisting patients and caregivers in setting realistic goals, defining specific actions, and agreeing on the steps needed to achieve those goals;
2. Providing intensive training in disease-specific skills for patients and caregivers;
3. Offering informational, emotional support, and problem-solving skills to enhance self-confidence, self-efficacy, and self-esteem in managing chronic illness;

4. Engaging with patients and their families in a positive, respectful, and culturally appropriate manner;
5. Providing ongoing follow-up;
6. Encouraging healthy behaviour change; and
7. Assisting patients and caregivers with psychosocial issues.

The second framework guiding our workshop was the Competency Framework for Cancer Nurses Providing Self-Management Support (Chan et al., 2023). This framework was developed using a three-stage consensus-building approach, which included a research team comprised of five professors in oncology nursing with expertise in cancer nursing research and education and self-management support. This framework outlines 10 core competencies and 42 performance criteria across six domains for the provision of self-management support by nurses for patients with cancer (Chan et al., 2023). Potential SMS strategies discussed at the workshop are SMS performance criteria from Chan et al. (2023) that align with characteristics identified by the Otero-Sabogal et al. (2008) framework for each of the three phases of the cancer trajectory: surgery, chemotherapy, and transition to primary care.

### Development of the Case Exemplar

The case exemplar focuses on a hypothetical female cancer patient named Susan (pseudonym) who represents common concerns of patients with cancer (Lewandowska et al., 2020; Ose et al., 2017). The case was developed in consultation with KAB, an oncology nurse with 35 years of experience working with patients with cancer of varying ages and cancer types. The case exemplar outlines SMS that a clinical nurse can employ to empower patients like Susan in coping with their concerns at different phases of the cancer trajectory.

## CASE EXEMPLAR

The following section will begin by narrating Susan's journey, which will be segmented into three phases of the cancer care trajectory: treatment, chemotherapy, and follow-up care. Following each excerpt of Susan's narrative, a table detailing key nursing interventions will be provided.

### Susan's Story

Susan is a 43-year-old married woman with three children aged 13, 10, and 8. She is employed full-time as an executive administrative assistant at a private corporation. Susan is close to her family and has a social circle of friends, including other moms. Susan routinely exercises and sees her healthy parents weekly. She also meets her network of friends at children's activities and socializes with them approximately once a month. Despite having a healthy lifestyle, strong family and social supports, and no family history of cancer, Susan noticed symptoms of mild rectal bleeding and constipation, initially attributing them to hemorrhoids. When the symptoms persisted, however, she became concerned and arranged a visit with her family doctor. Routine blood work revealed lower than normal hemoglobin levels, prompting her doctor to arrange a colonoscopy at an external clinic. Colonoscopy showed a malignant appearing mass in the ascending colon. Biopsy results confirmed invasive adenocarcinoma, grade 2, with stable microsatellite status.

## 1. Treatment Phase (Surgery)

Susan was referred to a gastroenterologist surgeon at a colorectal assessment centre (CAC). After a three-week wait, she met with the surgeon who organized staging tests (computer tomography [CT] scan of chest, abdomen, and pelvis) and baseline carcinoembryonic antigen (CEA). Susan returned to the CAC to discuss the test results with her surgical team and decided to proceed with surgery, rather than receiving neoadjuvant chemotherapy. She underwent a right hemicolectomy but, due to unforeseen complications, the surgeon performed an open excision and temporary colostomy rather than laparoscopy. Throughout the phase of diagnosis and surgery, she expressed concerns about caring for her children. Key oncology nursing SMS strategies are presented in Table 1.

## 2. Treatment Phase (Chemotherapy)

Following surgery, Susan was offered the following systemic therapy options: (a) oral capecitabine, (b) XELOX (capecitabine and oxaliplatin every three weeks), or (c) FOLFOX-6 (oxaliplatin, folinic acid/leucovorin, fluorouracil) treatments. After careful consideration, and due to her age, she decided to opt for FOLFOX chemotherapy. Susan was then referred for a peripherally inserted central catheter (PICC). Home care services were organized. She received FOLFOX chemotherapy every two weeks for six cycles in the chemotherapy unit and the 5FU infuser was connected prior to leaving the chemotherapy unit. Once home, a home care nurse provided initial treatment teaching, and the home care team

**Table 1**

*Oncology Nurse's Role in the Provision of SMS During the Surgical Treatment Phase Inspired by Chan et al. (2023) and Otero-Sabogal et al. (2018)*

Characteristics of SMS	Potential SMS Strategies
1. Support setting realistic goals, defining specific actions, and agreeing on the steps needed to achieve these goals	<ul style="list-style-type: none"> <li>• Establish rapport and gain Susan's trust to agree collaboratively on mutual goals for creating a post-operative action plan.</li> <li>• Use Motivational Interviewing and OARS (open-ended questions, affirmations, reflective listening, summarizing).</li> <li>• Assess Susan's current knowledge, social supports, psychosocial, and clinical factors.</li> <li>• Document the action plan and questions to ask at each visit.</li> </ul>
2. Providing intensive training in disease-specific skills for patients and caregivers	<ul style="list-style-type: none"> <li>• Improve activation and confidence to self-manage by intensively training Susan and her caregivers.</li> <li>• Engage Susan using education booklets.</li> <li>• Demonstrate wound care, deep breathing, and coughing techniques and employ the Teach-Back method.</li> <li>• Employ Closing the Loop teaching about other post-operative care aspects, such as medication use and diet.</li> </ul>
3. Offering informational, emotional support, and problem-solving skills to enhance self-confidence, self-efficacy, and self-esteem in managing chronic illness	<ul style="list-style-type: none"> <li>• Use Active Listening and validation of key concerns.</li> <li>• Collaborate on how to manage at home.</li> <li>• Ask Susan how her relatives or friends can help her address concerns of managing her home and caring for the children, i.e., Mom coming in, friends to drive children.</li> </ul>
4. Engaging with patients and their families in a positive, respectful, and culturally appropriate manner	<ul style="list-style-type: none"> <li>• Communicate in a culturally sensitive manner.</li> <li>• Assess Susan's health literacy.</li> <li>• Consider her ethnicity and cultural background in communication and education.</li> </ul>
5. Providing ongoing follow-up	<ul style="list-style-type: none"> <li>• Facilitate with care team members as required (i.e., enterostomal therapy nurse, PCP).</li> <li>• Timely follow-up telephone triage, tech app if available.</li> <li>• Discuss next steps in treatment and engage HCP as needed.</li> </ul>
6. Encouraging healthy behaviour change	<ul style="list-style-type: none"> <li>• Encourage/support self-confidence.</li> <li>• Use 5 As model (assess, advise, agree, assist, arrange).</li> <li>• Discuss why diet, exercise, bowel function are important.</li> </ul>
7. Assisting patients and caregivers with psychosocial issues	<ul style="list-style-type: none"> <li>• Engage the multidisciplinary team as needed.</li> <li>• Discuss Susan's next step in treatment &amp; engage team.</li> <li>• Explore skills she has effectively used previously and resources to cope with anxiety (such as PSOP, Social Worker, peer support programs, and CCS).</li> </ul>

Note. SMS = self-management support; PCP = primary care provider; HCP = healthcare professional; CCS = Canadian Cancer Society; PSOP = psychosocial oncology program.

remained available to contact, should issues arise thereafter. During the chemotherapy treatment, she expressed concerns about peripheral neuropathy, sexuality, potential reactions to FOLFOX, and general safety concerns. Key oncology nursing SMS strategies are presented in Table 2.

### 3. End of Treatment Phase (Discharge to Primary Care Provider)

Susan has now been under the care of a medical oncologist at the cancer centre for a year. During this time, she has experienced several side effects of treatment, including peripheral neuropathy with an Edmonton Symptom Assessment

Scale (ESAS) Score of 7, describing sensations of walking on sponges and burning, and fatigue. Additionally, Susan has been dealing with irregular bowel function, experiencing loose stools at times and constipation at other times.

Susan has expressed several concerns, including difficulty with multitasking and experiencing memory issues. She also shared her plans to return to work within the next month, raising concerns about managing her symptoms while transitioning back to her professional responsibilities. Furthermore, she confided that she initially felt these side effects were normal from treatment, but has been wondering over the past two

**Table 2**

*Oncology Nurse's Role in Provision of SMS During the Chemotherapy Treatment Phase Inspired by Chan et al. (2023) and Otero-Sabogal et al. (2008)*

Characteristics of SMS	Potential SMS Strategies
1. Support setting realistic goals, defining specific actions, and agreeing on the steps needed to achieve these goals	<ul style="list-style-type: none"> <li>• Establish rapport, gain, and maintain trust. Ask Susan – How are you managing?</li> <li>• Use OARS to discuss and collaboratively agree on goals for an action plan.</li> <li>• Assess Susan's current knowledge, access barriers, co-morbidities, psychosocial and clinical factors.</li> <li>• Encourage documentation of all contacts to call with concerns or questions, and questions to ask at each visit.</li> </ul>
2. Providing intensive training in disease-specific skills for patients and caregivers	<ul style="list-style-type: none"> <li>• Engage Susan by providing educational documents regarding the management of chemotherapy side effects (i.e., nausea, fatigue, and bowel concerns).</li> <li>• Bring educational documents to each visit to review and address questions.</li> <li>• Check for understanding of action plan treatment options.</li> <li>• Use teach-back and/or closing the loop teaching techniques to check her understanding of clinical advice about the 5FU infusor, diet, bowel concerns, PICC care, sexual relations.</li> </ul>
3. Offering informational, emotional support, and problem-solving skills to enhance self-confidence, self-efficacy, and self-esteem in managing chronic illness	<ul style="list-style-type: none"> <li>• Use Active Listening and validation of Susan's key concerns.</li> <li>• Encourage communication with her family and help her create to-do lists to seek assistance when needed.</li> <li>• Collaborate with her to find solutions for watching her kids sporting activities and managing the home.</li> </ul>
4. Engaging with patients and their families in a positive, respectful, and culturally appropriate manner	<ul style="list-style-type: none"> <li>• Provide culturally sensitive care.</li> <li>• Use preferred and plain language and provide culturally appropriate tools.</li> <li>• Simplify communication and customize educational materials to her health literacy and ethnicity/cultural background.</li> </ul>
5. Providing ongoing follow-up	<ul style="list-style-type: none"> <li>• Timely follow-up telephone triage from home care, cancer centre, medical oncologist on call, tech app if available.</li> <li>• Discuss next steps, treatment.</li> <li>• Engage HCPs as necessary.</li> </ul>
6. Encouraging healthy behaviour change	<ul style="list-style-type: none"> <li>• Encourage/support self-confidence.</li> <li>• Use 5 As model (assess, advise, agree, assist, arrange).</li> <li>• Discuss a plan for health behaviour change if applicable, document the plan.</li> <li>• Discuss why following diet and exercise guidelines is important to manage nausea, fatigue, and reduce the risk of recurrence.</li> </ul>
7. Assisting patients and caregivers with psychosocial issues	<ul style="list-style-type: none"> <li>• Discuss next steps in the treatment and engage HCP team.</li> <li>• Ask Susan about her coping skills, engage PICC team and support programs, such as peer or community support programs, as needed.</li> </ul>

Note. SMS = self-management support; OARS = open-ended questions, affirmations, reflective listening, summarizing; 5FU = fluorouracil; PICC team = peripherally inserted central catheter team; HCP = healthcare professional.

months why they are not improving and if they will get better. Susan expressed worries about the continuity of care, feeling apprehensive about potentially being “dumped back” to her primary care provider. Moreover, she voiced fears about cancer recurrence, questioning what tests she might need in the future to monitor her condition and detect any potential recurrence early on. Key oncology nursing SMS strategies are presented in Table 3.

## EVALUATION OF THE WORKSHOP

The workshop was attended by 34 participants and 30 completed an evaluation form prepared by the SIG co-chairs (CML, KB). Sociodemographic information is outlined on Table 4. Ninety-three percent of participants agreed to strongly agreed that the information they learned was relevant to their practice, while 84% acknowledged gaining new insights into survivorship through their workshop experience. Furthermore, participants reported that the workshop encouraged the early integration of SMS into their practice following a cancer diagnosis and provided them with tools and information necessary for culturally appropriate SMS.

## DISCUSSION AND CONCLUSION

This case exemplar demonstrates the importance of oncology nurses recognizing the uniqueness of cancer survivors (Charalambous, 2019; El-Akhras & Bilodeau, 2023) and the provision of SMS strategies to meet the individual physical, psychosocial, and life altering changes cancer survivors experience at different phases throughout the cancer care trajectory (Chan et al., 2023; Howell, 2018; Howell et al., 2021). This paper also provides an overview of self-management support strategies as options that oncology nurses may employ depending on the nurse’s role and area of clinical practice.

A first step to engaging individuals as partners in self-management of cancer and health is establishing trust and rapport (Chan et al., 2023). To accomplish this, nurses can utilize effective person-centred communication techniques, such as active listening, motivational interviewing, and OARS. OARS entails employing open-ended questioning (O), affirmations (A), simple, amplified, and complex reflections (R), as well as summarizations (S) (Chan et al., 2023). Moreover, nurses can utilize

**Table 3**

*Oncology Nurse’s Role in Provision of SMS During the End of Treatment Phase Inspired by Chan et al. (2023) and Otero-Sabogal et al. (2008)*

Characteristics of SMS	Potential SMS Strategies
1. Support setting realistic goals, defining specific actions, and agreeing on the steps needed to achieve these goals	<ul style="list-style-type: none"> <li>• Assess Susan’s current knowledge, psychosocial, and clinical concerns.</li> <li>• Use OARS to collaboratively agree on individual needs and set goals for the action plan/SCP.</li> <li>• Document a comprehensive SCP.</li> </ul>
2. Providing intensive training in disease-specific skills for patients and caregivers	<ul style="list-style-type: none"> <li>• Provide a SCP as a key educational tool.</li> <li>• Provide Susan with guidance on how to manage neuropathy, fatigue, loose stools, memory issues, review signs of recurrence, returning to work.</li> </ul>
3. Offering informational, emotional support, and problem-solving skills to enhance self-confidence, self-efficacy, and self-esteem in managing chronic illness	<ul style="list-style-type: none"> <li>• Validate Susan’s key concerns.</li> <li>• Collaborate on what works for her, i.e., use lists to aid with memory issues communicating with colleagues, use <a href="http://www.cancerandwork.ca">www.cancerandwork.ca</a> website to assist with returning-to-work concerns, recommend exercise guidelines for fatigue, use SCP to track guidelines (CEA, scans, follow-up visits).</li> </ul>
4. Engaging with patients and their families in a positive, respectful, and culturally appropriate manner	<ul style="list-style-type: none"> <li>• Employ culturally sensitive care and health literacy.</li> <li>• Communicate in a culturally customized way and engage support persons.</li> </ul>
5. Providing ongoing follow-up	<ul style="list-style-type: none"> <li>• Explain that the guidelines are evidenced-based and clarify when follow up with her PCP is recommended.</li> <li>• Review each item of the follow-up guideline.</li> <li>• Explain the “2-week rule” (patient to report the concern to their PCP if the concern persists for 2 weeks after initially being detected) and provide contact information should re-referral to the cancer centre be required.</li> </ul>
6. Encouraging healthy behaviour change	<ul style="list-style-type: none"> <li>• Encourage and support self-confidence.</li> </ul>
7. Assisting patients and caregivers with psychosocial issues	<ul style="list-style-type: none"> <li>• Inform Susan of available support and resources.</li> <li>• Provide information about applicable community support programs, such as employer support program, peer support, and occupational therapy.</li> </ul>

Note. SMS = self-management support; OARS = open-ended questions, affirmations, reflective listening, summarizing; SCP = survivorship care plan; CEA = carcinoembryonic antigen; PCP = primary care provider.

**Table 4**

*Sociodemographic Characteristics*

<b>Participant's Professional Characteristics</b>	<b>N = 30 (%)</b>
<b>Field of practice</b>	
<b>Clinical</b>	28 (93)
Staff Nurse	13 (43)
Nurse Navigator	6 (20)
Research Nurse	3 (10)
Clinical Manager	2 (7)
Clinical Nurse Specialist	2 (7)
Nurse Practitioner	1 (3)
Territorial Specialist	1 (3)
<b>Non-Clinical</b>	2 (7)
Education	2 (7)
<b>Specialty</b>	
Medical oncology/Systemic Therapy	13 (43)
Ambulatory care	11 (37)
Navigation	8 (27)
Hematology	2 (7)
Surgical Oncology	1 (3)
Gynecologic Oncology	1 (3)
Other (e.g., Management, Palliative Care)	6 (20)
Not Reported	2 (7)
<b>Professional Experience, yrs.</b>	
0–4	2 (7)
5–9	9 (30)
10–14	7 (23)
15–21	4 (13)
>21	8 (27)
<b>Professional Experience in Oncology, yrs.</b>	
0–4	10 (33)
5–9	11 (37)
10–14	2 (7)
15–21	3 (10)
>21	4 (13)
<b>Practice setting</b>	
<b>Specialized Care Settings</b>	22 (73)
Specialized Cancer Centre or Agency	10 (33)
Community Hospital	9 (30)
Academic Teaching Hospital	3 (10)
<b>Primary Health Care Settings</b>	4 (13)
Community Clinic	4 (13)
<b>Non-Clinical Setting</b>	10 (33)
Government/Health Service	4 (13)
University/College	4 (13)
Non-Profit Organization	2 (7)
<b>Region of practice</b>	
Ontario	10 (33)
New Brunswick	5 (17)
Quebec	5 (17)
Newfoundland	3 (10)
Alberta	2 (7)
Saskatchewan	2 (7)
British Columbia	1 (3)
Nova Scotia	1 (3)
Yukon, Northwest Territories, Nunavut	1 (3)

health coaching for behavioral change by applying the 5As framework (assess, advise, agree, assist, arrange) to identify with the cancer survivor interventions to develop personalized goals and action plans for adopting self-management behaviors (Chan et al., 2023; Howell et al., 2023).

It is important to note that integrating SMS into routine care necessitates a comprehensive system change across various levels of the organization and care sectors. This transformation will entail modifications in healthcare provider practices (microsystem capacity), at the organizational level (macrosystem, including policy), and in care protocols, pathways, and standards for cancer care delivery (mesolevel) (Howell et al., 2021). At the organizational and health policy levels, there is a need for further examination of reimbursements or incentives for participating in SMS, inclusion in oncology bundled payments, and allocating time during clinical encounters to integrate SMS into routine care (Howell et al., 2021). Additionally, enhancing the roles of advanced practice nurses and nurse navigators is crucial for delivering SMS effectively. In these roles, advanced practice nurses can act as facilitators of practice change, supporting staff nurses in key SMS functions, such as teach-back and closing the loop, ensuring continuity in routine care (Howell et al., 2021).

Oncology nurses play a key role in assisting patients in transitioning at each phase of the cancer trajectory (Watson et al., 2021; Young et al., 2020). Oncology nurses can facilitate the transition in cancer care with SMS by providing patients with the necessary tools, resources, and education to help them actively participate in their care (Watson et al., 2021; Young et al., 2020). However, nursing self-management support interventions are rarely integrated into routine clinical care for cancer patients (Charalambous et al., 2018) and nurses often lack the essential training and education to provide effective SMS for this population (Chan et al., 2020; Duprez et al., 2017). Nurses require training that goes beyond mere skill acquisition and that includes clear clinical pathways, such as case exemplars, to clarify the application of SMS in routine cancer care practices (Chan et al., 2023; Howell et al., 2021). Case studies or case exemplars can help nurses in providing self-management support by teaching important aspects of person-centred nursing care, and by illustrating how to apply theoretical frameworks in practice (Hackel & Fawcett, 2018). These educational strategies can help nurses and nursing students develop critical thinking and problem-solving skills, enhancing their self-confidence and ability to apply their knowledge in clinical practice (Hackel & Fawcett, 2018; Herron et al., 2019).

The paper provides the case exemplar presented at the 2023 CANO/ACIO conference survivorship workshop as an opportunity to educate clinical oncology nurses on proposed SMS strategies they may utilize in their clinical practice and underscores the importance of the oncology nurse's role in the provision of SMS at each phase of the cancer trajectory. Our evaluation results suggest this strategy is appropriate and effective to enhance oncology nurses' knowledge to engage and assist cancer survivors to self-manage. We suggest further workshops and continuous education to help

prepare oncology nurses with SMS strategies to assist cancer survivors engage in the participation of their care, ultimately to help improve their quality of life and outcomes (Chan et al., 2023; Foster, 2022; Vinette & Bilodeau, 2021). It is noteworthy to underline that this paper presents a realistic case exemplar along with evidence-based strategies for SMS. Nurse educators can utilize this to structure educational sessions in their respective settings.

## CONFLICT OF INTEREST

None

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