

# Canadian Oncology Nursing Journal

# Revue canadienne de soins infirmiers en oncologie

---

Volume 34, Issue 1 • Winter 2024  
eISSN: 2368-8076



Canadian Association of Nurses in Oncology  
Association canadienne des infirmières en oncologie



- 2** **Guest editorial: Amplifying our strengths**  
Lorelei Newton, Catriona J. Buick

## ARTICLES

- 4** **Developing an educational resource for gynecological cancer survivors and their caregivers: A methods and experience paper**  
By Jacqueline Galica, Amina Silva, Kathleen Robb
- 10** **Élaboration d'une ressource d'information à l'intention des survivantes d'un cancer gynécologique et de leurs proches aidants : exposé sur le vécu et les méthodes**  
Par Jacqueline Galica, Amina Silva et Kathleen Robb
- 16** **Caring for cancer patients in acute cancer care settings: Voices of South African nurses**  
By Johanna E. Maree, Jacoba J. M. Jansen van Rensburg, Sizakele N. Hadebe
- 22** **S'occuper des patients atteints de cancer : l'expérience d'infirmières et d'infirmiers d'Afrique du Sud travaillant en soins aigus**  
Par Johanna E. Maree, Jacoba J. M. Jansen van Rensburg, Sizakele N. Hadebe
- 28** **An integrative review of strategies to prevent and treat compassion fatigue in oncology nurses**  
By Jodi Collier, Tania Bergen, Hua Li
- 38** **Revue intégrative des stratégies de prévention et de traitement de la fatigue de compassion chez les infirmières en oncologie**  
Par Jodi Collier, Tania Bergen, Hua Li
- 49** **Breaking barriers: Indigenous nurse navigator role in oncology care for the Inuit**  
By Carolyn Roberts
- 57** **Lever les barrières : du rôle de l'infirmière pivot pour les Autochtones dans les soins oncologiques aux Inuits**  
Par Carolyn Roberts

## FEATURES/CHRONIQUES

- 66** **CAPO and CANO/ACIO joining forces to advance a national psychosocial oncology advocacy agenda**  
By Carmen G. Loiselle, Samar Attieh, Lorelei Newton
- 70** **L'ACOP/CAPO et l'ACIO/CANO joignent leurs forces pour faire valoir l'oncologie psychosociale à l'échelle nationale**  
Par Carmen G. Loiselle, Samar Attieh, Lorelei Newton
- 74** **PRACTICE REFLECTIONS**  
**Ethical considerations for nurses working in rare cancer care: Focus on sarcoma**  
Sarah J. Quinn
- 79** **RESEARCH REFLECTIONS**  
**Advancing linguistic and epistemic equity for sex, gender, and diversity in oncology care research: Moving forward and together as a community**  
Billy Vinette, Wing Lam Tock, Ricardo Souza Evangelista Sant'Ana, Christine Cassivi, Manon Lemonde, Christine Maheu
- 82** **2022 CANO/ACIO Annual Conference Abstracts Index**
- 92** **CANO/ACIO Annual Conference Workshop Abstracts**
- 140** **CANO/ACIO Annual Conference Poster Abstracts**



Canadian Association of Nurses in Oncology  
Association canadienne des infirmières en oncologie

Canadian Oncology Nursing Journal / Revue canadienne de soins infirmiers en oncologie is a refereed journal.

- Editor-in-Chief** Margaret I. Fitch, RN, PhD, 207 Chisholm Avenue, Toronto, ON M4C 4V9; 416-690-0369; [www.cano-acio.ca/ContactCONJEditor](http://www.cano-acio.ca/ContactCONJEditor)
- Editorial Board** Karine Bilodeau, inf., Ph.D., professeure adjointe, Faculté des sciences infirmières, Université de Montréal, 2375 chemin Côte-Ste-Catherine, bureau 7101, Montréal, QC H3T 1A8; 514-343-6111, poste 43254; [karine.bilodeau.2@umontreal.ca](mailto:karine.bilodeau.2@umontreal.ca)
- Manon Lemonde, IA, PhD, professeure agrégée, Faculty of Health Sciences, University of Ontario Institute of Technology, 2000 Simcoe Street N, Oshawa, ON L1G 0C5; [Manon.Lemonde@uoit.ca](mailto:Manon.Lemonde@uoit.ca)
- Dawn Stacey, RN, PhD, University of Ottawa, School of Nursing, 451 Smyth Road (Rm 1118), Ottawa, ON K1H 8M5; [dawn.stacey@uottawa.ca](mailto:dawn.stacey@uottawa.ca)
- Fay J. Strohschein, RN, PhD(c), Ingram School of Nursing, McGill University, Nursing Counsellor, Geriatric Oncology, Jewish General Hospital, 3755 Côte-Ste-Catherine, Montréal, QC H3T 1E2; 514-340-8222, ext. 3864; [Fay.strohschein@mail.mcgill.ca](mailto:Fay.strohschein@mail.mcgill.ca)
- Sally Thorne, RN, PhD, FCAHS, University of British Columbia, T201-2211 Wesbrook Mall, Vancouver, BC V6T 2B5; 604-822-7482; [sally.thorne@nursing.ubc.ca](mailto:sally.thorne@nursing.ubc.ca)
- Reviewers** A list of current CONJ reviewers is available at: <http://canadianoncologynursingjournal.com/>
- Managing Editor** Heather Coughlin, 613-633-1938; [heather@pappin.com](mailto:heather@pappin.com)
- Production** The Canadian Oncology Nursing Journal is produced in conjunction with Pappin Communications, 613-633-1938; [heather@pappin.com](mailto:heather@pappin.com)
- Statement** The Canadian Oncology Nursing Journal is the official publication of the Canadian Association of Nurses in Oncology, and is directed to the professional nurse caring for patients with cancer. The journal supports the philosophy of the national association. The philosophy is: "The purpose of this journal is to communicate with the members of the Association. This journal currently acts as a vehicle for news related to clinical oncology practice, technology, education, and research. This journal aims to publish timely papers, to promote the image of the nurse involved in cancer care, to stimulate nursing issues in oncology nursing, and to encourage nurses to publish in national media." In addition, the journal serves as a newsletter conveying information related to the Canadian Association of Nurses in Oncology; it intends to keep Canadian oncology nurses current in the activities of their national association. Recognizing the value of nursing literature, the editorial board will collaborate with editorial boards of other journals and indexes to increase the quality and accessibility of nursing literature.
- Indexing** The Canadian Oncology Nursing Journal/Revue canadienne de soins infirmiers en oncologie is registered with the National Library of Canada, eISSN 2368-8076, and is indexed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the International Nursing Index.
- Membership** All nurses with active Canadian registration are eligible for membership in CANO. Contact the CANO national office. Refer to the Communiqué section for name and contact information of provincial representatives.
- Publication** The journal is published quarterly in January, April, July, and October. The Canadian Oncology Nursing Journal is open access and available at [www.canadianoncologynursingjournal.com](http://www.canadianoncologynursingjournal.com). Published by the Canadian Association of Nurses in Oncology, 750 West Pender St., Suite 301, Vancouver, BC V6C 2T7; [www.cano-acio.ca](http://www.cano-acio.ca); 604-874-4322; Fax: 604-874-4378; [cano@malachite-mgmt.com](mailto:cano@malachite-mgmt.com)
- Author Information** Guidelines for authors are usually included in each issue. All submissions are welcome. At least one author should be a registered nurse; however, the editor has final discretion on suitability for inclusion. Authors are responsible for acknowledging all sources of funding and/or information.
- Language Policy/  
Politique linguistique** The Canadian Oncology Nursing Journal is officially a bilingual publication. All journal content submitted and reviewed by the editors will be printed in both official languages. La Revue canadienne de soins infirmiers en oncologie est une publication officiellement bilingue. Le contenu proprement dit de la Revue qui est soumis et fait l'objet d'une évaluation par les rédactrices est publié dans les deux langues officielles.
- Advertising** For general advertising information and rates, contact Heather Coughlin, Advertising Manager, Pappin Communications, 613-633-1938; [heather@pappin.com](mailto:heather@pappin.com). All advertising correspondence and material should be sent to Pappin Communications. Online rate card available at: [www.pappin.com](http://www.pappin.com)

Opinions expressed in articles published are those of the author(s), and do not necessarily reflect the view of the Canadian Association of Nurses in Oncology or the editorial board of the Canadian Oncology Nursing Journal. Acceptance of advertising does not imply endorsement by CANO or the editorial board of CONJ. All rights reserved. The law prohibits reproduction of any portion of this journal without permission of the editor.

Canadian Association of Nurses in Oncology, 750 West Pender St., Suite 301, Vancouver, BC, V6C 2T7. [cano@malachite-mgmt.com](mailto:cano@malachite-mgmt.com)

# Guest editorial: Amplifying our strengths

**A**s president and vice president of the Canadian Association of Nurses in Oncology (CANO/ACIO), and on behalf of the Board of Directors, we are pleased to have this opportunity to share the progress of CANO/ACIO over the past year. As we strive to enact our ambitious Strategic Plan, we believe it is important to ensure CANO/ACIO members are central in efforts to support endeavors that are important to oncology nurses across the country. To this end, we will be sending out a membership survey in early 2024. Please take an opportunity to share your thoughts and ideas with us, as we move forward. The strategic plan is meant to be a working document to serve CANO/ACIO and feedback is an important piece of this work.

## BACKGROUND

Drawing from our membership feedback survey in 2022, the board collaborated in the development of a new strategic plan, building on the strong foundation of previous strategic plans. Thus, the 2022–2025 Strategic Plan is built on this legacy of perseverance and resolve, reflecting ambitious advocacy efforts to advance our Vision and Mission. It is important to revisit our strategic plans routinely to ensure that the association's goals are aligned with the ever-evolving context of cancer care and are responsive to member feedback. Further information can be found at <http://canadianoncologynursing-journal.com/index.php/conj/article/view/1265/1048>.

CANO/ACIO's mission is to *advance cancer care nursing through advocacy, collaboration, the provision of practice resources, education, research and leadership for the benefit of all people living in Canada*. Our vision is that CANO/ACIO is a *recognized leader in pursuing cancer care nursing excellence and improving access and equity, nationally and internationally*.

## WHAT WE ARE DOING: OVERVIEW OF OUR STRATEGIC PRIORITIES

**CANO/ACIO is the source for valued and practical resources (Priority A):** It is increasingly clear that CANO/ACIO is a reliable source of resources surrounding oncology nursing (i.e., standards, position statements, and toolkits), which are accessed routinely by other countries. Extensive work is underway to develop new standards of practice, update existing standards, and develop position statements on critical topics of relevance to oncology nurses (e.g., radiation oncology nursing and virtual care oncology nursing). In addition, CANO/ACIO has provided support to special interest groups whose leadership has been instrumental in the development of resources (e.g., a geriatric oncology nursing toolkit).

**CANO/ACIO is an advocate in support of oncology nurses and people affected by cancer (Priority B):** We have expanded the CANO/ACIO Board of Directors to include a new position of Director-at-Large, Advocacy and Policy. The aim of this role is to provide a focused and equitable lens, as CANO/ACIO works toward our advocacy goals for both nurses and the Canadians we serve. The Director-at-Large (DAL) Advocacy and Policy portfolio will also continue the work of the Underserved Committee, including the dissemination and analysis of the rural and remote survey (stay tuned for the results of that survey in the new year). As well, analysis of the data collected through the Pan-Canadian Multidisciplinary Radiation Oncology Workforce Survey is ongoing. We are looking forward to reporting on that project, as it includes nursing respondents for the first time. CANO/ACIO work with Cancer Action Now Alliance (CANA) has proved fruitful for advocacy in partnership with patient-led groups (e.g., <https://vancouver.sun.com/opinion/opinion-we-need-urgent-action-to-improve-quality-of-life-for-cancer-patients-in-canada>; <https://www.healthinsight.ca/managing-illnesses/cancer-care/>

[understanding-the-role-of-oncology-nurses-in-advancing-patient-care/](https://prostatecanada.ca/) and Pros Talk Prostate at <https://prostatecanada.ca/>). We are pleased to report that there are new special interest groups established within CANO/ACIO for 2024 (i.e., Planetary Health and Clinical Trials) that will also engage in this advocacy work.

**CANO/ACIO is proactive in engaging external partners to achieve strategic objectives (Priority C):** CANO/ACIO has had a busy year connecting with external partners nationally. This effort has included the Canadian Cancer Society, the Canadian Association of Psychosocial Oncology, and the Canadian Venous Access Association in joint presentations at the respective conferences. Collaboration also occurred for the Pediatric Oncology Nursing Day offered at the CANO / ACIO conference and with Leukemia and Lymphoma Society of Canada. CANO/ACIO is a knowledge user for two large projects funded by the Canadian Institutes of Health Research: 1) Designing Engagement Strategies for Genomics-Informed Oncology Nursing: Comparative Prospective Cross-Jurisdictional Policy Analysis, and 2) Evaluation of the Implementation of Portfolio-based Certification to Improve Access to Quality Healthcare by Strengthening the Nursing Workforce (in submission). We anticipate these projects will enhance our efforts to reach into practice areas.

**CANO/ACIO is a nationally and internationally recognized leader (Priority D):** There has been considerable board representation at national forums and symposium regarding cancer care and advocacy. These have included 1) The Walrus Leadership Dinner on the State of Cancer in Canada, co-hosted by the Canadian Cancer Society, 2) Re-Envisioning the Delivery of Cancer Care in Canada: An Oncology Education Symposium in Collaboration with the Canadian Association of Medical Oncologists, and 3) Oncology Advocacy Forum (under the umbrella of Ottawa University and Ottawa

Research Institute). Internationally, we have just signed a Memorandum of Understanding with the European Oncology Nursing Society and will be working together on a virtual oncology nursing care position statement, as our first (of hopefully many) joint project. In addition, we are collaborating with our Oncology Nursing Society partners in the United States in the creation of two international position statements. One statement is on fertility preservation in individuals with cancer, and the other is about oncology nurse navigation (both are to be published soon). CANO/ACIO has expanded our membership categories to include our oncology nursing colleagues who reside in lower- and middle-income countries (LMIC). The creation of this new membership category contributes to our continuing collaboration with the International Society of Nurses in Cancer Care Nursing (ISNCC) in supporting oncology nursing colleagues from low- and middle-income countries at the International Cancer Nursing Conference (ICCN). In light of this direction, CANO/ACIO Board members presented the CANO/ACIO Standards and other resources to the international community at the recent ISNCC conference (ICCN23) held in Scotland. The emphasis was on our openness to having colleagues use and adapt for their local context, as needed, CANO/ACIO resources. As well, CANO/ACIO provided the keynote address (virtually) at the 2023 International Specialist Nursing Conference held in Mainland China.

**CANO/ACIO leads the appreciation for oncology Nurses (Priority E):** The creation of an Oncology Nursing Day Committee this past year was a success, and we will continue with this approach to lead appreciation for oncology nurses. CANO/ACIO is also intensifying financial support for members by creating new internship opportunities for students, increasing funds allocated to research grants and awards, as well as increasing the number of grants and awards available. In addition, we have just approved the creation of a Media Relations Committee within the DAL Communications portfolio to increase CANO/ACIO visibility to our existing members and the broader healthcare community.

**CANO/ACIO is a strong, efficient, and viable organization (Priority F):** CANO/ACIO aims to amplify Canadian oncology nurses' work from coast to coast. As we move forward, we will focus our efforts on actively engaging in succession planning and eliciting feedback from our members. The CANO/ACIO membership survey is an opportunity for members to provide valuable direction for the organization. Please consider completing the survey and do not hesitate to let us know if you have any questions. Also watch for the announcements inviting applications for new board members this spring. Consider how you would like to be engaged with CANO/ACIO. If you are not ready to consider joining the national board or committee level, you may consider participating in your local chapter or in a

Special Interest Group (SIG) in an area you are passionate about. There is a lot of good work to be done post pandemic!

## CONCLUSION/MOVING FORWARD

*"What we know matters, but who we are matters more." Brene Brown*

In addition to the above highlights, there are many more activities ongoing and planned. The landscape of cancer care is changing. As our members adapt to these changes, CANO/ACIO needs to be attentive to shifts in membership composition and needs. Our strategic plan is a dynamic document and intended to provide short- and long-term goals that steer the association's direction, actions, and initiatives. Flexibility is key, as we adjust to the unpredictable realities that often confront us. We value, and require, members' input now more than ever to ensure CANO/ACIO is moving in directions that are congruent with the voices and goals of our members.



**Lorelei Newton, PhD, RN**  
President  
Victoria, British Columbia  
lorelei@uvic.ca



**Catriona J. Buick, PhD**  
Vice-President  
Toronto, Ontario  
cbuick@yorku.ca

# Developing an educational resource for gynecological cancer survivors and their caregivers: A methods and experience paper

By Jacqueline Galica, Amina Silva, Kathleen Robb

## ACKNOWLEDGEMENT

*The project described in this manuscript involved the work of others who – although not meeting authorship criteria for this manuscript – are co-authors on the accompanying manuscript that reports project results. Those members include: Avery Regan, Stephanie Saunders, Claudia Romkey-Sinasac, Janet Giroux; Janet Jull, Christine Maheu, Josée-Lyne Ethier; Debora Stark; Julie Francis; Kardi Kennedy; and Stuart Peacock. This study was supported by a CIHR Catalyst Grant for Patient-Oriented Research awarded to Jacqueline Galica and Kathleen Robb (Application # 424922).*

## ABSTRACT

*Building upon the need for greater education, identified by gynecological cancer survivors and their caregivers, the objective of this paper is to describe our patient-clinician-researcher partnership to develop an evidence- and experiential-based educational resource. We engaged in five phases using multiple research methods: 1) assembling the essential expertise, 2) reviewing the literature, 3) drafting the resource, 4) testing the resource, and 5) disseminating the resource. Our diverse partnership provided expertise toward multiple research methods that produced results useful for each successive phase. This combination – a diverse partnership and multiple research methods – resulted in a useful resource to fulfill a gap identified by knowledge users. The combined features described in our paper fill a procedural gap for clinicians and researchers intending to develop educational resources that are empirically and experientially founded.*

## INTRODUCTION

The number of people surviving cancer is increasing (Canadian Cancer Statistics Advisory et al., 2022). Although this is good news, cancer survivors and their informal caregivers experience a variety of concerns after completing primary treatment (Canadian Partnership Against

Cancer/Partenariat canadien contre le cancer, 2018; Kent et al., 2016). These concerns may relate to physical, mental, and emotional matters (Canadian Partnership Against Cancer/Partenariat canadien contre le cancer, 2018), which can persist for years after treatment is complete. Given that unresolved concerns for cancer survivors result in greater use of health-care resources (i.e., emergency department visits; Lebel et al., 2013), greater awareness about what to expect after treatment can help mitigate some of their concerns (Galica et al., 2020; Galica et al., 2022). Considering these points, educational resources may be helpful to prepare survivors and their caregivers for the transition out of primary cancer treatment and improve their overall well-being.

Although there has been increased attention toward developing transitional educational interventions for cancer survivors (Liska et al., 2018; Nekhlyudov et al., 2019), the development, delivery and effectiveness of these interventions can vary widely (Hawkins et al., 2017). Furthermore, the involvement of knowledge users, such as patients and/or clinicians, in the development of these educational interventions is not always apparent. Involving knowledge users throughout the process of identifying the need for and development of educational interventions increases the likelihood of their relevance and sustained use (Boden et al., 2021; Lyon & Koerner, 2016).

Despite the importance of involving knowledge users in the development of resources, there is a lack of comprehensive guidance about how to co-develop interventions to address matters relevant to cancer care. To fill this gap, our aim for this paper is to describe our patient-clinician-researcher experience developing an evidence- and experiential-informed educational resource for cancer survivors, and their caregivers, at the end of primary cancer treatment. Building upon the need for greater education identified by gynecological cancer (GC) survivors in our region (Galica et al., 2020), we developed a five-phase process (Figure 1) to develop the resource: (1) assembling the essential expertise, (2) reviewing the literature, (3) drafting the resource, (4) testing the resource, and (5) disseminating the resource. In the following sections, we describe the methods enacted in each phase of our process. We also share some of our reflections on this process for those interested in developing educational resources with and for cancer patients, survivors, and their caregivers.

### Phase 1: Assembling the essential expertise

Healthcare interventions can be complex and therefore challenging to plan and implement. As such, to ensure an intervention's relevance, it is important to infuse multiple perspectives that are inclusive and pertinent to its development

## AUTHOR NOTES

Jacqueline Galica, Queen's University School of Nursing; Kingston, ON; Queen's Cancer Research Institute, Division of Cancer Care and Epidemiology, Kingston, ON

Amina Silva, Brock University School of Nursing; St. Catharines, ON

Kathleen Robb, Patient Partner

**Corresponding author:** Jacqueline Galica, Queen's University School of Nursing, 92 Barrie Street, Kingston, Ontario, K7L 3N6

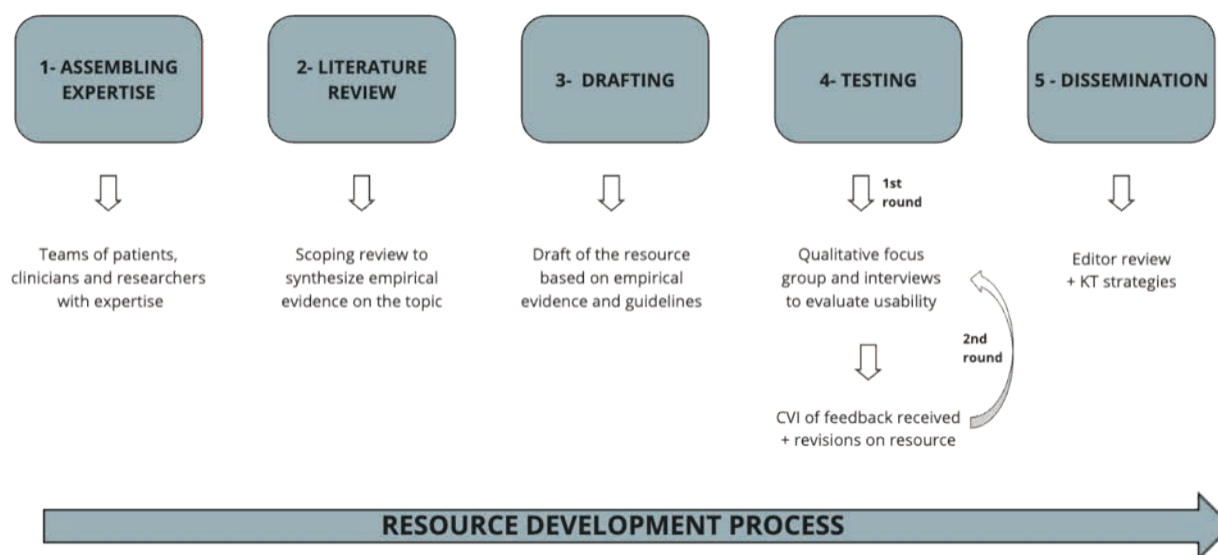
Email: [jacqueline.galica@queensu.ca](mailto:jacqueline.galica@queensu.ca)

DOI:10.5737/236880763414



**Figure 1**

*Stages of the Resource Development Process*



(O’Cathain et al., 2019). With this in mind, we assembled two teams of patients, clinicians, and researchers with GC expertise in the planning stages of this study: a core team that was responsible for implementing the research, and an advisory team having varying backgrounds and expertise to inform the study materials and processes. The teams were both led by a GC survivor (KR) and a psychosocial oncology nurse researcher (JG) who co-led all study processes and team meetings. These co-leads oversaw and worked alongside two research assistants (one graduate student who was a registered nurse and one undergraduate nursing student) who collectively worked as the core team. The co-leads assembled an advisory team consisting of three GC survivors and four GC clinicians: two medical oncologists, a Nurse Practitioner, and a social worker with expertise in psychosocial oncology. This advisory group was assembled based upon their diverse expertise in GC care (medical, nursing and psychosocial) before conducting the following phases. In each phase, specific instructions were not provided to the advisory group; instead, the advisory group was invited to contribute any and all feedback based upon their experiential and/or clinical perspective. After a review by the core team, their feedback was incorporated into the work of each phase and used to inform the planning for the subsequent phase(s). Further details are provided within each phase.

**Phase 2: Reviewing the literature**

To optimally meet the needs of knowledge users, it is imperative that evidence-based information be used throughout the development process. A scoping review, which is a method useful to summarize evidence about a topic (Munn et al., 2018), was used as a second step in our development of the resource. The review synthesized empirical literature

about the needs of GC survivors and their informal caregivers at the end of and following primary cancer treatment (Galica et al., 2022). The core team organized the needs identified in the included studies into seven content-specific areas: (1) physical needs, (2) sexuality-related concerns, (3) altered self-image, (4) psychological well-being, (5) social support needs, (6) supporting the return to work, and (7) healthcare preferences. These content areas were shared with our advisory team and their feedback was used to draft a model to guide clinical discussions to address GC survivors’ needs at the end of primary treatment (Galica et al., 2022).

**Phase 3: Drafting the resource**

Our core team used the content-specific areas identified in the scoping review (Galica et al., 2022) to draft an educational resource pertaining to six<sup>1</sup> dimensions of recovery for GC survivors and their caregivers. Each dimension is presented as a distinct chapter in the resource beginning with general information to introduce and describe that dimension followed by content that readers can use to assess and/or self-manage what they are experiencing in relation to that dimension. Readers are assured that not all dimensions, nor all details presented within each dimension, may be relevant to them. As such, reflective questions are posed and used to identify possible topics of conversation with healthcare providers and/or caregivers. Exemplars from qualitative research papers are

1 Notably, there are seven content areas (dimensions) described in the scoping review, but only six are relevant to the resource we developed. The content included within the ‘healthcare challenges and preferences’ was deemed as relevant only to clinicians and not applicable to the goals of the resource intended for survivors and their caregivers.

inserted as quotes within each chapter to illuminate the experiences of other cancer survivors in relation to that dimension. Strategies and resources to self-manage each dimension were retrieved from empirical reviews and guidelines. Each chapter includes ample space for note taking and coloured illustrations exist throughout.

The drafted resource was reviewed by the advisory team who used their lived and clinical experiences to evaluate the resource's content, usability, and potential applicability for GC survivors and their caregivers. All advisory members provided feedback to improve the resource (e.g., revised wording to improve accessibility, need for more content). The core team considered the relevance of all feedback with the intended purpose of the resource; suggestions were incorporated accordingly.

#### **Phase 4: Testing the resource**

We used a qualitative approach to assess the usefulness of the resource; such methods are useful to investigate the applicability of healthcare interventions through the collection of comprehensive feedback from knowledge users (Yardley et al., 2015). Gynecological cancer survivors and their informal caregivers were purposively recruited whereby GC clinicians at our regional cancer centre identified those with diverse perspectives (e.g., a variety of GC diagnoses and representing geographic locations across our region). Individuals and/or their informal caregivers (e.g., partners, family members, etc.) who had completed primary treatment for GC within the preceding five years were invited to participate.

We completed two rounds of data collection. In Round 1, participants received the drafted resource in their preferred format (hard copy or electronic). They had two weeks to review the resource and prepare feedback and suggestions for refinement. To guide their review, participants were asked to consider their own experiences at the end of primary cancer treatment and if/how the resource would have been useful to them at that time. They were also asked to consider what content was missing from the resource based upon their experiences. We met with participants in their preferred format – either a Zoom focus group or 1:1 interview – wherein they shared their feedback and suggestions for refining the resource. Given that the resource focussed on GC survivor concerns at the end of primary treatment, data collection from GC survivors and caregivers occurred separately. This permitted us to examine the nuanced perspective of each group in relation to a resource that addressed the needs of GC survivors. This approach also allowed us to understand how to improve the resource in a way that was meaningful to both groups. The focus groups and individual interviews were audio recorded and transcribed verbatim.

The core research team reviewed participants' feedback and suggestions for relevance with the intended purpose of the resource. Relevant feedback and suggestions were grouped using a content analysis approach (Vaismoradi et al., 2013) and assembled into a list of topics to be considered for inclusion. In this way, we used a content validation process (Yusoff, 2019) wherein the core team and advisory members used a

three-point scale (1 = no change needed, 2 = change could be considered, and 3 = change must be made) to evaluate the relevance of each topic considered for inclusion (Figure 2). Topics with an overall mean ranked as 2 or 3 were incorporated into a revised version of the resource.

In Round 2, the revised version of the resource was sent to Round 1 participants who again had two weeks to review and prepare their feedback and suggestions for refinement. Participants were provided with the same guidance for their second review (e.g., if/how useful, what content is missing). Thereafter, a second round of focus groups and individual interviews were conducted wherein participants provided suggestions and feedback to the revised version of the resource. Consistent with the Round 1 process, focus groups and interviews were audio recorded and transcribed verbatim and participants' feedback and suggestions were analyzed and reviewed for relevance. Although another content validation process (Yusoff, 2019) was planned, Round 2 feedback and suggestions for refinement were minor deeming the content validation process unnecessary: these minor feedback and suggestions were incorporated into the final version of the resource.

#### **Phase 5: Dissemination**

Being that the translation of evidence into clinical practice can take up to 17 years (Morris et al., 2011), engaging in carefully planned and relevant dissemination strategies are essential. Given the intent and processes used in this project, a diversity of patient, clinician, and researcher audiences were considered. The process of patient dissemination began with a plain language editor review of the resource for readability, content, grammar, cohesion, syntax, etcetera. Revisions to simplify language and ensure grammatical correctness were made while ensuring no changes to the resource's content nor meaning. Since some participants indicated a preference to receive the resource in hard copy, we identified printing options to support this mode of dissemination. The process of disseminating the resource to knowledge users occurred via academic presentations and manuscripts targeted at clinicians and researchers interested in patient education, cancer care, and survivorship.

## **DISCUSSION**

Our patient-clinician-researcher partnership conceptualized and completed a five-phase process using multiple research methods to develop an educational resource for GC survivors and their caregivers. The diversity of members reflected on our team brought expertise needed to comprehensively inform and implement each phase. These included the lived experiences of cancer survivors and/or caregivers, the perspectives of clinicians working in a cancer care system, and researchers with expertise to plan and oversee the methods used. The methods used in our process were also diverse (e.g., review and qualitative methods) and informed the implementation of each successive phase. This combined approach – diverse membership and multiple research methods – presents in an original process to develop an educational resource for cancer survivors and their caregivers.

**Figure 2**

*Content Validation Example*

Dear ,

We have received suggestions from focus group participants on the draft Guide intended to support survivors and their caregivers for life following primary treatment for gynecological cancer. Given your personal and/or clinical and research expertise in gynecological cancer survivorship care, we would like to ask you for your opinion about the relevance of each suggestion received. We have attached the most current draft of the Guide for your reference.

Please review each of the following suggestions/feedback and rate the relevance of each suggestion using instruction provided below. Space is provided for you to add comments and/or context that will assist us to revise the Guide as appropriate.

We ask that you provide your responses by .

Rating scale:	
1 =	the suggestion does not apply to the intent of the Guide; no change or addition is required
2 =	the suggestion has some relevancy to the intent of the Guide but is not critical; a change, addition or reference could be considered
3 =	the suggestion is critical to the intent of the Guide; a change or addition should be made

Rationale/Comments:
Please provide the rationale for your relevance rating and your recommendation about where the item, if relevant, could be included. Please suggest the level of detail that should be included (e.g., just acknowledge the item as an issue, or include it with its strategy and resources, or just enhance an existing reference to the item, etc.). If you are aware of any useful resources that could be helpful, please provide these details.

Suggestion	Relevance		
<p><b>1</b> Some participants (survivors) suggested that ‘end-of-life’ issues should be included along with strategies and resources to plan for death (e.g., information about MAID, palliative and hospice care options, etc.).</p> <p>Considering the intent of the guide, how do you rate the level of importance of this suggestion?</p>	1 ( )	2 ( )	3 ( )
<b><u>RATIONALE/COMMENTS</u></b>			

Although collaborations between knowledge users and researchers can improve clinical outcomes and research uptake (Boden et al., 2021; Lyon & Koerner, 2016), there is a lack of comprehensive guidance about how to co-develop interventions to address the informational needs of cancer patients, survivors and/or their caregivers. Our five-phase, multiple-research-methods approach provides cancer clinicians and/or researchers, particularly within gynecology oncology, with a process that addresses this gap. This process is innovative in that it integrates and prioritizes a patient-clinician-researcher partnership within a series of phases that involve multiple research methods. Furthermore, the research methods used in each phase produced results that were used within subsequent phases. Indeed, involving stakeholders in a multiple phase and multiple-methods-research process is recommended to develop interventions (O’Cathain et al., 2019). Our process builds upon this recommendation (O’Cathain et al., 2019) to integrate pertinent experiential and empirical knowledge to develop highly relevant educational resources for cancer patients, survivors, and/or their caregivers.

**Process insights, strengths and limitations**

When we completed the process of co-developing the resource, we reflected on our time of working together. In our reflections, we believe there are two noteworthy features of our collaboration that were essential to developing a relevant resource while maintaining a successful and rewarding research partnership. We believe that these features fueled our team’s determination to persist through the lengthy process, nearly four years in our case, to complete the five phases described above. Below we describe our reflections of these features that can be useful for other patient-researcher partnerships planning to – or in the process of – working together.

The first noteworthy feature is our team’s unwavering commitment to achieving the mutually defined goal of this project: to develop the resource. This commitment largely stemmed from the lived and clinical experiences of enduring the gap in cancer care that the resource intended to fill. However, due to the diversity of perspectives and availabilities of our team, it was useful to set clear and realistic timelines in order to keep the team engaged and motivated. This was particularly helpful as we faced adversities (e.g., recruitment challenges) that

resulted in revised project timelines. Such revisions were determined collaboratively, which sometimes proved challenging since our team included a core and advisory team who had various levels of involvement in project processes. In such instances, it was useful to refer to the role descriptions and expectations developed at the beginning of our partnership.

The second noteworthy feature of our team's success relates to our communication. Establishing spaces for thoughtful and respectful dialogue and clear role expectations was essential given the diversity of backgrounds reflected among team members. For instance, differences in perspectives stemmed from our lived experiences, either as a patient or clinician, which resulted in language differences to describe our perspectives and approaches to achieve the goal. Furthermore, our patient partner's disciplinary background was in executive-level strategic change management wherein projects were developed using rigorous project management methodology and change management frameworks. In this discipline, common terms and approaches used to develop projects varied greatly from those in the disciplinary backgrounds of our team's health researchers. One such example is the varied understanding of the term "dissemination". For our health researchers, this term broadly refers to knowledge translation strategies to promote the resource (e.g., via conference presentations). However, for our patient-partner with a business background, dissemination refers to the

broad distribution of the resource (e.g., circulated printed copies). These language differences resulted in initial tensions whereby team members felt left behind or misunderstood in the process of developing the resource. Admittedly, the ensuing conversations required careful listening, respectful tones, and ample time to truly understand each other's stance in relation to the conversation being had and the overall project goal. Notably, as we neared the end of the project, we more easily recognized such language differences and were able to expediently discuss these.

## CONCLUSION

Clinical guidelines and practice standards provide little-to-no guidance about supporting GC survivors and their caregivers through the transition from primary treatments; our process was intended to fill this gap using a combination of empirical and experiential evidence completed by a patient-clinician-researcher partnership. Although our process was completed to meet a need within our local cancer survivor community, our processes can be used by knowledge user-researcher partnerships within other geographical settings and population groups to develop relevant educational resources. Our reflections and learnings can be used to facilitate processes used by other teams.

## REFERENCES

- Boden, C., Edmonds, A. M., Porter, T., Bath, B., Dunn, K., Gerrard, A., Goodridge, D., & Stobart, C. (2021). Patient partners' perspectives of meaningful engagement in synthesis reviews: A patient-oriented rapid review. *Health Expectations*, 24(4), 1056–1071. <https://doi.org/10.1111/hex.13279>
- Canadian Cancer Statistics Advisory, Canadian Cancer Society, Statistics Canada, & The Public Health Agency of Canada. (2022). *Canadian cancer statistics: A 2022 special report on cancer prevalence*. The Public Health Agency of Canada. <https://cancer.ca/en/research/cancer-statistics/canadian-cancer-statistics>
- Canadian Partnership Against Cancer/Partenariat canadien contre le cancer. (2018). *Living with Cancer: A Report on the Patient Experience*. <https://s22457.pcdn.co/wp-content/uploads/2019/01/Living-with-cancer-report-patient-experience-EN.pdf>
- Galica, J., Giroux, J., Francis, J.-A., & Maheu, C. (2020). Coping with fear of cancer recurrence among ovarian cancer survivors living in small urban and rural settings: A qualitative descriptive study. *European Journal of Oncology Nursing*, 44. <https://doi.org/10.1016/j.ejon.2019.101705>
- Galica, J., Saunders, S., Romkey-Sinasac, C., Silva, A., Ethier, J., Giroux, J., Jull, J., Maheu, C., Ross-White, A., Stark, D., & Robb, K. (2022). The needs of gynecological cancer survivors at the end of primary treatment: A scoping review and proposed model to guide clinical discussions. *Patient Education and Counseling*, 105(7), 1761–1782. <https://www.sciencedirect.com/science/article/pii/S0738399121007667?via%3Dihub>
- Hawkins, J., Madden, K., Fletcher, A., Midgley, L., Grant, A., Cox, G., Moore, L., Campbell, R., Murphy, S., Bonell, C., & White, J. (2017). Development of a framework for the co-production and prototyping of public health interventions. *BMC Public Health*, 17(1). <https://doi.org/10.1186/s12889-017-4695-8>
- Kent, E. E., Rowland, J. H., Northouse, L., Litzelman, K., Chou, W.-Y. S., Shelburne, N., Timura, C., O'Mara, A., & Huss, K. (2016). Caring for caregivers and patients: Research and clinical priorities for informal cancer caregiving. *Cancer*, 122(13), 1987–1995. <https://doi.org/10.1002/cncr.29939>
- Lebel, S., Tomei, C., Feldstain, A., Beattie, S., & McCallum, M. (2013). Does fear of cancer recurrence predict cancer survivors' health care use? *Supportive Care in Cancer*, 21(3), 901–906. <https://doi.org/10.1007/s00520-012-1685-3>
- Liska, C. M., Morash, R., Paquet, L., & Stacey, D. (2018). Empowering cancer survivors to meet their physical and psychosocial needs: An implementation evaluation. *Canadian Oncology Nursing Journal*, 28(2), 76–81. <https://doi.org/10.5737/236880762827681>
- Lyon, A. R., & Koerner, K. (2016). User-Centered Design for Psychosocial Intervention Development and Implementation. *Clinical Psychology*, 23(2), 180–200. <https://doi.org/10.1111/cpsp.12154>
- Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: Understanding time lags in translational research. *Journal of the Royal Society of Medicine*, 104(12), 510–520. <https://doi.org/10.1258/jrsm.2011.110180>
- Munn, Z., Peters, M. D. J., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology*, 18(1). <https://doi.org/10.1186/s12874-018-0611-x>
- Nekhyudov, L., Mollica, M. A., Jacobsen, P. B., Mayer, D. K., Shulman, L. N., & Geiger, A. M. (2019). Developing a quality of cancer

- survivorship care framework: Implications for clinical care, research, and policy. *JNCI: Journal of the National Cancer Institute*, 111(11), 1120–1130. <https://doi.org/10.1093/jnci/djz089>
- O’Cathain, A., Croot, L., Duncan, E., Rousseau, N., Sworn, K., Turner, K. M., Yardley, L., & Hoddinott, P. (2019). Guidance on how to develop complex interventions to improve health and healthcare. *BMJ Open*, 9(8), e029954. <https://doi.org/10.1136/bmjopen-2019-029954>
- O’Cathain, A., Croot, L., Sworn, K., Duncan, E., Rousseau, N., Turner, K., Yardley, L., & Hoddinott, P. (2019). Taxonomy of approaches to developing interventions to improve health: A systematic methods overview. *Pilot and Feasibility Studies*, 5(1). <https://doi.org/10.1186/s40814-019-0425-6>
- Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, 15. <https://doi.org/10.1111/nhs.12048>
- Yardley, L., Morrison, L., Bradbury, K., & Muller, I. (2015). The person-based approach to intervention development: Application to digital health-related behavior change interventions. *Journal of Medical Internet Research*, 17(1), e30. <https://doi.org/10.2196/jmir.4055>
- Yusoff, M. S. B. (2019). ABC of content validation and content validity Index Calculation. *Education in Medicine Journal*, 11(2), 49–54. <https://doi.org/10.21315/eimj2019.11.2.6>

# Élaboration d'une ressource d'information à l'intention des survivantes d'un cancer gynécologique et de leurs proches aidants : exposé sur le vécu et les méthodes

Par Jacqueline Galica, Amina Silva et Kathleen Robb

## REMERCIEMENTS

*Le projet dont il est question ici est le fruit de la contribution de plusieurs collaborateurs qui, bien qu'ils ne puissent pas réclamer le statut d'auteurs du présent article, sont coauteurs du document d'accompagnement qui expose les résultats du projet. Ces coauteurs sont Avery Regan, Stephanie Saunders, Claudia Romkey-Sinasac, Janet Giroux, Janet Jull, Christine Maheu, José-Lyne Ethier, Debora Stark, Julie Francis, Kardi Kennedy et Stuart Peacock. La présente étude a été réalisée grâce à une Subvention « Catalyseur pour la recherche axée sur le patient » accordée par les IRSC à M<sup>mes</sup> Jacqueline Galica et Kathleen Robb (demande no 424922).*

## RÉSUMÉ

*Le présent article fait ressortir la nécessité de mieux informer les survivantes de cancer gynécologique (CG) et leurs proches aidants. Il vise à décrire le partenariat établi entre les patientes, les cliniciens et les chercheurs pour concevoir une ressource d'information fondée sur l'expérience et les données probantes. L'élaboration de cette ressource d'information a fait appel à plusieurs méthodes de recherche. Elle s'est déroulée en cinq étapes : 1) réunion de l'expertise nécessaire; 2) revue de la littérature; 3) ébauche de la ressource; 4) mise à l'essai; 5) diffusion de la ressource. La diversité des partenaires apportait l'expertise nécessaire à l'utilisation de multiples méthodes de recherche ayant produit des résultats utiles à chaque étape. Grâce à cette combinaison (partenariat diversifié et multiples méthodes de recherche), on a élaboré une ressource utile pour répondre à un manque observé par les utilisateurs des connaissances. La combinaison des caractéristiques décrites dans le présent article vient combler une lacune dans la procédure utilisée par les cliniciens et les chercheurs désireux d'élaborer des ressources d'information fondées à la fois sur l'expérience et la pratique.*

## AUTEURES

Jacqueline Galica, École des sciences infirmières de l'Université Queen's, Kingston, ON; Institut de recherche sur le cancer de l'Université Queen's, Division d'oncologie et d'épidémiologie; Kingston, ON

Amina Silva, École des sciences infirmières de l'Université Brock, St. Catharines, ON

Kathleen Robb, Patiente partenaire

**Auteur-ressource** : Jacqueline Galica, École des sciences infirmières de l'Université Queen's, 92, rue Barrie, Kingston (Ontario) K7L 3N6, Canada.  
Courriel : [jacqueline.galica@queensu.ca](mailto:jacqueline.galica@queensu.ca)

DOI:10.5737/2368807634110

## INTRODUCTION

Le nombre de survivants du cancer augmente (Canadian Cancer Statistics Advisory/Comité consultatif des statistiques canadiennes sur le cancer en collaboration avec la Société canadienne du cancer; Statistique Canada et Agence de santé publique du Canada, 2022). Bien qu'il s'agisse d'une bonne nouvelle, les survivants du cancer et leurs proches aidants, une fois le traitement primaire terminé, sont en proie à diverses inquiétudes (Canadian Partnership Against Cancer/Partenariat canadien contre le cancer, 2018; Kent et al., 2016) d'ordre physique, mental et émotionnel (Canadian Partnership Against Cancer/Partenariat canadien contre le cancer, 2018). Ces inquiétudes, lorsqu'elles ne sont pas apaisées, peuvent persister pendant des années après le traitement, ce qui amène les survivants à utiliser plus souvent des ressources médicales, notamment les services d'urgence (Lebel et al., 2013). En disant aux patients à quoi s'attendre après le traitement, on pourrait calmer certaines de leurs inquiétudes (Galica et al., 2020; Galica et al., 2022). Ainsi, il pourrait s'avérer utile d'avoir des ressources d'information pour préparer les survivants et leurs proches aidants à la transition qui suivra le traitement primaire pour favoriser leur bien-être global.

Bien qu'on accorde de plus en plus d'importance à l'enseignement aux survivants du cancer aux points de transition (Liska et al., 2018; Nekhlyudov et al., 2019), l'élaboration, la mise en œuvre et l'efficacité de ces ressources varient énormément (Hawkins et al., 2017). Par ailleurs, la participation des utilisateurs des connaissances (c'est-à-dire les patients et les cliniciens) à l'élaboration des ressources n'est pas toujours évidente. Le fait d'amener les utilisateurs des connaissances à participer à toutes les étapes du processus visant à cerner les besoins et à élaborer les interventions d'enseignement aux patients augmente la pertinence et la durabilité de ces interventions (Boden et al., 2021; Lyon et Koerner, 2016).

Il est important d'amener les utilisateurs des connaissances à participer à la création des ressources. Mais il n'existe aucune orientation générale sur la façon de collaborer pour élaborer les interventions abordant des questions pertinentes en oncologie. Afin de combler cette lacune, le présent article décrit l'expérience vécue par les chercheurs, cliniciens et patientes ayant travaillé à la création d'une ressource d'information fondée sur des données probantes et le savoir expérientiel ayant pour but d'aider les survivantes du cancer et leurs proches aidants à la fin du traitement primaire. Cette ressource d'information a été mise au point à la suite du besoin, exprimé par les

survivantes d'un cancer gynécologique de la région, d'être mieux renseignées (Galica et al., 2020). L'élaboration de la ressource s'est faite en cinq étapes (voir la figure 1) : 1) réunion de l'expertise nécessaire; 2) revue de la littérature; 3) ébauche de la ressource; 4) mise à l'essai; 5) diffusion de la ressource. Les prochaines sections de l'article présenteront les méthodes employées à chaque étape ainsi que des réflexions sur ces méthodes afin d'aider dans leur démarche les personnes souhaitant collaborer avec les patients atteints d'un cancer, les survivants et leurs proches aidants pour créer des ressources d'information à leur intention.

### Étape 1 : Réunion de l'expertise nécessaire

Dans le domaine des soins de santé, les interventions peuvent être complexes et donc difficiles à planifier et à mettre en œuvre. Pour qu'elles soient utiles, elles doivent tenir compte de divers points de vue à la fois inclusifs et adaptés au contexte (O'Cathain et al., 2019). C'est dans cette optique qu'au moment de planifier la présente étude, on a réuni deux équipes de patientes, de cliniciens et de chercheurs connaissant bien les cancers gynécologiques (CG), soit une équipe principale chargée de mettre en œuvre la recherche, et une équipe consultative formée de personnes ayant diverses provenances et compétences pour guider le déroulement de l'étude. Ces deux équipes ont été dirigées par une survivante d'un CG (KR) et une infirmière chercheuse en oncologie psychosociale (JG) qui toutes deux ont mené l'étude à toutes les étapes et animé les réunions d'équipe. Ces coresponsables ont collaboré avec deux assistantes de recherche qu'elles supervisaient (une infirmière autorisée étudiant aux cycles supérieurs et une étudiante de premier cycle en sciences infirmières); ensemble, elles formaient l'équipe principale. Les

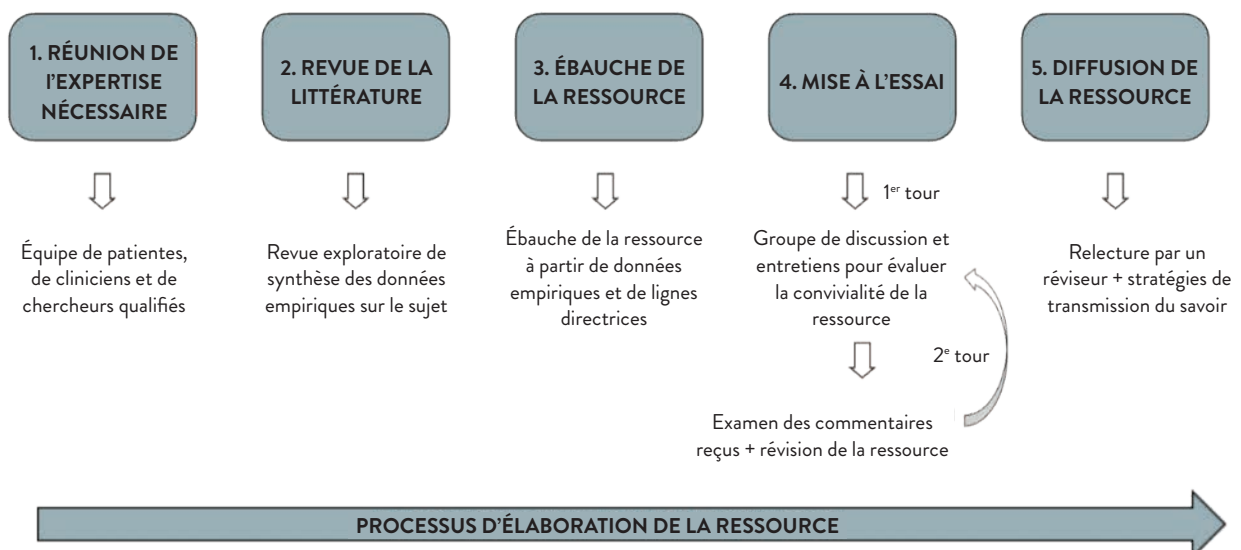
coresponsables ont réuni une équipe consultative constituée de trois survivantes d'un CG et de quatre cliniciens spécialiste des CG : deux oncologues, une infirmière praticienne et une travailleuse sociale en oncologie psychosociale. Les membres de cette équipe consultative ont été choisis, avant même de passer aux étapes suivantes, en raison de leur vaste expertise de prise en charge du CG (soins médicaux, infirmiers et psychosociaux). À aucune des étapes de l'étude, les membres de l'équipe consultative n'ont reçu de directives précises; ils ont plutôt été invités à faire part de leurs commentaires, nourris de leur expérience et de leur point de vue clinique. Ces commentaires, d'abord examinés par l'équipe principale, étaient ensuite pris en compte à chaque étape du travail et guidaient la préparation de l'étape ou des étapes subséquentes. D'autres détails se trouvent dans les sections consacrées à chacune des étapes.

### Étape 2 : Revue de la littérature

Pour répondre de façon optimale aux besoins des utilisateurs des connaissances, il faut nécessairement utiliser de l'information fondée sur des données probantes à toutes les étapes du processus. La deuxième étape de l'élaboration de la ressource consistait en une revue exploratoire, une méthode utile pour résumer les données sur un sujet donné (Munn et al., 2018). Cette revue a permis de synthétiser la recherche empirique portant sur les besoins des survivantes d'un CG et de leurs proches aidants à la fin du traitement primaire et pendant la période qui suit (Galica et al., 2022). L'équipe principale a réparti les besoins cernés dans les différentes études recensées en sept catégories : 1) besoins physiques; 2) préoccupations liées à la sexualité; 3) altération de l'image de soi; 4) bien-être psychologique; 5) besoin de soutien social; 6)

Figure 1

Étapes de l'élaboration de la ressource



soutien à la reprise du travail; 7) préférences en matière de traitements médicaux. Ces catégories ont été communiquées aux membres de l'équipe consultative; leurs commentaires ont servi à rédiger l'ébauche d'un modèle pour guider les discussions en cliniques afin de répondre aux besoins des survivantes d'un CG à la fin du traitement primaire (Galica et al., 2022).

### Étape 3 : Ébauche de la ressource

Les membres de l'équipe principale ont utilisé les catégories établies grâce à la revue exploratoire (Galica et al., 2022) pour ébaucher une ressource qui renseignera les survivantes et leurs proches aidants sur six<sup>1</sup> dimensions du rétablissement à la suite d'un cancer gynécologique. Chacune de ces dimensions est présentée dans un chapitre distinct de la ressource; chaque chapitre donne de l'information générale de base sur la dimension abordée, puis du contenu permettant aux lecteurs d'évaluer ou de prendre en charge eux-mêmes leur expérience pour ce qui touche cet aspect. Les lecteurs sont informés que ce ne sont pas toutes les dimensions et les détails qui sont pertinents dans leurs cas. On leur pose des questions de réflexion pour connaître les sujets de discussion désirés avec les professionnels de la santé ou les proches aidants. Des exemples tirés de recherches qualitatives, présentés sous forme de citations dans chaque chapitre, illustrent l'expérience vécue d'autres survivantes du cancer en lien avec une dimension particulière. Des stratégies et des ressources d'auto-prise en charge de chaque dimension ont été extraites de revues empiriques et de lignes directrices. Dans chaque chapitre, on trouve des illustrations en couleur et assez d'espace pour prendre des notes.

À la lumière de leur vécu et de leurs expériences en clinique, les membres de l'équipe consultative ont examiné l'ébauche de la ressource et évalué son contenu, sa convivialité et ses applications possibles pour les survivantes d'un CG et leurs proches aidants. Tous ont formulé des commentaires pour améliorer la ressource (ex. révision du texte pour rendre la ressource plus accessible, enrichissement du contenu). Les membres de l'équipe principale, quant à eux, ont examiné la pertinence des commentaires à la lumière de l'objectif recherché pour la ressource. Les suggestions ont été retenues en conséquence.

### Étape 4 : Mise à l'essai

L'utilité de la ressource a été évaluée à l'aide d'une méthode qualitative. Ce type de méthode est utile pour étudier l'applicabilité d'interventions en soins de santé en recueillant des commentaires détaillés auprès des utilisateurs des connaissances (Yardley et al., 2015). Pour ce faire, des survivantes d'un CG et leurs proches aidants naturels ont été préalablement recrutés. Des cliniciens spécialistes des CG du centre régional de cancérologie ont examiné les dossiers pour faire ressortir des

cas présentant des perspectives variées (ex. différents diagnostics de CG, variété de la provenance géographique dans la région). Les femmes ayant terminé un traitement primaire du CG au cours des cinq années précédentes et leurs proches aidants (conjoint, membres de la famille, etc.) ont été invités à participer.

La collecte de données s'est déroulée en deux tours. Au premier tour, les participants ont reçu l'ébauche de la ressource (en format papier ou électronique, au choix). Ils disposaient de deux semaines pour prendre connaissance de la ressource et formuler commentaires et suggestions d'amélioration. Pour les guider, on leur a demandé de se remettre en mémoire l'expérience vécue à la fin du traitement primaire; ils devaient juger si la ressource leur aurait été utile à ce moment-là et dire comment ils l'auraient utilisée. On leur a aussi demandé de voir s'il manquait du contenu. Les discussions avec les participants ont eu lieu en groupe sur Zoom ou lors d'entretiens individuels. Les participants ont fait part de leurs commentaires et suggestions d'amélioration. Comme la ressource visait à cerner les inquiétudes de survivantes d'un CG à la fin du traitement primaire, la collecte de données auprès des patientes et des proches aidants s'est déroulée séparément. Cela a permis d'examiner les différences de points de vue sur la création d'une ressource destinée à répondre aux besoins des survivantes, et de trouver des façons d'améliorer cette ressource pour la rendre utile aux deux groupes. Les discussions en groupe et les entretiens individuels ont été enregistrés et le contenu retranscrit verbatim.

Les membres de l'équipe principale ont examiné les commentaires et les suggestions des participants pour s'assurer de leur pertinence par rapport à l'objectif de la ressource. Les commentaires et suggestions jugés pertinents ont été regroupés à l'aide d'une méthode d'analyse de contenu (Vaismoradi et al., 2013) et réunis en une liste de points à examiner et à possiblement intégrer dans la ressource. De la même façon, on a utilisé une méthode de validation de contenu (Yusoff, 2019) pour évaluer la pertinence de chaque point dont on pourrait envisager l'ajout. Les membres de l'équipe principale et ceux de l'équipe consultative ont utilisé une échelle en 3 points (où 1 signifie qu'aucun changement n'est nécessaire, 2 qu'un changement pourrait être envisagé, et 3 qu'un changement est nécessaire) pour évaluer la pertinence de chaque sujet à qui pourrait être ajouté (figure 2). Les sujets auxquels les participants avaient attribué 2 ou 3 points ont été intégrés à la version révisée de la ressource.

Au deuxième tour, on a présenté la version révisée de la ressource aux participants du premier tour. Encore une fois, ils disposaient de deux semaines pour en prendre connaissance et formuler leurs commentaires et suggestions d'amélioration. Les consignes à suivre pour ce deuxième examen étaient les mêmes (dire si la ressource est utile et dans quelle mesure, et s'il manque du contenu). Puis, on a mené une deuxième série de discussions de groupe et d'entretiens individuels au cours desquels les participants ont formulé commentaires et suggestions pour améliorer cette nouvelle version de la ressource. Comme au premier tour, les consultations de groupe et les entretiens individuels ont été enregistrés et le contenu

1 Il est à noter que la revue exploratoire mentionne sept catégories de besoins, mais seulement six sont pertinents pour la ressource élaborée. On a jugé que l'information recueillie sur « les difficultés et les préférences en matière de soins de santé » n'intéressait que les cliniciens et qu'elle ne correspondait pas aux objectifs de la ressource, destinée aux survivantes et à leurs proches aidants.



Figure 2

*Élaboration d'une ressource d'information*

Madame, Monsieur,

Nous avons reçu, de la part de participants à un groupe de discussion, des suggestions pour améliorer l'ébauche du guide de soutien destiné aux survivantes d'un cancer gynécologique et à leurs proches aidants à la fin du traitement primaire. Compte tenu de vos compétences personnelles, cliniques ou scientifiques dans le domaine des soins aux survivantes d'un cancer gynécologique, nous aimerions connaître votre opinion sur la pertinence des suggestions reçues. Pour votre gouverne, nous joignons la toute dernière ébauche du guide.

Veillez lire les suggestions et les commentaires qui suivent et, à l'aide des directives ci-après, évaluez-en la pertinence. Vous disposerez d'espace pour ajouter des commentaires et des explications qui nous aideront à réviser le guide.

Veillez fournir vos réponses d'ici le \_\_\_\_\_.

Échelle d'évaluation	
1 =	La suggestion ne s'applique pas au but visé par le guide; aucun changement ni ajout n'est nécessaire.
2 =	La suggestion a une certaine pertinence par rapport au but visé par le guide, mais elle n'est pas essentielle. Un changement, un ajout ou une mention pourrait être envisagé.
3 =	La suggestion est essentielle au but visé par le guide; il convient de procéder à un changement ou à un ajout.

Justification/Commentaires :
Veillez justifier la note attribuée, et indiquez l'endroit où votre recommandation devrait s'insérer, le cas échéant. Veuillez préciser le degré de détail nécessaire (faut-il seulement reconnaître que ce point est un problème, l'inclure au guide en présentant une stratégie et des ressources, simplement clarifier une mention existante de ce point, etc.). Si vous connaissez des ressources qui pourraient être utiles, donnez-en la référence.

Suggestion :		Pertinence		
1	Certaines participantes (des survivantes) ont suggéré de tenir compte des questions liées à la fin de vie et de présenter des stratégies et des ressources permettant de faire des arrangements en prévision du décès (ex. information sur l'aide médicale à mourir et les soins palliatifs).	1	2	3
	En tenant compte du but visé par le guide, quelle note donneriez-vous au degré d'importance de cette suggestion?	( )	( )	( )
<b>JUSTIFICATION/COMMENTAIRES</b>				

des discussions retranscrit afin de permettre d'examiner la pertinence des commentaires et des suggestions. Un autre processus de validation de contenu (Yusoff, 2019) était prévu, mais comme les suggestions d'amélioration et les commentaires recueillis au deuxième tour portaient sur des points mineurs, cette dernière validation du contenu a été jugée superflue; les ajustements mineurs ont donc été intégrés directement à la version finale de la ressource.

### Étape 5 : Diffusion de la ressource

Le transfert des connaissances de la recherche à la pratique clinique peut prendre jusqu'à 17 ans (Morris et al., 2011). Il est donc primordial de mettre en œuvre des stratégies de diffusion bien adaptées au contexte et soigneusement planifiées. Pour satisfaire à l'objectif du présent projet et à la méthodologie employée, on a recruté des patientes, des cliniciens et des chercheurs de divers horizons. En guise de première étape au processus de diffusion, on a demandé à un réviseur de s'assurer que le langage utilisé était clair et simple; cette personne vérifiait également la lisibilité, le contenu, la grammaire, la syntaxe, la cohérence, etc. Des changements

ont ensuite été apportés pour rendre le texte plus clair et corriger la grammaire tout en ne changeant rien ni au contenu ni au sens. Comme certains participants préféraient recevoir la ressource en format papier, il a fallu trouver des moyens de l'imprimer. On a fait connaître la ressource aux utilisateurs des connaissances par des exposés universitaires et des documents destinés aux cliniciens et aux chercheurs s'intéressant à l'enseignement aux patients, aux soins oncologiques et à la survivance.

### DISCUSSION

Le partenariat patients-cliniciens-chercheurs a permis de conceptualiser et de mener à bien un processus en cinq étapes en ayant recours à de multiples méthodes de recherche pour élaborer une ressource d'information à l'intention des survivantes de CG et de leurs proches aidants. La diversité de compétences des membres de l'équipe a permis de réunir l'expertise nécessaire pour guider chaque étape et de la mettre en œuvre jusqu'au bout. Cette expertise s'appuyait sur les expériences vécues des survivantes du cancer et des proches aidants, ainsi que sur les points de vue des cliniciens travaillant en

oncologie et des chercheurs ayant de l'expérience dans la planification et la supervision des méthodes utilisées. Ces méthodes étaient elles aussi diversifiées (ex. tant pour la revue de littérature que pour l'analyse qualitative) et ont guidé la mise en œuvre de chacune des étapes. Cette approche combinant diversité d'expérience des membres et variété des méthodes de recherche constitue une façon originale d'élaborer une ressource d'information à l'intention des survivants du cancer et de leurs proches aidants.

La collaboration entre les utilisateurs de connaissances et les chercheurs peut améliorer les résultats cliniques et la capacité d'exploiter les données produites par la recherche (Boden et al., 2021; Lyon et Koerner, 2016), mais il n'existe pas de directives détaillées pour élaborer conjointement des interventions répondant aux besoins d'information des patients atteints de cancer, des survivants et des proches aidants. La méthode de recherche en cinq étapes a fourni aux cliniciens et aux chercheurs en oncologie, en particulier dans le domaine de la gynécologie-oncologie, une manière de combler cette lacune. Il s'agit d'une méthode novatrice au sens où elle permet de prioriser l'établissement d'un partenariat entre patients, cliniciens et chercheurs et de l'intégrer à une série d'étapes faisant intervenir de multiples méthodes de recherche. De plus, la méthodologie utilisée à chaque étape a produit des résultats utiles pour les étapes suivantes. Ainsi, pour élaborer de nouvelles interventions, on recommande que toutes les parties concernées prennent part à un processus de recherche en plusieurs étapes faisant appel à différentes méthodes (O'Cathain et al., 2019). La présente démarche s'appuie sur cette recommandation (O'Cathain et al., 2019) et intègre des connaissances pertinentes et empiriques pour créer des ressources d'information adaptées aux patients atteints de cancer, aux survivants et aux proches aidants.

### Leçons à retenir, points forts et limites du processus

Une fois le travail d'élaboration conjointe de la ressource terminé, le travail de réflexion a pu commencer. Il en est ressorti que le modèle de collaboration possédait deux caractéristiques notables, qui ont été essentielles à la création d'une ressource pertinente, mais aussi à l'établissement d'un partenariat de recherche fructueux et gratifiant. Ces caractéristiques ont alimenté la détermination de l'équipe à poursuivre le travail de longue haleine (qui a duré presque quatre ans) et à aller au bout des cinq étapes décrites ci-haut. Nous présentons ci-après nos réflexions sur les caractéristiques susceptibles d'être utiles à l'élaboration d'autres partenariats patients-chercheurs (en préparation ou déjà en cours).

La première caractéristique notable est la détermination inébranlable de l'équipe à atteindre l'objectif mutuellement défini du projet, c'est-à-dire élaborer la ressource. Cette détermination découlait en grande partie des expériences personnelles et cliniques du manque d'information en matière de soins oncologiques, une lacune que la ressource visait justement à combler. Mais en raison de la variabilité des points de vue et de la disponibilité des membres de l'équipe, il a été utile de fixer des délais clairs et réalistes pour maintenir la détermination et la motivation de tous. Cela s'est révélé particulièrement profitable devant

certaines difficultés (ex. problèmes de recrutement) qui ont forcé la révision du calendrier de projet. Cette révision s'est faite en concertation et n'a pas toujours été facile, car le groupe était constitué d'une équipe principale et d'une équipe consultative dont l'intervention variait selon l'étape du projet. Il a été utile de consulter les descriptions des rôles et des attentes établies au début du partenariat.

La deuxième caractéristique notable du succès de l'équipe concerne sa façon de communiquer. Il a été essentiel de créer un espace de discussion ouvert et respectueux, et de définir clairement les attentes face aux rôles attendus, puisque les membres de l'équipe provenaient d'horizons divers. Par exemple, les patientes et les cliniciens n'avaient pas vécu les mêmes expériences, ce qui entraînait des différences de points de vue ainsi que des différences dans le langage utilisé pour présenter les points de vue et les méthodes qui, selon eux, permettraient d'atteindre l'objectif. La patiente partenaire occupait un poste de direction dans le domaine de la gestion du changement stratégique, un secteur qui fait appel à une méthodologie de gestion de projets rigoureuse, de même qu'à des cadres de gestion du changement très stricts. Dans ce domaine, les termes courants et les approches de création de projets sont très différents de ceux qu'utilisent les chercheurs en santé de notre équipe. Prenons, à titre d'exemple, les sens variés du terme « diffusion ». Pour les chercheurs en santé, ce terme désignait, au sens large, les stratégies de transfert de connaissances servant à faire connaître la ressource (ex. les présentations données lors d'une conférence). Mais pour notre patiente partenaire, qui provient du milieu des affaires, le terme « diffusion » désignait la distribution à grande échelle de la ressource (ex. mise en circulation d'exemplaires imprimés). Au début, ces différences de sens ont provoqué des tensions. Les membres de l'équipe se sentaient incompris ou laissés pour compte dans le processus d'élaboration de la ressource. Les entretiens qui ont suivi ont donc nécessité une écoute attentive, l'emploi d'un ton respectueux et un temps suffisant pour bien comprendre le point de vue de tous et l'objectif global du projet. Il est intéressant de noter que, vers la fin du projet, il était plus facile de reconnaître les différences linguistiques et de les tirer au clair rapidement.

### CONCLUSION

Les lignes directrices cliniques et les normes de pratique fournissent peu ou pas de directives sur la manière de soutenir les survivantes d'un CG et leurs proches aidants au cours de la période de transition après le traitement primaire. Pour combler cette lacune, la présente étude a fait appel à une méthodologie combinant données empiriques et savoir expérientiel à un partenariat patientes-cliniciens-chercheurs. Le but était de répondre à un besoin ressenti par les survivantes du cancer de la région. Cette méthodologie pourrait aussi servir à la création de partenariats entre les chercheurs et les utilisateurs des connaissances dans d'autres régions ou d'autres populations dans le but d'élaborer des ressources d'information pertinentes. Les réflexions et les leçons tirées de la présente étude faciliteront le travail des autres équipes qui tenteront l'expérience.

## RÉFÉRENCES

- Boden, C., Edmonds, A. M., Porter, T., Bath, B., Dunn, K., Gerrard, A., Goodridge, D., & Stobart, C. (2021). Patient partners' perspectives of meaningful engagement in synthesis reviews: A patient-oriented rapid review. *Health Expectations*, 24(4), 1056–1071. <https://doi.org/10.1111/hex.13279>
- Canadian Cancer Statistics Advisory in collaboration with the Canadian Cancer Society; Statistics Canada and the Public Health Agency of Canada. (2022). *Canadian Cancer Statistics: A 2022 special report on cancer prevalence*. Canadian Cancer Society. <https://cancer.ca/en/research/cancer-statistics/canadian-cancer-statistics>
- Canadian Partnership Against Cancer/Partenariat canadien contre le cancer. (2018). *Living with Cancer: A Report on the Patient Experience*. Canadian Partnership Against Cancer/Partenariat canadien contre le cancer. <https://s22457.pcdn.co/wp-content/uploads/2019/01/Living-with-cancer-report-patient-experience-EN.pdf>
- Galica, J., Giroux, J., Francis, J.-A., & Maheu, C. (2020). Coping with fear of cancer recurrence among ovarian cancer survivors living in small urban and rural settings: A qualitative descriptive study. *European Journal of Oncology Nursing*, 44. <https://doi.org/10.1016/j.ejon.2019.101705>
- Galica, J., Saunders, S., Romkey-Sinasac, C., Silva, A., Ethier, J., Giroux, J., Jull, J., Maheu, C., Ross-White, A., Stark, D., & Robb, K. (2022). The needs of gynecological cancer survivors at the end of primary treatment: A scoping review and proposed model to guide clinical discussions. *Patient Education and Counseling*, 105(7), 1761–1782. <https://www.sciencedirect.com/science/article/pii/S0738399121007667?via%3Dihub>
- Hawkins, J., Madden, K., Fletcher, A., Midgley, L., Grant, A., Cox, G., Moore, L., Campbell, R., Murphy, S., Bonell, C., & White, J. (2017). Development of a framework for the co-production and prototyping of public health interventions. *BMC Public Health*, 17(1). <https://doi.org/10.1186/s12889-017-4695-8>
- Kent, E. E., Rowland, J. H., Northouse, L., Litzelman, K., Chou, W.-Y. S., Shelburne, N., Timura, C., O'Mara, A., & Huss, K. (2016). Caring for caregivers and patients: Research and clinical priorities for informal cancer caregiving. *Cancer*, 122(13), 1987–1995. <https://doi.org/10.1002/cncr.29939>
- Lebel, S., Tomei, C., Feldstain, A., Beattie, S., & McCallum, M. (2013). Does fear of cancer recurrence predict cancer survivors' health care use? *Supportive Care in Cancer*, 21(3), 901–906. <https://doi.org/10.1007/s00520-012-1685-3>
- Liska, C. M., Morash, R., Paquet, L., & Stacey, D. (2018). Empowering cancer survivors to meet their physical and psychosocial needs: An implementation evaluation. *Canadian Oncology Nursing Journal*, 28(2), 76–81. <https://doi.org/10.5737/236880762827681>
- Lyon, A. R., & Koerner, K. (2016). User-Centered Design for Psychosocial Intervention Development and Implementation. *Clinical Psychology*, 23(2), 180–200. <https://doi.org/10.1111/cpsp.12154>
- Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: understanding time lags in translational research. *Journal of the Royal Society of Medicine*, 104(12), 510–520. <https://doi.org/10.1258/jrsm.2011.110180>
- Munn, Z., Peters, M. D. J., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology*, 18(1). <https://doi.org/10.1186/s12874-018-0611-x>
- Nekhlyudov, L., Mollica, M. A., Jacobsen, P. B., Mayer, D. K., Shulman, L. N., & Geiger, A. M. (2019). Developing a Quality of Cancer Survivorship Care Framework: Implications for Clinical Care, Research, and Policy. *JNCI: Journal of the National Cancer Institute*, 111(11), 1120–1130. <https://doi.org/10.1093/jnci/djz089>
- O'Cathain, A., Croot, L., Duncan, E., Rousseau, N., Sworn, K., Turner, K. M., Yardley, L., & Hoddinott, P. (2019). Guidance on how to develop complex interventions to improve health and healthcare. *BMJ Open*, 9(8), e029954. <https://doi.org/10.1136/bmjopen-2019-029954>
- O'Cathain, A., Croot, L., Sworn, K., Duncan, E., Rousseau, N., Turner, K., Yardley, L., & Hoddinott, P. (2019). Taxonomy of approaches to developing interventions to improve health: a systematic methods overview. *Pilot and Feasibility Studies*, 5(1). <https://doi.org/10.1186/s40814-019-0425-6>
- Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, 15. <https://doi.org/10.1111/nhs.12048>
- Yardley, L., Morrison, L., Bradbury, K., & Muller, I. (2015). The Person-Based Approach to Intervention Development: Application to Digital Health-Related Behavior Change Interventions. *Journal of Medical Internet Research*, 17(1), e30. <https://doi.org/10.2196/jmir.4055>
- Yusoff, M. S. B. (2019). ABC of Content Validation and Content Validity Index Calculation. *Education in Medicine Journal*, 11(2), 49–54. <https://doi.org/10.21315/eimj2019.11.2.6>

# Caring for cancer patients in acute cancer care settings: Voices of South African nurses

By Johanna E. Maree, Jacoba J. M. Jansen van Rensburg, Sizakele N. Hadebe

## ABSTRACT

*Little is known about the experience of nurses in Africa caring for cancer patients. This study was undertaken to provide a straightforward description of the experiences of South African nurses caring for patients in acute cancer care settings. Purposive sampling selected 20 nurses with whom there were in-depth interviews. Most of the participants were female registered oncology nurses with more than five years' experience. Three themes were identified: defining the cancer nursing experience, the challenges experienced in caring for cancer patients, and challenges imposed by the health-care system. Most of the participants believed they were called by God to care for cancer patients. However, the challenges they experienced led to guilt feelings and believing the care they provided was insufficient. They were subjected to workplace violence, missed the support from senior nursing management, and displayed signs of burnout. Addressing these challenges could limit their emotional distress and prevent burnout.*

## INTRODUCTION

Like the rest of the world, cancer is a major healthcare problem in South Africa. According to the World Health Organization (2020), 107,467 people were newly diagnosed with cancer in 2020, while 57,373 cancer deaths occurred in the same year. This relates to 23.3% of deaths caused by non-communicable diseases. Breast cancer is the most common cancer in South Africa followed by cancer of the cervix, prostate, and lung. Unfortunately, most patients present with advanced disease due to limited education, lack of knowledge about cancer, and health system inefficiencies (Joffe et al., 2018).

South Africa hosts two healthcare systems, private and public. The public healthcare sector, providing government-funded healthcare to more than 80% of citizens (Stattistica, 2020), is under tremendous pressure and patients are subjected to long waiting times, rushed appointments due to the patient load,

and poor clinical practices (Young, 2016). However, cancer treatment takes place in specialized departments of designated hospitals and patients have access to systemic anti-cancer treatments, radiotherapy, surgery, and stem cell transplants or a combination of treatments. Generally, patients receive treatment on an outpatient basis, but can undergo repeated admissions to hospital wards during the illness trajectory. A multi-professional team is responsible for their treatment and care. Most nurses forming part of this team are registered general nurses (RN), whilst a small percentage have completed a post-registration program in oncology nursing (RON).

Nurses practising in acute cancer care must have knowledge and expertise in order to render holistic care to patients, as their roles focus on assessment, education, symptom management, and supportive care. The nurses also care for and support the patients' families and caregivers, as they share the burden cancer imposes on the patients (Yates et al., 2020).

Currently, there is little known about the experiences of nurses caring for cancer patients in South Africa, as studies primarily focus on patient experiences. Only one South African study, conducted in 2008, could be found (Van Rooyen et al., 2008). New treatment modalities have developed since the publication of this study, and the challenges public health-care is currently facing, could influence nursing care.

## PURPOSE OF THE STUDY

The study was undertaken to provide a straightforward description of the experiences of South African nurses caring for patients in acute cancer care settings.

## METHODS

### Design

This study used a qualitative descriptive design that is especially suitable to answer research questions of special importance to practitioners, such as the case in this study. (Bradshaw et al., 2017; Sandelowski, 2000).

### Setting

The study took place at an academic hospital in Gauteng Province, South Africa. The hospital has 1,088 beds, and more than 4,000 professional and support staff members, and serves as a referral hospital for South Africa and the rest of Africa. The Radiation Oncology Department treats approximately 3,500 cancer patients per year (Bingo et al., 2020), whilst 150 to 200 patients receive treatment daily in the medical oncology clinic. The radiation oncology ward has 25 beds, while the medical oncology ward has 23 beds. Nursing unit managers head the different units and are responsible for the nursing care, nursing staff members, and the resources needed for the delivery of healthcare (Armstrong et al., 2015).

## AUTHOR NOTES

Johanna E. Maree, RN, DCur (Corresponding author), Department of Nursing Education, University of the Witwatersrand, 7 York Road, Parktown 2194, Johannesburg  
Tel: +27 833265749  
Email: [Lize.maree@wits.ac.za](mailto:Lize.maree@wits.ac.za)

Jacob J. M. Jansen van Rensburg, RN, PhD, University of the Witwatersrand, 7 York Road, Parktown 2194, Johannesburg  
Tel: +27 82277989  
Email: [kotie230@gmail.com](mailto:kotie230@gmail.com)

Sizakele N. Hadebe, RN, Department of Nursing Education, University of the Witwatersrand, 7 York Road, Parktown 2194, Johannesburg  
Tel: +27 767308234  
Email: [sizakeleh33@gmail.com](mailto:sizakeleh33@gmail.com)

DOI: 10.5737/2368807634116

## Population and sampling

The population consisted of all registered nurses practising in cancer care settings at the study setting. The inclusion criteria were having at least one year's experience in this field of nursing. The sampling method used was grid-based purposive sampling. The sampling grid ensured there was inclusion of nurses from all the cancer units in the study, whilst purposive sampling allowed the selection of participants experienced with the topic at hand and information rich (Gray & Grove, 2021; Palinkas et al., 2015).

## Recruitment and data collection

After obtaining ethical clearance from the University (#M170846) and permission from the hospital, nurses meeting the inclusion criteria were approached while on duty and invited to participate in the study. After explaining the study, the nurses received an information sheet. Following this was the obtaining of written informed consent for both participating in and audio recording of the interviews, and agreement of a day and time for the collection of data. There were 25 nurses recruited, but only 20 interviews conducted as, the researchers deemed 20 interviews ( $n = 20$ ) sufficient to achieve informational redundancy.

The collection of demographic data occurred first, followed by in-depth interviews asking a single broad question, "Please tell me, how do you experience caring for patients with cancer?" Using probes and asking prompting questions was to enhance an in-depth discussion of experiences and encouraged participants to reflect on their experiences openly. The interviews were conducted in English, in a private room in the hospital during participants' off-duty times and lasted between 45 and 60 minutes. A distress protocol applied and, in two instances, the interviews had to stop due to the emotional distress of the participants. However, both participants declined referral to the psychologist arranged for the purpose of the study and preferred to continue the interview, as they felt it allowed them the opportunity to debrief.

## Data management and analysis

Demographic data were entered onto an Excel spreadsheet and analyzed by means of descriptive statistics. The audio recorded interviews were transcribed word for word and the names of the participants replaced with numbers. Data analysis utilized qualitative content analysis, (Sandelowski, 2000), using an inductive approach (Bradshaw et al., 2017; Elo & Kyngäs, 2008). The steps followed were reading the transcripts various times, while making notes and headings in the margins. The headings were transferred to coding sheets and sub-themes were generated. The sub-themes were grouped under higher order headings to create themes. All three researchers were involved in the data analyses and used reflexivity in regular discussions, to become aware of how their knowledge and experiences could influence the findings of the study.

## Trustworthiness

The principles of Lincoln and Guba explained by Bradshaw et al. (2017) and Shenton (2004), were used to enhance the trustworthiness of the study. Credibility was enhanced by adopting well-established research methods, peer scrutiny of the research project, and member checks. The background

and experience of the research team also enhanced credibility, as the team had more than 10 years' experience in the field of oncology nursing, on average, while two members were experienced qualitative researchers. Confirmability was enhanced by means of an audit trail and a description of the demographic characteristics of the participants. Describing the research design and its implementation enhanced dependability, while using purposive sampling and describing the limitations of the study enhanced confirmability.

## RESULTS

### The participants

Most participants were female (18 of 20), and half (10 of 20) were married. Most (14 of 20) were older than 45 years, five were between the ages 35 and 45 years and one was younger than 35 years. More than half (13 of 20) were registered oncology nurses, whilst the rest (7 of 20) were general nurses; 10 had more than 10 years' experience in the field of cancer nursing, five had 5 to 10 years' experience, whilst the rest (5 of 20) had less than five years' experience.

### Themes identified

There were three themes and six sub-themes identified. Each theme will be described briefly below and additional illustrative quotes are provided in Table 1.

#### Theme 1. Defining the cancer nursing experience

##### Subtheme 1. Cancer nursing is a calling

Most participants were of the opinion God chose them to care for cancer patients. The participants agreed that not all their colleagues had a calling and those not chosen by God struggled to cope with the challenges of cancer nursing. They thought not staying in cancer nursing for a prolonged period and resigning was a sign there was no calling from God. The participants said:

*"I think this is my calling to look after cancer patients..."*  
(P19, RN).

*"Some of them resign, because they see that they don't belong here, I think it must be a calling ..."* (P3, RON).

##### Subtheme 2: The qualities of a cancer nurse

The participants were of the opinion nurses require certain qualities to care for the patients appropriately. Most agreed a nurse should be passionate about her profession, empathetic, sympathetic, loving, peaceful, emotionally strong, and calm. One participant said:

*"In oncology you need somebody who is caring and somebody who has listening skills, somebody who sympathizes with the patients."* (P6, RON).

The participants also agreed that knowledge and experience play a vital role in caring for cancer patients. The majority regarded specialist education and training as superior to experience only as it enhanced their ability to function as an independent practitioner and consultant, which boosted their self-confidence. This was described as:

*"After oncology training, I was more confident because now I knew what I was doing, I understood why things were happening the way they were happening."* (P20, RON)

**Table 1**

Additional Narratives According to the Themes

---

**Theme 1. Defining the cancer nursing experience**

---

**Subtheme 1. Caring for cancer patients is a calling**

*I feel like I am very fortunate that God chose to work through me to touch those patients and their families (P15, RN).*

*I feel when I care for patients in need of help, I feel like I am serving the Great Man who is our God by helping those in need of care, especially when the patient is constantly in pain (P17, RN).*

**Subtheme 2. The qualities of a cancer nurse**

*What is pushing me is that I am a nurse and I was born a nurse. I always collect myself and go to work. It's my passion (P2, RN).*

*We don't want adrenalin; we need peaceful people. We need people that understand and is calm like they understand that they are in a different situation (P13, RON).*

---

**Theme 2. The challenges experienced in caring for cancer patients**

---

**Subtheme 1. Providing end-of-life care in acute care settings**

*When you go to the acute [patient], they are like 'sister am I going to be like that?' So it's frustrating, really (P13, RON).*

*I need to be honest with you, you stay with them until ... I cannot tell you because in actual fact, it is not supposed to be happening (P10, RON).*

*Still, it's painful watching people die each and every day and doing so much and it's still not helping (P20, RON).*

**Subtheme 2. Coping with the family**

*You are being insulted ... you have fingers pointing at you telling you how useless you are ... It pulls you down like where did I go wrong? (P13, RON).*

*That is the most difficult part dealing with the relatives because somehow they will be telling you that they are going to sue you. They will be angry at you, and they will keep telling you that they are going to sue you (P2, RN).*

---

**Theme 3. Challenges imposed by the healthcare system**

---

**Sub-theme 1. The ever-increasing workload.**

*We have high number of patients [in the clinic] so the queue is very long... Short staff is not an excuse anymore for you to not render quality service ... (P16, RON).*

*I feel bad because most of the time, you have to babysit somebody who came on duty to work or to serve the patients, you have to babysit and look for what they are doing to the patient (P6, RON).*

*It's exhausting and demanding... I don't have time to myself especially when it comes to mealtimes ... but it's highly impossible at times. (P 18, RON).*

**Sub-theme 2: The need for support**

*There is no one to say what you are going through in this ward ... (P8, RN).*

*We need to be supported a lot because sometimes you feel like now you are crushed and you also need someone to pick you up, but that is not happening ... we should be able to debrief ... (P10, RON).*

**Theme 2. The challenges experienced in caring for cancer patients**

**Subtheme 1. Providing end-of-life care in acute care settings**

The participants experienced the presence of patients treated with palliative intent only, as time consuming, physically and emotionally exhausting, frustrating, and discouraging. The participants agreed there was often neglect of patients receiving anticancer treatment, which evoked guilt feelings. They also believed witnessing the condition of the terminally ill patients caused fear and anxiety in those who were acutely ill. A participant explained:

*"Sometimes you will admit a patient for supportive care and the doctor will tell you just make the patient comfortable... sometimes you feel like you end up neglecting other patients because of those patients because you are constantly looking after them" (P12, RN).*

Some participants had difficulty in caring for dying patients and accepting that a patient has died. Having to witness the deaths of three to four patients per day was overwhelming. However, support from colleagues, pastors, and psychologists, and days without a death helped the participants cope. In addition, nursing a patient with a good prognosis also helped to cope with the deaths of those terminally ill. A participant explained:

*"There are some days where the day will go by without seeing patients dying in front of you... actually that again keeps us going when we see patient getting better" (P8, RN).*

**Sub-theme 2: Coping with the family**

Caring for the family was not easy and the participants experienced families as mostly rude, physically and verbally aggressive, and unappreciative of their work. They experienced their working environment as unsafe due to the aggressive nature of family actions and the threats of litigations posed on them. A participant described her experience:

*"The other thing is our patients' relatives ... there was a patient who passed on ... the relative wanted to hit me with a fist. He ended up breaking the walls ... if I didn't run away at that time, that relative was going to hit me ..." (P6, RON).*

Even though the relationship between families and the participants was often poor, the participants agreed some relatives were appreciative and understanding, which encouraged them. One explained:

*"Other families are very appreciative. It is so encouraging to get just a simple thank you ... every single day they will be like, you are doing a good job" (P12, RN).*

**Theme 3. Challenges imposed by the healthcare system**

**Sub-theme 1. The ever-increasing workload**

The participants experienced a constant workload increase and a shortage of staff. They felt they had to make do with the available staff, but felt guilty about the time they spent with the patients. Having time to take a breather also became a challenge. A participant explained:

*“I feel bad because we are always rushing, we don't have time to sit with the patient and try to allay her anxiety and make her feel at home ... even when you are at home, you think about what you did, you feel like you didn't do enough” (P10, RON).*

The high workload did not allow for the rendering of best quality of care and led to errors. Some participants corrected the mistakes other members of the multi-professional team made. In addition, some were so exhausted that they doubted whether they would return to work. A participant said:

*“At the same time, you don't just nurse the patient, you nurse their family, you nurse your colleagues, you nurse the doctors, you nurse everyone in the hospital, so it's just too much ... physically it takes a toll because it's really busy, when you knockoff you're so tired ... you are like I don't want to go back tomorrow” (P8, RN).*

### *Sub-theme 2: The need for support*

The participants' opinions were that the senior nursing management added to their emotional distress. They needed debriefing opportunities and emotional support to stay motivated, but experienced management to be unsupportive, available only when adverse incidents occurred and constantly searching for mistakes. Management also failed to mentor or give advice when challenges were encountered. A participant said:

*“The person you report directly to does not have a clue about nursing oncology patients, so she doesn't understand some of the things, so they don't offer any advises...” (P16, RON).*

## **DISCUSSION**

The participants in the study were typical of nursing in South Africa in terms of age and gender. However, what was surprising, was the sample consisted primarily of registered oncology nurses, as only 699 of approximately 400,000 nurses on the register are registered oncology nurses (South African Nursing Council, 2021). Irrespective of being a registered oncology nurse or general nurse, the participants believed their work was a calling, and that God had chosen them to care for cancer patients. Raatikainen (1997) found nurses who believed they were called, practiced on a high professional level, and had a good understanding of the patients' needs and the importance of the patients' families. In addition, these nurses were able to support their patients well and offered support to the families.

As evidenced from the study, the participants were subjected to workplace violence inflicted by some family members. Family members have been found to be the primary perpetrators of workplace violence against nurses (Choi & Lee, 2017). Similar to what was found in the current study, Granek et al. (2019), in a study focusing on oncologists, described incidences where family members behaved in a violent manner toward the staff. Radiation therapists also described workplace violence, but the perpetrators were not family members, but the patients themselves (Sperduti et al., 2018), which could be related to the fact that family members are not allowed in the treatment room.

The study provided evidence that caring for dying patients in acute cancer care settings was not easy. Manicom (2011), when investigating the place of death of South African cancer patients using private healthcare, found that irrespective of having good access to hospice care, 34.2% of the 424 recorded deaths took place in medical wards under the care of an oncologist. How this relates to public healthcare is not known. However, McWhan (1991) reasons that the main responsibility of nurses practising in acute care settings is to care for patients receiving active treatment. Burt, et al. (2008) found caring for palliative patients unpredictable and time consuming, and that it leads to additional pressures if added to the care load of generalist nurses. Fuly, et al. (2016) also found the more compromised the functional ability of the patient is, the higher the nursing care activities are. This was also evident from the current study, as the participants found the time spent in caring for dying patients resulted in neglecting the care of acutely ill patients, a situation that led to guilt feelings, as they believed they did not provide optimal care to the acutely ill patients.

As seen from the study, the participants experienced the workload as increasingly overbearing. The fact that they were always rushing and did not have time to provide the best quality nursing care, added to the emotional distress they experienced. Lawler et al. (2020), when investigating the perceived results the workforce pressure has on the nursing care of cancer patients, found psychosocial care to patients and their families one of the most forsaken aspects of care. As seen from the current study, not having time to sit with patients and allay their anxiety, indicates the opportunity for nurses to provide psychosocial support and care, an aspect of cancer care that limits suffering (Maree et al., 2021), has already been eroded by the workload.

In addition, as evident from the study, the workload has led to errors that demanded correction from some participants. Having to be the watchdog over the practices of nursing colleagues and other healthcare professionals and having to care for colleagues, patients, and their families was so exhausting that some participants doubted whether they would have the strength to return to hospital the next day, which could indicate burnout syndrome. Workload and the nature of oncology nursing have been identified as the major contributors to burnout syndrome (Cañadas-De la Fuente et al., 2018), which is related to emotional and physical fatigue due to long-term job stresses (Wentzel & Brysiewicz, 2018). Although colleagues provided social support, the participants experienced the senior nursing management as unsupportive, which is not in the best interest of either the participants or the patients, as burnout has a direct influence on patient care (Velando-Soriano et al., 2020).

Lastly, as evident from the study, the participants expressed a need for debriefing opportunities. Wentzel et al. (2011), when investigating barriers and facilitators to the loss of cancer patients, found debriefing sessions were helpful to some nurses, but not all benefited from it. However, McCorkle (2016) urges nurses to form a group to share their stories in the absence of regular debriefing sessions, in order to gain insight into their experiences, to stay healthy, and to be able to care for cancer patients.

## LIMITATIONS

The study took place in one academic hospital forming part of the public healthcare system, and the majority of participants were registered oncology nurses. Considering the differences in the provision of cancer care across South Africa, the findings of this study might not reflect the experiences of nurses practising in other cancer care settings. In addition, no qualitative study presents the only truth, as other researchers could interpret the raw data differently.

## CONCLUSION

Most nurses who participated in this study believed God called them to care for cancer patients. However, they

## REFERENCES

- Armstrong, S. J., Rispel, L. C., & Penn-Kekana, L. (2015). The activities of hospital nursing unit managers and quality of patient care in South African hospitals: A paradox? *Global Health Action*, 8, 26243. <https://doi.org/10.3402/gha.v8.26243>
- Bingo, S. A. M., Maree, J. E., & Jansen van Rensburg, J. J. M. (2020). Living with cancer of the head and neck: A qualitative inquiry into the experiences of South African patients. *European Journal of Cancer Care*, 29(2), e13205.
- Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, 4, 2333393617742282. <https://doi.org/10.1177/2333393617742282>
- Burt, J., Shipman, C., Addington-Hall, J., & White, P. (2008). Nursing the dying within a generalist caseload: A focus group study of district nurses. *International Journal of Nursing Studies*, 45(10), 1470–1478. <https://doi.org/10.1016/j.ijnurstu.2008.01.003>
- Cañadas-De la Fuente, G. A., Gómez-Urquiza, J. L., Ortega-Campos, E. M., Cañadas, G. R., Albendín-García, L., & De la Fuente-Solana, E. I. (2018). Prevalence of burnout syndrome in oncology nursing: A meta-analytic study. *Psychooncology*, 27(5), 1426–1433. <https://doi.org/10.1002/pon.4632>
- Choi, S.-H., & Lee, H. (2017). Workplace violence against nurses in Korea and its impact on professional quality of life and turnover intention. *Journal of Nursing Management*, 25(7), 508–518. <https://doi.org/10.1111/jonm.12488>
- Elo, S., & Kyngäs, H. (2008). The qualitative content analysis. *Journal of Advanced Nursing*, 62, 107–115. <https://doi.org/10.1111/j.1365-2648.2007.04569.x>
- Fuly, P. D., Pires, L. M., Souza, C. Q., Oliveira, B. G., & Padilha, K. G. (2016). Nursing workload for cancer patients under palliative care. *Revista da Escola de Enfermagem da USP*, 50(5), 792–799. <https://doi.org/10.1590/s0080-623420160000600012>
- Granek, L., Ben-David, M., Bar-Sela, G., Shapira, S., & Ariad, S. (2019). “Please do not act violently towards the staff”: Expressions and causes of anger, violence, and aggression in Israeli cancer patients and their families from the perspective of oncologists. *Transcultural Psychiatry*, 56(5), 1011–1035. <https://doi.org/10.1177/1363461518786162>
- Gray, J., & Grove, S. (2021). *Burns and Grove’s The Practice of Nursing Research* (9th ed.). Elsevier.
- Joffe, M., Ayeni, O., Norris, S. A., McCormack, V. A., Ruff, P., Das, I., ... Cubasch, H. (2018). Barriers to early presentation of breast cancer among women in Soweto, South Africa. *PLoS One*, 13(2), e0192071.
- Lawler, J., Leary, A., Lofton, L., & Bushe, D. (2020). Perceptions of the cancer care left undone in primary and community services: A mixed methods evaluation. *Health & Social Care in the Community*, 28(6), 2117–2124. <https://doi.org/10.1111/hsc.13022>
- Manicom, C. (2011). Where do our patients die? A review of the place of death of cancer patients in Cape Town, South Africa. *Palliative and Supportive Care*, 9(1), 31–41. <https://doi.org/10.1017/S1478951510000520>
- Maree, J. E., Holtzlander, L., & Maree, J. E. (2021). The experiences of women living with cervical cancer in Africa: A metasynthesis of qualitative studies. *Cancer Nursing*, 44(5), 419–430. <https://doi.org/10.1097/ncc.0000000000000812>
- McCorkle, R. (2016). Debriefing as an essential part of keeping ourselves healthy. *Cancer Nursing*, 39(2), 163–164. <https://doi.org/10.1097/ncc.0000000000000340>
- McWhan, K. (1991). Caring for dying patients in acute hospital wards: A review. *Nursing Practice*, 5(1), 25–28. <https://doi.org/10.7748/ns.6.8.25.s76>
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, 42(5), 533–544. <https://doi.org/10.1007/s10488-013-0528-y>
- Raatikainen, R. (1997). Nursing care as a calling. *Journal of Advanced Nursing*, 25(6), 1111–1115.
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334–340.
- Shenton, A. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63–75.
- South African Nursing Council. (2021). Statistics for 2020. <https://ncsacoms.co.za/2010-stats-2/>
- Sperduti, A., Hindle, D., Shessel, A., Pidgeon, B., Akmal, H., Chaulk, G., ... Rosewall, T. (2018). Treating too lightly? Radiation therapists’ experiences of workplace violence when providing care to cancer patients and their families. *Journal of Medical Imaging and Radiation Sciences*, 49(1), 56–61. <https://doi.org/https://doi.org/10.1016/j.jmir.2017.11.001>
- Statistica. (2020). Share of individuals who are members of medical aid schemes in South Africa in 2018, by population group. <https://www.statista.com/statistics/1115752/share-of-medical-aid-scheme-members-in-south-africa-by-population-group/>
- Van Rooyen, D., Le Roux, L., & Kotzé, W. (2008). The experiential world of the oncology nurse. *Health SA Gesondheid* 13(3), 18–30.



- Velando-Soriano, A., Ortega-Campos, E., Gómez-Urquiza, J. L., Ramírez-Baena, L., De La Fuente, E. I., & Cañadas-De La Fuente, G. A. (2020). Impact of social support in preventing burnout syndrome in nurses: A systematic review. *Japan Journal of Nursing Science*, 17(1), e12269.
- Wentzel, D. L., & Brysiewicz, P. (2018). A survey of compassion satisfaction, burnout and compassion fatigue in nurses practicing in three oncology departments in Durban, South Africa. *International Journal of Africa Nursing Sciences*, 8, 82–86. <https://doi.org/10.1016/j.ijans.2018.03.004>
- Wenzel, J., Shaha, M., Klimmek, R., & Krumm, S. (2011). Working through grief and loss: Oncology nurses' perspectives on professional bereavement. *Oncology Nursing Forum*, 38(4), E272–282. <https://doi.org/10.1188/11.Onf.E272-e282>
- World Health Organization. (2020). *Cancer country profile 2020. Burden of cancer South Africa*. [https://www.who.int/cancer/country-profiles/ZAF\\_2020.pdf?ua=1](https://www.who.int/cancer/country-profiles/ZAF_2020.pdf?ua=1)
- Yates, P., Charalambous, A., Fennimore, L., Nevidjon, B., So, W. K., Suh, E. E., Woodford, E., & Young, A. (2020). Position statement on cancer nursing's potential to reduce the growing burden of cancer across the world. *Cancer Nursing*, 43(6), 433–435.
- Young, M. (2016). Private versus public healthcare in South Africa. Honours Thesis, Western Michigan University, Michigan.

# S'occuper des patients atteints de cancer : l'expérience d'infirmières et d'infirmiers d'Afrique du Sud travaillant en soins aigus

Par Johanna E. Maree, Jacoba J. M. Jansen van Rensburg, Sizakele N. Hadebe

## RÉSUMÉ

*On sait peu de choses de l'expérience des infirmières et infirmiers d'Afrique du Sud qui soignent les patients atteints de cancer. La présente étude avait pour but de décrire en termes simples l'expérience du personnel infirmier travaillant dans les milieux de soins aigus. Par échantillonnage dirigé, on a sélectionné 20 infirmières et infirmiers qui ont ensuite passé des entrevues détaillées. Il s'agissait pour la plupart de femmes, infirmières autorisées en oncologie, ayant plus de 5 ans d'expérience. Trois thèmes sont ressortis des discussions : la définition de l'expérience des soins infirmiers oncologiques, les difficultés de la prestation de soins aux patients atteints de cancer, et les problèmes attribuables au système de santé. Pour la plupart, les personnes ayant participé à l'étude croyaient que Dieu les avait appelées à travailler auprès des patients atteints de cancer. Toutefois, à cause des difficultés vécues, elles se sentaient coupables et n'avaient pas l'impression de donner des soins adéquats. En outre, elles étaient victimes de violence dans leur milieu de travail, ne bénéficiaient pas du soutien des cadres de gestion des soins infirmiers, et montraient des signes d'épuisement professionnel. Pour réduire la détresse émotionnelle et prévenir l'épuisement, il faudra trouver une solution à ces problèmes.*

## INTRODUCTION

En Afrique du Sud, comme partout ailleurs dans le monde, le cancer est un problème de santé majeur. Selon l'Organisation mondiale de la Santé (2020), 107 467 personnes ont reçu un premier diagnostic de cancer en 2020; la même année, 57 373 personnes en sont mortes, ce qui représente 23,3 % des décès causés par des maladies non transmissibles. En Afrique du Sud, c'est le cancer du sein qui est le plus fréquent, suivi

des cancers du col de l'utérus, de la prostate et du poumon. Malheureusement, dans la plupart des cas, la maladie n'est détectée qu'au stade avancé, à cause d'un manque d'éducation, de connaissances sur le cancer et d'efficacité du système de santé (Joffe et al., 2018).

L'Afrique du Sud a deux systèmes de santé : l'un public, l'autre privé. Le système public, financé par le gouvernement, fournit des soins à plus de 80 % de la population (Statista, 2020); il subit d'énormes pressions : les temps d'attente sont longs et les rendez-vous expéditifs à cause du nombre de patients; la qualité des pratiques cliniques en souffre (Young, 2016). Les traitements oncologiques sont donnés néanmoins par des services spécialisés, dans des centres hospitaliers désignés offrant des traitements systémiques, de la radiothérapie, des traitements chirurgicaux, des greffes de cellules souches ou une combinaison de différents traitements. En général, les patients sont traités en consultation externe, mais ils sont parfois hospitalisés à plusieurs reprises au cours de la trajectoire de la maladie. Le traitement et les soins sont confiés à une équipe interdisciplinaire. La plupart des professionnels de cette équipe sont des infirmiers ou infirmières générales autorisées, certains ayant complété un programme de spécialisation en soins infirmiers oncologiques (inf. aut. onc.).

Les infirmières qui s'occupent des malades en phase aiguë doivent posséder le savoir et l'expertise nécessaires pour offrir des soins holistiques, leur rôle étant axé sur l'évaluation, l'éducation, la prise en charge des symptômes et les soins de soutien. Les infirmières doivent également s'occuper des familles et des proches aidants, qui partagent avec les patients le fardeau du cancer (Yates et al., 2020).

À l'heure actuelle, on sait peu de chose de l'expérience vécue par les infirmières et infirmiers qui soignent les patients atteints de cancer en Afrique du Sud, les recherches portant surtout sur l'expérience des patients. Une seule étude sud-africaine, menée en 2008, a été recensée (Van Rooyen, Le Roux et Kotze, 2008). Or, de nouveaux modes de traitement ont fait leur apparition depuis sa publication; de plus, les problèmes qui touchent actuellement le système de santé public pourraient avoir une incidence sur les soins infirmiers.

## BUT DE L'ÉTUDE

La présente étude a été entreprise dans le but de décrire en termes simples l'expérience des infirmières et infirmiers d'Afrique du Sud qui s'occupent de patients atteints de cancer dans les milieux de soins aigus.

## AUTEURES

Johanna E. Maree, inf. aut., D.Cur. (auteure-ressource), Département de sciences infirmières, Université du Witwatersrand, 7 York Road, Parktown 2194, Johannesburg  
Tél. : +27 833265749  
Courriel : [Lize.maree@wits.ac.za](mailto:Lize.maree@wits.ac.za)

Jacob J. M. Jansen van Rensburg, inf. aut., Ph.D., Université du Witwatersrand, 7 York Road, Parktown 2194, Johannesburg  
Tél. : +27 82277989  
Courriel : [kotie230@gmail.com](mailto:kotie230@gmail.com)

Sizakele N. Hadebe, inf. aut., Département de sciences infirmières, Université du Witwatersrand, 7 York Road, Parktown 2194, Johannesburg  
Tél. : +27 767308234  
Courriel : [sizakeleh33@gmail.com](mailto:sizakeleh33@gmail.com)

DOI:10.5737/2368807634122

## MÉTHODOLOGIE

### Devis

Le devis qualitatif descriptif choisi pour cette étude convient bien au modèle d'entrevues de recherche qui posent aux praticiens et praticiennes des questions revêtant une importance particulière, comme c'est le cas ici (Bradshaw et al., 2017; Sandelowski, 2000).

### Contexte

L'étude a été réalisée dans un hôpital universitaire de la province de Gauteng, en Afrique du Sud. Cet hôpital dispose de 1 088 lits et emploie plus de 4 000 professionnels de la santé et travailleurs de soutien, en plus de servir d'établissement de recours non seulement pour l'Afrique du Sud, mais aussi pour le reste du continent africain. Le service de radiothérapie reçoit chaque année environ 3 500 patients atteints de cancer (Bingo et al., 2020), et la clinique d'oncologie médicale traite chaque jour entre 150 et 200 patients. Le service de radiothérapie dispose de 25 lits et le service d'oncologie médicale de 23. Les gestionnaires gèrent à la fois les différentes unités, les soins infirmiers, les membres du personnel infirmier et les ressources nécessaires à la prestation des soins de santé (Armstrong et al., 2015).

### Population et échantillonnage

La population était constituée d'infirmiers et d'infirmières autorisés qui soignaient les patients atteints de cancer en phase aiguë dans l'établissement où se déroulait l'étude. Le seul critère d'inclusion était d'avoir au moins un an d'expérience dans ce domaine particulier des soins infirmiers. L'échantillonnage dirigé a été réalisé par maillage; le maillage a permis d'inclure dans l'étude des infirmières et infirmiers de toutes les unités de cancérologie, tandis que l'échantillonnage de type « dirigé » a permis de sélectionner des infirmières et infirmiers connaissant bien le sujet étudié et capables de fournir une grande quantité d'information (Gray et Grove, 2021; Palinkas et al., 2015).

### Recrutement et collecte de données

Après obtention de l'approbation éthique de l'université (no M170846) et la permission de l'hôpital, on a joint les infirmières et infirmiers répondant au critère d'inclusion pendant les heures de travail pour les inviter à participer. On leur a expliqué l'étude et remis une fiche d'information. Par la suite, on a obtenu par écrit le consentement de participation et d'enregistrement audio des entrevues, puis on a fixé le jour et l'heure de la collecte de données. En tout, 25 infirmières et infirmiers ont été recrutés, mais seulement 20 entrevues ont été menées, les chercheuses ayant établi que ce nombre ( $n = 20$ ) était suffisant pour atteindre le point de redondance informationnelle.

On a d'abord procédé à la collecte de données démographiques, puis aux entrevues détaillées. Les personnes rencontrées devaient répondre à une seule question assez générale : « Parlez-moi de votre expérience des soins prodigués aux patients atteints de cancer. » L'utilisation de questions de relance ou d'exploration avait pour but d'approfondir la discussion et d'encourager les participantes à réfléchir ouvertement à leurs expériences. Les entrevues se déroulaient en anglais,

dans une salle privée de l'hôpital hors de leur quart de travail, et ont duré entre 45 et 60 minutes. Un protocole de détresse était prévu; il a été appliqué à deux entrevues, interrompues à cause du désarroi ressenti par les participantes. Ces dernières ont toutefois refusé de consulter les services de psychologie retenus aux fins de l'étude et ont préféré poursuivre l'entrevue, disant que cela leur donnait l'occasion de faire le point.

### Gestion et analyse des données

Les données démographiques ont été inscrites dans une feuille de calcul Excel et analysées à l'aide de statistiques descriptives. Les enregistrements audio ont été retranscrits verbatim et les noms des participantes remplacés par des chiffres. Les données ont fait l'objet d'une analyse de contenu qualitative (Sandelowski, 2000) par approche inductive (Bradshaw et al., 2017; Elo et Kyngäs, 2008). Pour ce faire, les chercheuses ont relu les transcriptions plusieurs fois en inscrivant des notes et des titres de rubriques dans les marges. Ces titres ont été transférés dans des feuilles de codage pour en faire ressortir des sous-thèmes qui ont ensuite été regroupés en catégories plus générales, les thèmes. Les trois chercheuses ont participé à l'analyse des données et appliqué dans leurs discussions générales une démarche de réflexivité pour comprendre l'influence de leurs connaissances et de leurs expériences sur les conclusions de la présente étude.

### Fiabilité

Les principes de Lincoln et Guba, expliqués par Bradshaw et collaborateurs (2017) ainsi que par Shenton (2004), ont été appliqués pour renforcer la fiabilité de l'étude. La crédibilité a quant à elle été assurée par l'adoption de méthodes de recherche ayant fait leurs preuves, par l'évaluation du projet de recherche par les pairs et par des rencontres de contrôle. La formation et l'expérience des chercheuses ajoutaient également à la crédibilité; l'équipe de recherche possédait en moyenne plus de 10 ans d'expérience en oncologie, et deux des membres avaient aussi de l'expérience en recherche qualitative. La confirmabilité a été assurée par la vérification méthodologique et le portrait démographique des participantes. La description du devis de recherche et de sa mise en application renforce la fiabilité, tandis que l'échantillonnage dirigé et l'admission des limites de l'étude améliorent la confirmabilité.

## RÉSULTATS

### Participantes

Il s'agissait surtout de femmes (18 sur 20); la moitié (10 sur 20) étaient marié(e)s. La plupart (14 sur 20) avaient plus de 45 ans; 5 avaient entre 35 et 45 ans, un seul participant à l'étude avait moins de 35 ans. Plus de la moitié (13 sur 20) étaient infirmières ou infirmiers en oncologie; les autres (7 sur 20) en pratique générale; 10 travaillent depuis plus de 10 ans en soins infirmiers en oncologie; 5 avaient entre 5 et 10 ans d'expérience; les autres (5 sur 20) avaient moins de 5 ans d'expérience.

### Thèmes

Trois thèmes et six sous-thèmes sont ressortis. Chaque thème fera l'objet d'une brève description. Le tableau 1 présente des citations explicatives supplémentaires.

**Tableau 1**

Citations supplémentaires sur les différents thèmes

---

**Thème 1. Définition de l'expérience des soins infirmiers en oncologie**

---

**Sous-thème 1. Vocation des infirmières en oncologie**

*Je pense que je suis très chanceuse que Dieu ait choisi, à travers moi, d'aider ces patients et leurs proches. (P15, inf. aut.)*

*Lorsque je donne des soins aux patients qui ont besoin d'aide, j'ai l'impression de servir le Seigneur, surtout lorsqu'un patient vit une souffrance constante. (P17, inf. aut.)*

**Sous-thème 2. Qualités des infirmières en oncologie**

*Ce qui me motive, c'est le fait d'être infirmière. Je suis née pour ça. Je trouve toujours un moyen de me recentrer et d'aller travailler. C'est ma passion. (P2, inf. aut.)*

*Ce n'est pas d'adrénaline dont nous avons besoin, mais de calme. Nous avons besoin de gens compréhensifs et calmes, qui comprennent qu'ils sont dans une situation différente. (P13, inf. aut. onc.)*

---

**Thème 2. Difficultés associées aux soins des patients atteints de cancer**

---

**Sous-thème 1. Soins de fin de vie en milieu de soins aigus**

*Lorsqu'on va voir [les patients] en phase aiguë, ils nous disent « est-ce que je vais finir comme ça? » Alors, c'est vraiment frustrant. (P13, inf. aut. onc.)*

*Je dois être honnête avec vous, on reste avec la personne jusqu'à ce que... je ne peux pas en dire plus parce qu'en réalité, ce n'est pas censé arriver. (P10, inf. aut. onc.)*

*C'est quand même douloureux de voir des gens mourir tous les jours, et malgré tous nos efforts, rien ne les aide. (P20, inf. aut. onc.)*

**Sous-thème 2. Relations avec la famille**

*On se fait insulter... On se fait pointer du doigt et on nous dit qu'on est complètement inutile... C'est décourageant et on se demande ce qu'on a fait de mal. (P13, inf. aut. onc.)*

*C'est la partie la plus difficile, traiter avec les familles, parce qu'elles disent qu'elles vont nous poursuivre en justice. Elles se fâchent contre nous et n'arrêtent pas de dire qu'elles vont nous traîner en justice. (P2, inf. aut.)*

---

**Thème 3. Problèmes attribuables au système de santé**

---

**Sous-thème 1. Augmentation constante de la charge de travail**

*Nous avons un nombre élevé de patients [à la clinique], alors l'attente est très longue... Nous ne pouvons plus mettre la baisse de qualité des services sur le dos de la pénurie de personnel... (P16, inf. aut. onc.)*

*Je me sens mal parce que la plupart du temps, il faut surveiller les gens qui viennent travailler ou s'occuper des patients. Il faut les surveiller et vérifier les soins qu'ils donnent aux patients. (P6, inf. aut. onc.)*

*C'est épuisant et exigeant... Je n'ai pas de temps pour moi, particulièrement à l'heure des repas... c'est parfois franchement impossible. (P18, inf. aut. onc.)*

**Sous-thème 2. Besoin de soutien**

*Il n'y a personne à qui parler de ce qu'on vit dans cette unité... (P8, inf. aut.)*

*Nous avons besoin de beaucoup de soutien parce que, parfois, nous nous sentons anéanties et nous avons besoin de nous faire remonter le moral, mais ça n'arrive pas... Il faudrait que nous puissions faire le point... (P10, inf. aut. onc.)*

**Thème 1. Définition de l'expérience des soins infirmiers en oncologie**

*Sous-thème 1. Vocation de l'infirmière en oncologie*

Pour la plupart, les participants et participantes croyaient que Dieu les avait choisis pour s'occuper des patients cancéreux, mais disaient aussi que tous leurs collègues ne possédaient pas cette vocation, et que sans elle, il devenait pénible de s'acquitter des lourdes tâches associées aux soins infirmiers oncologiques. Selon ces participants, le fait de ne pas rester longtemps en oncologie ou de démissionner était un signe de l'absence de vocation divine :

*« Je crois que m'occuper des patients atteints de cancer est ma vocation... » (P19, inf. aut.)*

*« Certains démissionnent parce qu'ils comprennent qu'ils ne sont pas à leur place. Je pense qu'il faut avoir la vocation [...] » (P3, inf. aut. onc.)*

*Sous-thème 2. Qualités de l'infirmière en oncologie*

De l'avis des participants, les infirmières et infirmiers doivent posséder certaines qualités pour s'occuper correctement des patients. Pour la plupart, elles s'entendaient pour dire que l'infirmière doit être empathique et passionnée par son travail, agir avec sympathie et bienveillance, rester calme, posséder une certaine stabilité émotionnelle et dégager une force tranquille. L'une des participantes l'a exprimé ainsi :

*« En oncologie, il faut être très humain, capable d'écouter et d'éprouver de la sympathie envers les patients. » (P6, inf. aut. onc.)*

Pour les participants, les connaissances et l'expérience jouaient également un rôle vital dans le soin des patients atteints de cancer. La majorité considérait que la formation spécialisée était préférable à la seule expérience, car elle leur permettait de devenir des praticiennes et praticiens indépendants et des infirmières et infirmiers conseils, ce qui renforçait leur confiance en soi :

*« Après ma formation en oncologie, j'étais plus confiante parce que je savais enfin ce que je faisais, je comprenais pourquoi les choses se passaient ainsi. » (P20, inf. aut. onc.)*

**Thème 2. Difficultés associées aux soins des patients atteints de cancer**

*Sous-thème 1. Soins de fin de vie en milieu de soins aigus*

Les participants trouvaient que les patients recevant des soins exclusivement palliatifs leur prenaient beaucoup de temps, étaient source de fatigue physique et émotionnelle, et suscitaient en eux des sentiments de frustration et de découragement. Les autres patients en traitement oncologique s'en trouvaient souvent négligés, ce qui leur causait de la culpabilité. Selon eux, de fait de voir les patients en phase terminale causait de la peur et de l'anxiété chez les patients en phase aiguë. Un participant l'a expliqué ainsi :

*« Parfois, un patient est admis pour recevoir des soins de soutien et le médecin demande de simplement assurer son confort... mais on a parfois l'impression de négliger les autres patients à cause de ça, parce qu'on est constamment en train de s'occuper de cette personne en particulier. » (P12, inf. aut.)*

Certains participants avaient de la difficulté à s'occuper des mourants et à accepter leur décès. Il était douloureux de voir mourir trois ou quatre patients par jour. Mais certaines journées, personne ne mourait, ce qui les aidait à garder le moral. Ils pouvaient aussi compter sur le soutien des collègues, des pasteurs et des psychologues. De plus, lorsqu'un infirmier ou une infirmière soigne des patients au pronostic encourageant, il est plus facile d'accepter le décès des personnes en phase terminale. Une participante l'exprime ainsi :

« Certains jours, aucun patient ne meurt sous nos yeux... lorsque nous voyons des patients qui vont mieux, ça nous aide à continuer. » (P8, inf. aut.)

### Sous-thème 2. Relations avec la famille

Il n'était pas facile de s'occuper des membres de la famille des patients; ils étaient impolis la plupart du temps, agressifs verbalement et physiquement, et jamais reconnaissants du travail accompli. Les infirmiers et infirmières ne trouvaient pas leur milieu de travail sûr à cause des comportements agressifs des proches et des menaces de litiges qu'ils laissaient planer. En voici un témoignage :

« L'autre chose, c'est la famille des patients... un des patients est décédé... un membre de sa famille voulait me donner un coup de poing. Il a fini par briser les murs... si je n'étais pas partie en courant, il m'aurait frappée... » (P6, inf. aut. onc.)

Bien que les relations avec les familles ne soient pas toujours cordiales, les participants disent être encouragés lorsque des proches sont reconnaissants et compréhensifs.

« D'autres membres de la famille étaient très reconnaissants. C'est tellement encourageant de se faire dire un simple "merci"... chaque jour, ils nous disaient qu'on faisait du bon travail. » (P12, inf. aut.)

### Thème 3. Problèmes attribuables au système de santé

#### Sous-thème 1 : Augmentation constante de la charge de travail

La pénurie de personnel et l'augmentation constante de leur charge de travail pesaient sur les participants, qui savaient qu'ils devaient s'arranger avec le personnel disponible, mais se sentaient coupables de ne plus avoir assez de temps avec les patients. Il devenait même difficile de prendre une pause. En voici un exemple :

« Je me sens mal parce qu'on doit toujours se dépêcher, nous n'avons pas le temps de nous asseoir avec les patients pour les mettre à l'aise et pour tenter d'apaiser leur anxiété... même une fois chez nous, nous repensons à ce que nous avons fait et nous avons l'impression de ne pas en faire assez. » (P10, inf. aut. onc.)

La lourde charge de travail nuit à la qualité des soins et cause des erreurs. Certains participants corrigeaient les erreurs commises par d'autres membres de l'équipe multidisciplinaire. De plus, certains étaient tellement épuisés qu'ils hésitaient à retourner au travail.

« On ne s'occupe pas que du patient, mais aussi de sa famille; on voit également aux besoins de nos collègues, des médecins, de tout le monde dans l'hôpital, c'est juste trop de travail... physiquement, c'est pénible parce que nous sommes vraiment occupées. Après le travail, on est tellement fatiguées... on se demande si on y retournera le lendemain. » (P8, inf. aut.)

### Sous-thème 2. Besoin de soutien

Les infirmières et infirmiers rencontrés étaient d'avis que les cadres de gestion des soins infirmiers ajoutaient à leur détresse psychologique. Ils avaient besoin d'occasions de faire le point et de soutien psychologique pour conserver leur motivation, mais selon leur expérience, les gestionnaires n'étaient pas d'une grande aide et n'étaient disponibles qu'en cas d'incidents problématiques, et toujours en train de chercher des erreurs. La direction ne jouait pas non plus le rôle de mentor ou de conseiller lorsque les infirmières et infirmiers vivaient des difficultés. Une participante l'a exprimé ainsi :

« Votre supérieure directe ne sait rien des soins à donner aux patients en oncologie, donc elle ne comprend pas certaines choses et n'offre aucun soutien... » (P16, inf. aut. onc.)

## DISCUSSION

En termes d'âge et de sexe, les participants à l'étude présentaient un portrait typique de la profession infirmière en Afrique du Sud. Il était toutefois surprenant que l'échantillon soit constitué principalement d'infirmières autorisées en oncologie, étant donné que seulement 699 des 400 000 infirmières autorisées du pays sont spécialisées dans ce domaine (South African Nursing Council, 2021). Qu'elles travaillent en oncologie ou en pratique générale, les personnes rencontrées croyaient que leur profession était une vocation, que Dieu les avait choisis pour prendre soin des patients atteints de cancer. Raatikainen (1997) a conclu que les infirmières qui croyaient répondre à l'appel de Dieu faisaient preuve d'un grand professionnalisme et comprenaient bien les besoins des patients et l'importance des familles, qu'elles soutenaient bien leurs patients et savaient offrir de l'aide aux proches.

Comme l'a révélé la présente étude, les participantes subissaient de la violence au travail de la part de certains proches des patients; les familles des patients constituent la principale cause de violence envers le personnel infirmier (Choi et Lee, 2017). Dans la même veine que la présente étude, les travaux sur les oncologues de Granek, Ben-David, Bar-Sela, Shapira et Ariad (2019) décrivent des incidents de violence perpétrée contre le personnel par des proches des patients. Les radiothérapeutes ont également fait mention de violence en milieu de travail, mais de la part des patients eux-mêmes, pas de leurs proches (Sperduti et al., 2018), ce qui pourrait s'expliquer par le fait que la famille n'est pas admise dans la salle de traitement.

L'étude prouve qu'il n'est pas facile de s'occuper de personnes mourantes en contexte de soins aigus. Manicom (2011), dans ses travaux sur le lieu de décès de patients sud-africains atteints de cancer soignés dans le système privé, a observé que 34,2 % de 424 décès rapportés avaient eu lieu dans une unité médicale sous les soins d'un oncologue, que les patients aient eu ou non un bon accès à des soins de fin de vie. Le lien avec système de santé public n'a pas été établi; cependant, McWhan (1991) soutient que la principale responsabilité des infirmières en soins aigus est de s'occuper des patients sous traitement actif. Selon Burt, Shipman, Addington-Hall et White (2008), les soins palliatifs sont imprévisibles, prennent du temps et entraînent des pressions supplémentaires lorsqu'ils s'ajoutent à la charge de

travail des infirmières en pratique générale. Fuly, Pires, Souza, Oliveira et Padilha (2016) ont également constaté que, plus les capacités fonctionnelles d'un patient sont atteintes, plus les soins infirmiers s'intensifient. C'est aussi le constat de la présente étude; les participantes sont d'avis que le temps consacré aux mourants les force à négliger les patients en phase aiguë; elles se sentent alors coupables de ne pas avoir prodigué à ces derniers des soins qu'elles jugent optimaux.

Comme l'illustre la présente étude, les participants et participantes trouvaient leur charge de travail de plus en plus lourde. L'urgence constante dans laquelle le travail se fait et le manque de temps pour offrir des soins infirmiers de qualité optimale amplifiaient leur détresse émotionnelle. Lawler, Leary, Lofton et Bushe (2020), dans leurs travaux sur les conséquences perçues de la pression du milieu professionnel sur les soins infirmiers prodigués aux patients atteints de cancer, ont conclu que l'aspect le plus négligé des soins était le soutien psychosocial des patients et de leurs proches. La présente étude souligne aussi le manque de temps pour s'asseoir avec les patients et calmer leur anxiété, preuve que la charge de travail gruge déjà les possibilités d'offrir du soutien et des soins psychosociaux, qui sont pourtant un aspect des soins oncologiques qui apaise la souffrance (Maree, Holtslander et Maree, 2021).

L'étude montre également que la charge de travail élevée conduit à des erreurs, que doivent alors corriger les infirmières. Devoir jouer au chien de garde et surveiller les pratiques des collègues et des autres professionnels de la santé, en plus de s'occuper des patients et des familles est si épuisant que certaines participantes doutaient d'avoir la force de revenir à l'hôpital le lendemain, un signe possible d'épuisement professionnel. La charge de travail et la nature des soins oncologiques sont les facteurs contributifs les plus importants à l'épuisement professionnel (Cañadas-De la Fuente et al., 2018), un état lié à une fatigue émotionnelle et physique due à un stress prolongé au travail (Wentzel et Brysiewicz, 2018). Bien que les collègues fournissent un certain soutien social, les cadres de gestion des soins infirmiers n'étaient pas aidants, ce qui ne sert ni les infirmières ni les patients, puisque l'épuisement professionnel a une incidence directe sur les soins (Velando-Soriano et al., 2020).

Enfin, comme le montre la présente étude, les participants et participantes ont exprimé le besoin de pouvoir faire le

point. Dans leurs recherches sur les facteurs positifs et négatifs touchant les infirmières lors du décès des patients atteints de cancer, Wenzel, Shaha, Klimmek et Krumm (2011) ont conclu que les réunions permettant de faire le point étaient bénéfiques pour certaines infirmières, mais pas pour toutes. McCorkle (2016) enjoint tout de même les infirmières qui n'ont pas accès à des réunions régulières pour faire le point à former un groupe où raconter leurs expériences afin d'en tirer des leçons, de conserver leur équilibre et d'arriver à s'occuper des patients atteints de cancer.

## LIMITES

L'étude a été menée dans un hôpital universitaire du système de santé public; la majorité des personnes y ayant participé étaient des infirmières autorisées en oncologie. Comme la prestation des soins oncologiques varie d'un endroit à l'autre de l'Afrique du Sud, les conclusions de la présente étude pourraient ne pas correspondre à l'expérience des infirmières en oncologie pratiquant dans d'autres milieux. De plus, puisque d'autres chercheurs pourraient interpréter autrement les données brutes, on ne pourra jamais contenir l'entière réalité dans une seule étude qualitative.

## CONCLUSION

La plupart des infirmiers et infirmières participant à l'étude croyaient avoir été appelés par Dieu à s'occuper des patients atteints de cancer. Ils vivaient cependant des difficultés nuisant à la qualité des soins offerts aux patients en phase aiguë et se sentaient coupables, ayant l'impression que les soins qu'ils arrivaient à prodiguer étaient insuffisants. Plusieurs participants avaient été victimes de violence dans leur milieu de travail, ne pouvaient pas compter sur le soutien des cadres de gestion des soins infirmiers, et montraient des signes d'épuisement professionnel. Pour limiter la détresse émotionnelle et prévenir l'épuisement professionnel, il faudrait contrer la pénurie de personnel, apporter du soutien au personnel infirmier, enseigner à gérer les proches agressifs et donner des occasions de faire le point avec des pairs. Enfin, pour mieux comprendre l'expérience des infirmiers et infirmières en oncologie d'Afrique du Sud, les recherches à venir devront rassembler des professionnels et professionnelles de différents milieux, publics comme privés, dans les villes, les banlieues et les campagnes.

## RÉFÉRENCES

- Armstrong, S. J., Rispel, L. C., & Penn-Kekana, L. (2015). The activities of hospital nursing unit managers and quality of patient care in South African hospitals: A paradox? *Global Health Action*, 8, 26243–26243. <https://doi.org/10.3402/gha.v8.26243>
- Bingo, S. A. M., Maree, J. E., & Jansen van Rensburg, J. J. M. (2020). Living with cancer of the head and neck: A qualitative inquiry into the experiences of South African patients. *European Journal of Cancer Care*, 29(2), e13205.
- Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, 4, 2333393617742282. <https://doi.org/10.1177/2333393617742282>
- Burt, J., Shipman, C., Addington-Hall, J., & White, P. (2008). Nursing the dying within a generalist caseload: A focus group study of district nurses. *International Journal of Nursing Studies*, 45(10), 1470–1478. <https://doi.org/10.1016/j.ijnurstu.2008.01.003>
- Cañadas-De la Fuente, G. A., Gómez-Urquiza, J. L., Ortega-Campos, E. M., Cañadas, G. R., Albendín-García, L., & De la Fuente-Solana, E. I. (2018). Prevalence of burnout syndrome in oncology nursing: A meta-analytic study. *Psychooncology*, 27(5), 1426–1433. <https://doi.org/10.1002/pon.4632>
- Choi, S.-H., & Lee, H. (2017). Workplace violence against nurses in Korea and its impact on professional quality of life and turnover intention. *Journal of Nursing Management*, 25(7), 508–518. <https://doi.org/10.1111/jonm.12488>

- Elo, S., & Kyngäs, H. (2008). The qualitative content analysis. *Journal of Advanced Nursing*, 62, 107–115. <https://doi.org/10.1111/j.1365-2648.2007.04569.x>
- Fuly, P. D., Pires, L. M., Souza, C. Q., Oliveira, B. G., & Padilha, K. G. (2016). Nursing workload for cancer patients under palliative care. *Revista da Escola de Enfermagem da USP*, 50(5), 792–799. <https://doi.org/10.1590/s0080-623420160000600012>
- Granek, L., Ben-David, M., Bar-Sela, G., Shapira, S., & Ariad, S. (2019). “Please do not act violently towards the staff”: Expressions and causes of anger, violence, and aggression in Israeli cancer patients and their families from the perspective of oncologists. *Transcultural Psychiatry*, 56(5), 1011–1035. <https://doi.org/10.1177/1363461518786162>
- Gray, J., & Grove, S. (2021). *Burns and Grove’s The Practice of Nursing Research* (9th ed.). Elsevier.
- Joffe, M., Ayeni, O., Norris, S. A., McCormack, V. A., Ruff, P., Das, I., ... Cubasch, H. (2018). Barriers to early presentation of breast cancer among women in Soweto, South Africa. *PLoS One*, 13(2), e0192071.
- Lawler, J., Leary, A., Lofton, L., & Bushe, D. (2020). Perceptions of the cancer care left undone in primary and community services: A mixed methods evaluation. *Health & Social Care in the Community*, 28(6), 2117–2124. <https://doi.org/10.1111/hsc.13022>
- Manicom, C. (2011). Where do our patients die? A review of the place of death of cancer patients in Cape Town, South Africa. *Palliative and Supportive Care*, 9(1), 31–41. <https://doi.org/10.1017/S1478951510000520>
- Maree, J. E., Holtslander, L., & Maree, J. E. (2021). The experiences of women living with cervical cancer in Africa: A metasynthesis of qualitative studies. *Cancer Nursing*, 44(5), 419–430. <https://doi.org/10.1097/ncc.0000000000000812>
- McCorkle, R. (2016). Debriefing as an essential part of keeping ourselves healthy. *Cancer Nursing*, 39(2), 163–164. <https://doi.org/10.1097/ncc.0000000000000340>
- McWhan, K. (1991). Caring for dying patients in acute hospital wards: A review. *Nursing Practice*, 5(1), 25–28. <https://doi.org/10.7748/ns.6.8.25.s76>
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, 42(5), 533–544. <https://doi.org/10.1007/s10488-013-0528-y>
- Raatikainen, R. (1997). Nursing care as a calling. *Journal of Advanced Nursing*, 25(6), 1111–1115.
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334–340.
- Shenton, A. (2008). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63–75.
- South African Nursing Council. (2021). Statistics for 2020. <https://ncsacoms.co.za/2010-stats-2/>
- Sperduti, A., Hindle, D., Shessel, A., Pidgeon, B., Akmal, H., Chaulk, G., ... Rosewall, T. (2018). Treating too lightly? Radiation therapists’ experiences of workplace violence when providing care to cancer patients and their families. *Journal of Medical Imaging and Radiation Sciences*, 49(1), 56–61. <https://doi.org/https://doi.org/10.1016/j.jmir.2017.11.001>
- Statistica. (2020). Share of individuals who are members of medical aid schemes in South Africa in 2018, by population group. <https://www.statista.com/statistics/1115752/share-of-medical-aid-scheme-members-in-south-africa-by-population-group/>
- Van Rooyen, D., Le Roux, L. & Kotzé, W. (2008). The experiential world of the oncology nurse. *Health SA Gesondheid* 13(3), 18–30.
- Velando-Soriano, A., Ortega-Campos, E., Gómez-Urquiza, J. L., Ramírez-Baena, L., De La Fuente, E. I., & Cañadas-De La Fuente, G. A. (2020). Impact of social support in preventing burnout syndrome in nurses: A systematic review. *Japan Journal of Nursing Science*, 17(1), e12269.
- Wentzel, D. L., & Brysiewicz, P. (2018). A survey of compassion satisfaction, burnout and compassion fatigue in nurses practicing in three oncology departments in Durban, South Africa. *International Journal of Africa Nursing Sciences*, 8, 82–86. <https://doi.org/10.1016/j.ijans.2018.03.004>
- Wenzel, J., Shaha, M., Klimmek, R., & Krumm, S. (2011). Working through grief and loss: Oncology nurses’ perspectives on professional bereavement. *Oncology Nursing Forum*, 38(4), E272–282. <https://doi.org/10.1188/11.Onf.E272-e282>
- World Health Organization. 2020. *Cancer country profile 2020. Burden of cancer South Africa*. [https://www.who.int/cancer/country-profiles/ZAF\\_2020.pdf?ua=1](https://www.who.int/cancer/country-profiles/ZAF_2020.pdf?ua=1)
- Yates, P., Charalambous, A., Fennimore, L., Nevidjon, B., So, W. K., Suh, E. E., ... Young, A. (2020). Position statement on cancer nursing’s potential to reduce the growing burden of cancer across the world. *Cancer Nursing*, 43(6), 433–435.
- Young, M. (2016). Private versus public healthcare in South Africa. Honours Thesis, Western Michigan University, Michigan.

# An integrative review of strategies to prevent and treat compassion fatigue in oncology nurses

By Jodi Collier, Tania Bergen, Hua Li

## ABSTRACT

Compassion fatigue is understood as the combination of secondary traumatic stress and cumulative burnout caused by reduced ability to cope with one's environment. As such, compassion fatigue can be a significant workplace hazard for nurses in oncology. Findings from this integrative review reveal a lack of awareness and understanding of compassion fatigue among oncology nurses even if this group has been identified as high risk for experiencing compassion fatigue. Strategies such as self-care, mindfulness, and resiliency-based interventions to cope with compassion fatigue are reviewed herein along with related effectiveness. Some studies underscore that prevention-focused rather than treatment-focused interventions for compassion fatigue may be more effective. The responsibility for promoting and protecting oncology nurses' well-being is essential and must be spearheaded by organizations, administration, educational institutions, care teams, and individual nurses.

**Keywords:** compassion fatigue, secondary traumatic stress, vicarious trauma, burnout, oncology, nurse

## INTRODUCTION

A cancer diagnosis and its treatment often represent a traumatic life experience for affected individuals, families, and friends, as well as healthcare professionals. Oncology nurses routinely provide care to patients and their families across the cancer trajectory. Nurses' desire to make a difference and help those in need draws them to the profession, but the cumulative weight of this type of work is not without occupational, psychosocial, and physical costs. Best understood as the combination of secondary traumatic stress (STS) and burnout, compassion fatigue (CF) impacts an individual physically, psychologically, and spiritually (Todaro-Franceschi, 2019). Compassion fatigue is known to contribute to nurse turnover and negatively impact employee retention, ultimately impacting quality of care (Sinclair et al., 2017). According to the International Council of Nurses (2022), the estimated global

nursing shortage has gone from 5.9 million in 2020 to a projected 13 million post-pandemic, adding burden to nurses who also witness daily suffering, acute symptomatology, and death.

## BACKGROUND

Compassion fatigue as a concept first appeared in nursing literature in 1992 when Carla Joinson, an emergency room nurse, observed a distinct form of burnout among her colleagues. Building upon Joinson's observations, Figley (2002) deemed CF as the cost of caring, a result of cumulative exposure to the trauma of others, leading to the depletion of oneself. Antecedents to CF have been identified as: (1) chronic exposure to suffering, (2) compassion, (3) lack of professional boundaries, (4) use of self, (5) exposure to stress, and (6) a lack of self-care measures (Peters, 2018). Understanding the precursors of CF is an essential step in prevention, risk reduction, and intervention development. Recognizing CF in oneself or in coworkers can be challenging as signs and symptoms can be insidious and overlap with those of other conditions (Todaro-Franceschi, 2019). Avoidance, loss of motivation, loss of purpose, disengagement, substance use, and difficulty concentrating are related to CF (Todaro-Franceschi, 2019). These CF symptoms can extend to cause physical, emotional, spiritual, and behavioural changes in an individual, significantly impacting their quality of life (Sinclair et al., 2017). Risk factors for CF include working in close physical and emotional proximity to patients, working in high-risk settings such as oncology or intensive care, exposure to trauma, heavy workloads, and sustained empathic engagement with patients (Todaro-Franceschi, 2019). Coetzee and Klopper (2010) in their original concept analysis define CF as:

*The final result of a progressive and cumulative process that is caused by prolonged, continuous, and intense contact with patients, the use of self, and exposure to stress. It evolves from a state of compassion discomfort which is not effaced through adequate rest, leads to compassion stress that exceeds nurses' endurance levels and, ultimately, results in compassion fatigue. (p.237).*

## Burnout

Burnout is best understood as deriving from the employee-employer relationship as a result of heavy workloads, poor management, and staff shortages (Todaro-Franceschi, 2019). Burnout can occur in any occupational setting and is not unique to the nursing profession. Compassion fatigue is differentiated from burnout in that it derives from the nurse-patient relationship (Peters, 2018). Burnout typically follows a cumulative predicative course, whereas CF tends to be more acute and less predictable (Figley, 2002).

## Secondary Traumatic Stress & Vicarious Traumatization

Secondary traumatic stress is defined as a type of post-traumatic stress disorder condition resulting from empathetic

## AUTHOR NOTES



Jodi Collier, RN, BScN, MN, CON(C), Alberta Health Services, 3942 50a Ave, Red Deer, AB, T4N 6R2, [jodi.collier@ahs.ca](mailto:jodi.collier@ahs.ca)



Tania Bergen, RN, BSN, MN, Faculty Instructor, College of Nursing, University of Saskatchewan



Hua Li, RN, MPH, PhD, Assistant Professor, College of Nursing, University of Saskatchewan

Corresponding author: Jodi Collier, [Jodi.Collier@ahs.ca](mailto:Jodi.Collier@ahs.ca)

DOI:10.5737/2368807634128



engagement with patients who have experienced trauma (Arnold, 2020). From diagnosis, to surgery, to the disfiguring side effects of chemotherapy, oncology patients experience a myriad of trauma. Figley (2002) uses STS and CF interchangeably as the same construct, stating that CF is a more palatable label than STS as the individual is not labelled as traumatized. With origins in the discipline of psychology, vicarious traumatization is described as the alteration of one's worldview and perception of control and safety as a result of the empathetic stress experienced from involvement with a patient who has undergone trauma firsthand (Arnold, 2020). While vicarious traumatization and STS are closely tied, vicarious trauma can be thought of as the act or exposure to trauma with STS as the natural stress response to vicarious trauma (Arnold, 2020).

### Compassion Satisfaction

Compassion satisfaction is the positive feelings that a nurse experiences by caring for patients in need (Stamm, 2010). Compassion satisfaction can be understood as the affirming, empowering, uplifting moments that enhance a nurse's professional quality of life, reaffirming their decision and desire to enter a caregiving profession. Compassion satisfaction is protective for nurses at risk of developing CF (Stamm, 2010).

Despite CF being a relatively new concept in nursing literature, it is likely that the complexity of terms and concepts has prevented the furthering of research regarding a phenomenon that has been lingering unchecked for decades. Burnout, CF, STS, and vicarious traumatization are all closely related yet distinct phenomena that frequently coexist, thus furthering confusion in nursing research and discourse. The spotlight on nurses during the COVID-19 pandemic may have acted as a catalyst, revealing the emotional toll that this profession can have on an individual.

### PURPOSE

The purpose of this integrative review is to search the literature for evidence-based strategies published between 2013 and 2023 aimed at preventing and treating CF in oncology nurses. Given the established knowledge that nurses suffering from CF have an increased desire to leave the profession, have increased practice errors, and experience impaired judgement, serve as the fuel for this review (Peters, 2018). Based on findings, the goal will be to add recommendations for future research direction and create awareness about the current state of evidence regarding interventions against CF in oncology nursing.

### METHODS

Integrative reviews are an effective tool for uncovering the current state of science on a topic, which can then be used to influence practice or aid in theory development (Whittemore & Knaf, 2005). Using Whittemore and Knaf's (2005) methodology as a guide, this review will include experimental and non-experimental research to aid in uncovering the effectiveness of current strategies in preventing and treating CF in oncology nurses.

Using Boolean operators, an in-depth search of the CINAHL, PubMed, Google Scholar, and Web of Science

databases was conducted for full text, peer-reviewed articles published between 2013 and 2023. Keywords searched include "compassion fatigue" "or" "secondary traumatic stress" "or" "burnout" "and" "nursing" "and" "oncology" "and" "intervention" "or" "strategy." A total of 860 publications were identified, as well as an additional four articles found through individual review of the reference lists of initial articles, resulting in 864.

Article abstracts and titles were reviewed by a single reviewer. This initial step in screening titles and abstracts narrowed the selections to 468 publications. Articles were then reviewed based on the following criteria: (1) the article was original research of any type (e.g., qualitative, quantitative, mixed methods), (2) the article was specific to oncology nursing, (3) the article was a peer-reviewed full text English-language publication from January 1, 2013, to December 31, 2022, and (4) the article included an intervention aimed at CF. The review step based on these criteria resulted in a total of 41 publications. The final step included a full manuscript review of the 41 remaining publications and exclusion if: (1) the publication was not original research, (2) did not include a CF-related intervention, and (3) was not done in the oncology setting with at least half of participants being nurses. This left a total of 18 publications. [See PRISMA in Figure 1, Appendix A.] Data extraction was completed using a standard table to delineate: author (year), country, research design, study aim, sample size and scale, and main findings. Summary table of articles is provided in Appendix B.

### FINDINGS

A total of 18 articles were retained for this review. Twelve of these studies were conducted in the United States, two from Canada, two from Turkey, one from Portugal, and one from the United Kingdom. The most common study design was pre-test/post-test. Two studies utilized mixed-methods, and one relied on a randomized control trial [RCT]. Sample sizes varied across studies from 13 to 189 with a mean of 65.9 and a total of 1,253 oncology nurses from inpatient, outpatient, pediatric, and stem cell transplant settings. Years of professional experience varied from less than five years (e.g., Jakel et al., 2016) to a mean of 17.7 years (e.g., Esplen et al., 2022). Following an in-depth review of the 18 retained studies, three types of CF-related interventions were identified: mindfulness-based (four publications: Delaney, 2018; Duarte & Pinto-Gouveia, 2016; Hevezi, 2016; & Qualls et al., 2022), self-care (five publications: Anderson & Gustavson, 2016; Hand et al., 2019; Phillips et al., 2020; Sullivan et al., 2019; & Yilmaz et al., 2018), and resilience-based (nine publications: Blackburn et al., 2020; Esplen et al., 2022; Jakel et al., 2016; Klein et al., 2017; Pehlivan & Guner, 2020; Pfaff et al., 2017; Potter et al., 2013; Schuster, 2021; Zajac et al., 2017). See Appendix B for detailed findings. Below, each type of intervention is reviewed.

#### Mindfulness-based interventions

Mindfulness is the act of intentionally, non-judgmentally, focusing on what one's mind and body is experiencing in the present moment (Hevezi, 2016). With roots in Buddhist tradition, mindfulness has been identified as a strategy one can

use to cope with stressful situations. Traditional mindfulness-based stress reduction interventions consist of two- to three-hour long sessions repeated weekly for eight weeks alongside daily requirements for meditation (Delaney, 2018). Given the substantial time commitment for mindfulness interventions, it is not surprising that the studies included in this review used a modified four-week intervention (Hevezi, 2016; Qualls et al., 2022) or six-week intervention (Duarte & Pinto-Gouveia, 2016) with just one retaining the traditional eight-week timeframe (Delaney, 2018). All four studies were a non-randomized design with one sample, while only the Duarte and Pinto-Gouveia (2016) study included a control group for comparison. Duarte and Pinto-Gouveia (2016) report significant reductions in CF in the experimental group of nurses versus the comparison group, and significant reductions in burnout. Of note, all interventions took place on-site at the workplace during work hours.

### Self-care interventions

Self-care strategies include attention to the basic building blocks of health and wellbeing, diet, exercise, sleep, coping strategies, education, and expressive art. Specific strategies identified in this review included knitting, debriefing, massage sessions, story-telling, song writing, self-care education, respite rooms, counselling, and grief support (Anderson & Gustavson, 2016; Hand et al., 2019; Phillips et al., 2020; Sullivan et al., 2019; Yilmaz et al., 2018). Yilmaz et al. (2018) were able to demonstrate increases in compassion satisfaction and decreases in burnout and CF, which may be attributed to the nurse-led design of their intervention. The complexity of the storytelling and song writing intervention employed by Phillips et al. (2020) raises questions of replicability, as the facilitator was an oncology nurse who was also a singer/songwriter.

### Resilience-based interventions

A resilient individual is one who has the capability to adapt, endure, and cope in adverse situations (Merriam-Webster, 2020). Important components of resilience include individuals and their environments, and the ability to grow and learn from tough situations. Resilience has been found to be an important strategy for coping with work-related stress in oncology (Pehlivan & Guner, 2020). Resilience-focused interventions have been found to have positive impacts on both individual nurses as well as organizations in the form of staff retention, productivity, and decreased turnover (Blackburn et al., 2020).

Blackburn et al. (2020) implemented the THRIVE<sup>®</sup> program, which consists of an eight-hour retreat, a six-week facilitated group study on social media, and a two-hour wrap-up session. Results from the THRIVE<sup>®</sup> program revealed statistically significant increases in resilience ( $p = 0.0268$ ), decreases in burnout ( $p = 0.005$ ), and STS ( $p = 0.004$ ), which were measured and sustained at two, four, and six months post-intervention. A secondary finding from Blackburn et al. (2020) was that nurses who participated in the THRIVE<sup>®</sup> program had a turnover rate of 6.1% versus the national average of 17.1%, demonstrating benefits for individuals and organizations alike. The continuing education intervention by Esplen et al. (2022) revealed that, despite a mean of 17.7 years of nursing

experience, participants reported that this was the first opportunity they had had to learn about CF and their personal risk factors for it. In the same sample ( $N = 189$ ), 88% reported that their work-related well-being and quality of life were not addressed in yearly performance reviews.

## DISCUSSION

Mindfulness-based interventions demonstrate much potential as an effective strategy against CF in oncology nurses. Further information into the exact length and composition of mindfulness interventions is important for organizations to determine feasibility and for individual commitment to the program. Ongoing research is needed to document the feasibility and effectiveness of shorter-, as opposed to longer-term interventions. Overall, mindfulness interventions appear to show significant promise for decreasing CF as well. Participants' verbatim statements from the mixed-method study (Delaney, 2018) and post-intervention surveys (Duarte & Pinto-Gouveia, 2016) reveal wide acceptance from these participants for mindfulness interventions. Repeated findings such as the noted decrease in burnout and CF post mindfulness intervention adds strength to the argument for this type of intervention.

The use of self-care strategies as a treatment post CF demonstrates mixed results from the studies in this review. A possible explanation for this could be that self-care strategies are better used as prevention, as opposed to treatment. The timing of self-care strategies as a treatment could be viewed more as after-care strategies, as the individual is already affected and struggling to manage their self-care. Another concern with self-care strategies is that many put the responsibility on the individual who is suffering, to fix themselves. It is difficult to understand how appropriate it is to suggest that a nurse try engaging in yoga once they have experienced a soul-crushing trauma. Yoga or art or journaling are incredible strategies for health and wellness, however the timing of these interventions is critical. A medical mindset of diagnose and treat is perhaps influencing the current approaches and understanding of self-care.

Resiliency-based studies used longitudinal design, and different measures administered at different intervals (e.g., at least three months post-test to 12 months post-test). Studies failing to show statistically significant improvements post-intervention noted low baseline burnout and STS in their pre-intervention surveys, thus leaving little room for change, regardless of intervention (Jakel et al., 2017; Pfaff et al., 2017). Inclusion criteria in future studies should include staff that are currently demonstrating at least a moderate level of CF or burnout.

An overwhelming theme in all studies, obtained frequently from the open-ended post-intervention surveys, was positive participant feedback regarding the interventions. In the RCT (Pehlivan & Guner, 2020), a perplexing finding of CF scores increasing in participants immediately post intervention when compared to baseline may tie into the finding by Esplen et al. (2022) that, despite many years of nursing experience, awareness and education around CF remains low among nurses. Nurses identified time as one of the largest limitations for

participation in interventions in both the self-care and resilience-based interventions. Support and involvement of organizations are, therefore, a key component in the success and implementation of CF interventions (Pehlivan & Guner, 2020; Pfaff et al., 2017; Schuster, 2020).

## LIMITATIONS

Limitations of this review include having a single reviewer, increasing the possibility for human error. A second limitation is the fact that only one RCT was identified and included. Thirdly, the majority of articles originated in the United States. Various healthcare systems could present different challenges. The nursing demographic represented in this review was primarily white females between the ages of 22 and 65 years. As the global nursing population becomes more diverse, a more representative sample will be key for informing current practice.

### Limitations in publications included

Of the 18 publications included in this review, multiple limitations, such as the self-selection of study participants, were noted. Participants may have volunteered out of interest and desire for the intervention. Participants in the massage intervention were involved in the design and implementation of the project and self-reported all data. This may have led to bias in their desire to see the project succeed (Hand et al., 2019). Overall, small sample sizes and limited longitudinal follow-up in the studies included in this review make it difficult to determine whether interventions are sustained or only have short-term benefits. Further research that contains follow-up beyond the six-month mark post intervention, as well as including a control groups, is required. Data that could inform ideal duration of the intervention itself would be useful for organizations, as this impacts feasibility and cost to implement. The study conducted by Zajac et al. (2017) did not match the pre and post-test data to the individual participants and included seven different facilitators in their intervention, which raises the issue of consistency. Despite having a control group, Jakel et al. (2016) provided CF education to both the experimental and control group, thus possibly confounding results. With only one RCT to date evaluating an intervention against CF in oncology nurses, further RCT's are required.

## RECOMMENDATIONS

Creating clinical awareness of CF is an essential first step in addressing CF (Todaro-Franceschi, 2019). Acknowledging CF offers both validation for those suffering and identification for those at risk. The finding that nurses with a mean of 17.7 years of cancer care experience had never heard of CF, or their own personal risk factors reveals a pressing need for more

education (Esplen et al., 2022). Along with the need for awareness is the need for ongoing, and not just one-time interventions, as found by Klein et al. (2017) when participants scores were not sustained at the six-month mark. The use of mindfulness interventions and resilience-based interventions should be considered by organizations and individual nurses throughout their career. Armed with the knowledge of what CF is and the ability to identify risk factors nurses and organizations are in a good place to employ and evaluate interventions.

Based on this review, there are multiple mindfulness, self-care, and resilience-based strategies that can be effective for CF but, unfortunately, there is no one accepted evidence-based approach. A benefit of this finding is that long-term complicated interventions were not necessarily found to be superior to shorter, focused interventions (Pehlivan & Guner, 2020). Considerations from this review are that nurse-led interventions were well received (Hand et al., 2019; Schuster, 2021; Yilmaz et al.2018), the feedback from participants was overwhelmingly positive regardless of intervention type, and resiliency training can influence nurse retention (Blackburn et al., 2020). To screen for and create awareness, simple strategies such as completing the Professional Quality of Life Scale-Version 5 [ProQOL-5] on a yearly basis in annual education or performance reviews can prevent CF from going unchecked (Esplen et al. .2022). Ongoing reinforcement of self-care strategies should not be forgotten as a preventative strategy. The finding that a CF intervention can significantly decrease turnover nearly threefold should strengthen the argument for organizational involvement (Blackburn et al. 2020).

### Compassion fatigue intervention model

Based on the findings of this review, a CF Intervention Model has been developed, Appendix C, to encompass the recommendations and findings. The model emphasizes the overarching need for awareness of CF in high-risk settings, as this was the primary finding of this review. The model highlights the need for interventions throughout the trajectory of a nurse's career, offering broad, as opposed to detailed suggestions given the current state of CF literature.

## CONCLUSION

Compassion fatigue is a workplace hazard in oncology nursing (Stamm, 2010). Mindfulness, self-care, and resilience-based interventions demonstrate promise in addressing CF. More research is needed to determine exactly what type and length of intervention is more effective. The current post-pandemic landscape has left the nursing profession in a concerning state that demands action. Acknowledgement of CF by organizations validates the trauma of those suffering and shed light on a previously dark aspect of healthcare.

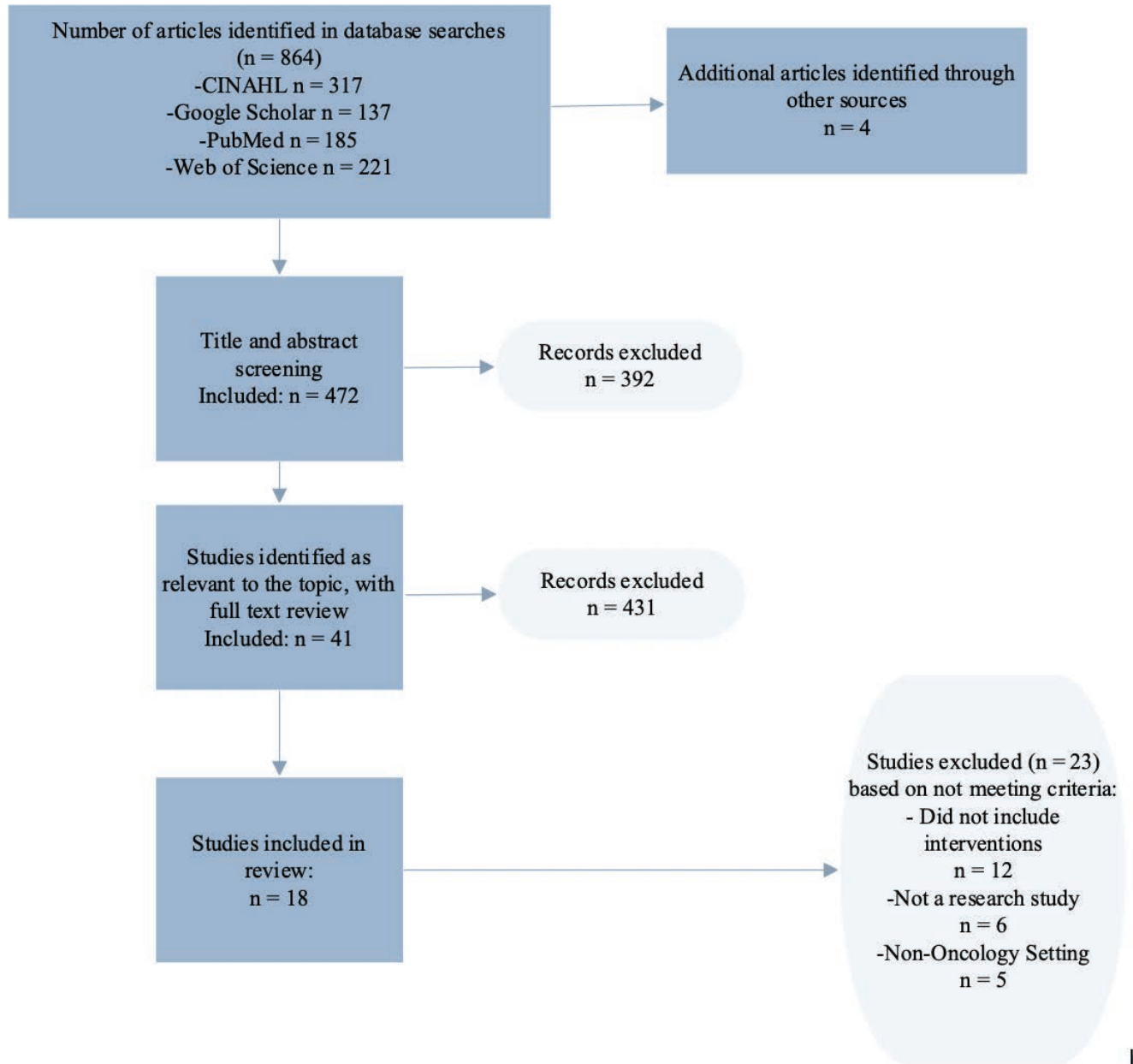
## REFERENCES

- Anderson, L., & Gustavson, C. (2016). The impact of a knitting intervention on compassion fatigue in oncology nurses. *Clinical Journal of Oncology Nursing*, 20(1), 102–104. <https://doi.org/10.1188/16.CJON.102-104>
- Arnold, T. (2020). An evolutionary concept analysis of secondary traumatic stress in nurses. *Nursing Forum*, 55(2), 149–156. <https://doi.org/10.1111/nuf.12409>

- Blackburn, L., Thompson, K., Frankenfield, R., Harding, A., & Lindsey, A. (2020). The THRIVE© Program: Building oncology nurse resilience through self-care strategies. *Oncology Nursing Forum*, 47(1), 25–34. <https://doi.org/10.1188/20.ONF.E25-E34>
- Coetzee, S. & Klopper, H. (2010). Compassion fatigue within nursing practice: A concept analysis. *Nursing and Health Sciences*, 12(2), 235-243. <https://doi.org/10.1111/j.1442-2018.2010.00526.x>
- Delaney, M. (2018). Caring for the caregivers: Evaluation of the effect of an eight-week pilot mindful self-compassion (MSC) training program on nurses' compassion fatigue and resilience. *Public Library of Science One*, 13(11), 1–20. <https://doi.org/10.1371/journal.pone.0207261>
- Duarte, J., & Pinto-Gouveia, J. (2016). Effectiveness of a mindfulness-based intervention on oncology nurses' burnout and compassion fatigue symptoms: A non-randomized study. *International Journal of Nursing Studies*, 64, 98–107. <http://dx.doi.org/10.1016/j.ijnurstu.2016.10.002>
- Espen, M., Wong, J., Vachon, M., & Leung, Y. (2022). A continuing educational program supporting health professionals to manage grief and loss. *Current Oncology*, 29(3), 1461–1474. <https://doi.org/10.3390/curroncol29030123>
- Figley, C. (1995). The transmission of trauma. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. (pp. 248–254). Brunner-Routledge.
- Figley, C. (Ed.). (2002). *Treating compassion fatigue*. Brunner-Routledge. <https://doi-org.cyber.usask.ca/10.4324/9780203890318>
- Hand, M., Margolis, J., & Staffileno, B. (2019). Massage chair sessions: Favorable effects on ambulatory cancer center nurses' perceived level of stress, blood pressure, and heart rate. *Clinical Journal of Oncology Nursing*, 23(4), 375–381. <https://doi.org/10.1188/19.CJON.375-381>
- Hevezi, J. (2016). Evaluation of a mediation intervention to reduce the effects of stressors associated with compassion fatigue among nurses. *Journal of Holistic Nursing*, 34(4), 343–350. <https://doi.org/10.1177/0898010115615981>
- International Council of Nurses. (2022). *The global nursing shortage and nurse retention*. [https://www.icn.ch/sites/default/files/inline-files/ICN%20Policy%20Brief\\_Nurse%20Shortage%20and%20Retention\\_0.pdf](https://www.icn.ch/sites/default/files/inline-files/ICN%20Policy%20Brief_Nurse%20Shortage%20and%20Retention_0.pdf)
- Jakel, P., Kenney, J., Ludan, N., Miller, P., McNair, N., & Matesic, E. (2016). Effects of the use of the provider resilience mobile application in reducing compassion fatigue in oncology nursing. *Clinical Journal of Oncology Nursing*, 20(6), 611–616. <https://doi.org/10.1188/16.CJON.611-616>
- Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, 22(4), 116.
- Kennedy, S., & Booth, R. (2022). Vicarious trauma in nursing professionals: A concept analysis. *Nursing Forum*, 57(5), 893–897. <https://doi.org/10.1111/nuf.12734>
- Klein, C., Riggerback-Hays, J., Sollenberger, L., Harney, D., & McGarvey, J. (2018). Quality of life and compassion satisfaction in clinicians: A pilot intervention study for reducing compassion fatigue. *American Journal of Hospice & Palliative Medicine*, 35(6), 882–888. <https://doi.org/10.1177/1049909117740848>
- McEwen, M. (2019). Theory analysis and evaluation. In M. McEwen & E.M. Wills (Eds.), *Theoretical basis for nursing*, (5<sup>th</sup> ed., pp. 94–113). Lippincott, Williams, & Wilkins.
- Merriam-Webster. (2020). Resiliency. *Merriam-Webster.com dictionary*. <https://www.merriam-webster.com/dictionary/resiliency>
- Pehlivan, T., & Guner, P. (2020). Effect of a compassion fatigue resiliency program on nurses' professional quality of life, perceived stress, resilience: A randomized controlled trial. *Journal of Advanced Nursing*, 76(12), 3584–3596. <https://doi.org/10.1111/jan.14568>
- Peters, E. (2018). Compassion fatigue in nursing: A concept analysis. *Nursing Forum*, 53(4), 466–480. <https://doi.org/10.1111/nuf.12274>
- Pfaff, K., Freeman-Gibb, L., Patrick, L., DiBiase, R., & Moretti, O. (2017). Reducing the “cost of caring” in cancer care: Evaluation of a pilot interprofessional compassion fatigue resiliency programme. *Journal of Interprofessional Care*, 31(4), 512–519. <http://dx.doi.org/10.1080/13561820.2017.1309364>
- Phillips, C., Volker, D., Davidson, K., & Becker, H. (2020). Storytelling through music: A multidimensional expressive arts intervention to improve emotional well-being of oncology nurses. *Journal of Clinical Oncology*, 16(4), 405–413. <https://doi.org/10.1200/JOP.19.00748>
- Potter, P., Deshields, T., Berger, J., Clarke, M., Olsen, S., & Chen, L. (2013). Evaluation of a compassion fatigue resiliency program for oncology nurses. *Oncology Nursing Forum*, 40(2), 180–187. <https://doi.org/10.1188/13.ONF.180-187>
- Qualls, B., Payton, E., Aikens, L., & Carey, M. (2022). Mindfulness for outpatient oncology nurses: A pilot study. *Holistic Nursing Practice*, 36(1), 28–36. <https://doi.org/10.1097/HNP.0000000000000487>
- Schuster, M. (2021). Creating the hematology/oncology/stem cell transplant advancing resiliency team: A nurse-led support program for hematology/oncology/stem cell transplant staff. *Journal of Pediatric Oncology Nursing*, 38(5), 331–341. <https://doi.org/10.1177/10434542211011046>
- Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-MacDonald, L. (2017). Compassion fatigue: A meta-narrative review of healthcare literature. *International Journal of Nursing Studies*, 69, 9–24. <http://dx.doi.org/10.1016/j.ijnurstu.2017.01.003>
- Stamm, B. (2010). *The concise ProQOL manual*. <https://ProQOL.org>
- Sullivan, C., King, A., Holdiness, J., Durrell, J., Roberts, K., Spencer, C., Roberts, J., Ogg, S., Moreland, M., Browne, E., Cartwright, C., Crabtree, V., Baker, J., Brown, M., Sykes, A., & Mandrell, B. (2019). Reducing compassion fatigue in pediatric oncology nurses. *Oncology Nursing Forum*, 46(3), 338–347. <http://doi.org/10.1188/19.ONF.338-347>
- Todaro-Franceschi, V. (2019). *Compassion fatigue and burnout in nursing: Enhancing professional quality of life*. (2nd ed.). Springer Publishing Company.
- Whittemore, R. & Knaf, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing*, 52(5), 546–553. <http://doi.org/10.1111/j.13652648.2005.03621.x/pdf>
- Yilmaz, G., Ustun, B., & Gunusen, N. (2018). Effect of a nurse-led intervention programme on professional quality of life and post-traumatic growth in oncology nurses. *International Journal of Nursing Practice*, 24(6), 1–7. <https://doi.org/10.1111/ijn.12687>
- Zajac, L., Moran, K., & Groh, C. (2017). Confronting compassion fatigue: Assessment and intervention in inpatient oncology. *Clinical Journal of Oncology Nursing*, 21(4), 446–453. <https://doi.org/10.1188/17.CJON.446-453>

## Appendix A

Figure 1  
PRISMA flow chart



## Appendix B

Figure 2

Summary of the articles included in the literature review

Author (year), Country	Research Design	Study Aim	Sample Size & Scale	Findings
Anderson & Gustavson et al. (2016), U.S.	Non-randomized pre/post intervention study	Determine the effect of a knitting intervention on compassion fatigue in oncology nurses.	n = 39 oncology nurses Professional Quality of Life Scale Version 5 (ProQol-5)	Data collected pre and post a 6-week knitting intervention revealed a significant improvement in BO and STS scores.
Blackburn et al., (2020), U.S.	Quasi-Experimental	Develop an evidence-based program to address burnout and secondary trauma in oncology nurses/workers with a focus on resilience.	n = 164 oncology staff (n = 160 were nurses) The Compassion Fatigue Short Scale & Connor-Davidson Resilience Scale	THRIVE program Resulted in improved resilience scores and decreased burnout. Sustained for 6 months post intervention.
Delaney (2018), United Kingdom	Observational mixed research pilot study	Gain preliminary empirical evidence on the effect of an 8-week Mindful Self-Compassion training intervention on nurses CF and resilience and describe the effect of the lived experience of training on participants	n = 13 Neff Self Compassion Scale Frieburg Short Mindfulness Scale ProQol-5 Connor-Davidson Resilience Scale	Eight-week pilot mindful self-compassion training program resulted in significant improvements to pre and post BO and STS scores. Resilience and CS scores also increased.
Duarte & Pinto-Gouveia (2016), Portugal	Quasi-Experimental Non-randomized controlled study	Explore the effectiveness of an on-site abbreviated mindfulness-based intervention for burnout and compassion fatigue symptoms in nurses.	n = 94 oncology nurses Statistical analysis with ANOVA and ANCOVA	Nurses in intervention group reported significant decreases in CF, BO, stress and increases in satisfaction with life (medium to large effect size).
Esplen et al. (2022), Canada	Non-randomized pre/post intervention study	Increase knowledge and confidence in understanding CF and burnout in oncology staff through the use of a continuing education program.	n = 189 oncology staff (n = 173 nurses) Revised Grief Experience Inventory Kirkpatrick Model for Evaluation of Training Programs	Post intervention survey showed improvements in confidence and knowledge across several domains. High satisfaction reported post-program.
Hand et al. (2019), U.S.	Quasi-Experimental	To determine the impact of a massage chair intervention on nurses perceived stress, blood pressure, and heart rate	n = 51 nurses Statistical analysis with paired-t tests and descriptive statistics	Nurses participated in 200 massage chair sessions over 6 months resulting in reductions in stress, BP, and HR.

Author (year), Country	Research Design	Study Aim	Sample Size & Scale	Findings
Hevezi (2016), U.S.	Non-randomized pre/post intervention study	Evaluate whether short meditations decrease compassion fatigue and improve compassion satisfaction in oncology nurses	n = 15 oncology nurses ProQol-5	After participating in structured meditations nurses reported significant increases in CS, and decreases in BO and STS.
Jakel et al. (2016), U.S.	Quasi-Experimental longitudinal pre/post intervention study	Determine if the use of the Provider Resilience Mobile App improves nurses' professional quality of life.	n = 25 oncology nurses ProQol-5, Provider Resilience Mobile Application.	No significant relationship found between intervention and control groups on STS, BO, or CS.
Klein et al. (2018), U.S.	Exploratory pre/post interventional pilot study	Determine efficacy of an educational program on CS, CF, STS, resilience, and quality of life.	n = 18 ProQol-5	A noted increase in CS and a small decrease in BO was noted among participants.
Pehlivan & Guner (2020), Turkey	Randomized Control Trial	Implement a CF Resiliency Program for oncology nurses as a short-term and long-term program and compare impact on nurses CF, BO, CS, perceived stress, and resilience.	N = 125 oncology nurses randomly assigned into an experimental 1, 2, or control group ProQol-5 Perceived Stress Scale Resilience Scale for Adults	Group 1 participated in a short-term program, Group 2 a long-term program, and control group neither. Findings revealed that program length was irrelevant, all groups experienced increased CS
Pfaff et al. (2017), Canada	Mixed Method Study	Determine if a 6-week pilot CF resiliency program impacted CF, CS, and clinical stress in oncology staff.	Qualitative n = 12 Quantitative n = 32 ProQol-5 Compassion Satisfaction Scale Burnout Scale STS Scale Index of Clinical Stress Silencing Response Scale	Participants reported reduced clinical stress and increase awareness of CF upon program completion.
Phillips et al. (2020), U.S.	Two Group non-randomized (experimental and control) Quasi-Experimental Pilot Study	What is the effect of a multidimensional intervention (Storytelling through music) which combines expressive art and self-care skills, on the emotional well-being of oncology nurses.	n = 43 oncology nurses ProQol-5 Patient-Reported Outcomes Measurement Information System (PROMIS) Insomnia Severity Index University of California Loneliness Scale Self-Reflection and Insight Scale Self-Compassion Scale	2 group (intervention & control) 6-week intervention (expressive arts and self care skills) with 4-point data collection (2 pre and 2 post). Significant improvement over time in both groups, greater in the intervention group.

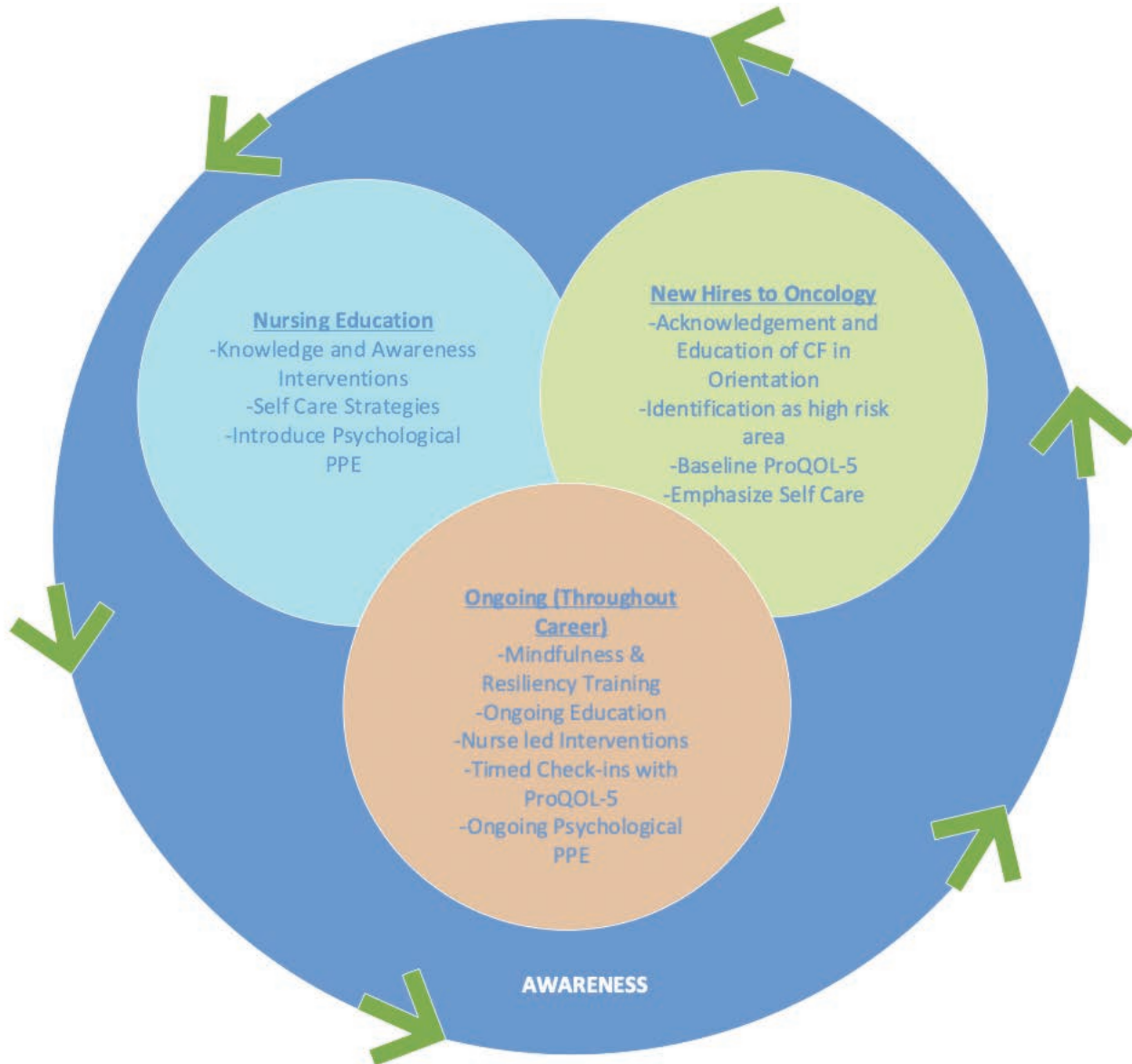
Author (year), Country	Research Design	Study Aim	Sample Size & Scale	Findings
Potter et al. (2013), U.S.	Descriptive Pilot Study	Evaluate a resiliency program intended to educate oncology nurses about CF	n = 13 oncology nurses ProQol-5 Maslach Burnout Inventory-Human Services Survey Impact of Event Scale Revised Nursing Job Satisfaction Scale	Five-week program (4 x 90 min sessions) with a 4-hour retreat between sessions 4 and 5 for debriefing found decreased STS scores
Qualls et al. (2022), U.S.	Prospective pre/post test pilot study	Investigate a Mindfulness Based Stress Reduction (MBSR) intervention on self-reported stress and improvement in BO, CF, CS post intervention. A second aim was to evaluate HR, BP, RR pre and post intervention.	n = 13 oncology nurses ProQol-5 MOON Experience Post Survey	MBSR intervention was effective at decreasing HR, BP, and RR post intervention. Statistically significant improvements noted to BO, STS, and CF.
Schuster (2021), U.S.	Pilot Program	Pre-program and mid-program survey collection Evaluate a sustainable peer to peer onsite support program for staff with the goal of improving workplace culture, teamwork, morale, and wellbeing.	N = 92 oncology staff members Likert scales at pre and mid intervention.	Themes gathered: importance of awareness of own health and wellbeing, importance of organizations using wellness program for retention
Sullivan et al. (2019), U.S.	Quasi-Experimental Study	Develop an evidence-based CF program and evaluate its impact on BO, STS, and CS in oncology nurses	N = 59 oncology nurses Professional Quality of Life Scale Version 5 Connor-Davidson Resilience Scale-2	Pilot self-care program focusing on education, health, grief, and a respite room showed improvement in STS scores.
Yilmaz et al. (2018), Turkey	Quasi-Experimental Study	Evaluate the effect of a nurse led intervention program on CF, CS, and BO in oncology nurses.	N = 43 oncology nurses Professional Quality of Life Scale Version 5 Post-Traumatic Growth Inventory	Five-week nurse-led intervention program improved professional quality of life scores and post-traumatic growth.
Zajac et al. (2017), U.S.	Mixed Method Sequential Design	To address CF in nurses by developing an intervention for bereavement support after patient death	N = 91 oncology nurses Professional Quality of Life Version 5 Pre/Post Intervention.	Mindfulness debriefing sessions were helpful in acknowledging grief and loss. Post intervention scores failed to show efficacy against CF.



Appendix C

Figure 3

Compassion fatigue intervention model



# Revue intégrative des stratégies de prévention et de traitement de la fatigue de compassion chez les infirmières en oncologie

Par Jodi Collier, Tania Bergen, Hua Li

## RÉSUMÉ

*La fatigue (ou usure) de compassion est un mélange de traumatisme secondaire et d'épuisement professionnel cumulatif résultant d'une difficulté à composer avec son environnement. De par la nature de leurs fonctions, les infirmières en oncologie sont particulièrement sujettes à la fatigue de compassion. Les conclusions de la présente revue intégrative révèlent un manque de sensibilité et de compréhension envers les infirmières en oncologie qui éprouvent de la fatigue de compassion, et ce, même s'il s'agit d'un groupe à haut risque. Il sera ici question de l'efficacité des stratégies d'autosoins, de pleine conscience et d'interventions visant à renforcer la résilience pour surmonter la fatigue de compassion. Certaines études suggèrent que les interventions préventives seraient plus efficaces que les interventions curatives. Il est essentiel de promouvoir et de protéger le bien-être des infirmières en oncologie; c'est aux organisations, aux administrations, aux établissements d'enseignement, aux équipes soignantes et à chaque infirmière d'y voir.*

**Mots-clés :** fatigue de compassion, traumatisme secondaire, traumatisme vicariant, épuisement professionnel, oncologie, infirmière

## INTRODUCTION

Le diagnostic de cancer et le traitement de la maladie constituent souvent une expérience traumatisante pour les personnes malades et leurs proches, mais aussi pour les professionnels de la santé. Les infirmières en oncologie interagissent régulièrement avec les patients et leurs familles tout au long de la trajectoire de soins. Les infirmières veulent se sentir utiles et aider les gens dans le besoin; c'est ce qui les amène à faire ce travail. Toutefois, la charge cumulative des tâches à accomplir n'est pas sans conséquences professionnelles, psychosociales et physiques. La fatigue de compassion, décrite comme une combinaison de traumatisme secondaire

et d'épuisement professionnel, entraîne des effets physiques, psychologiques et spirituels (Todaro-Franceschi, 2019). Nous savons qu'elle contribue au roulement du personnel infirmier en plus de nuire à la rétention des employés et à la qualité des soins (Sinclair et al., 2017). Le Conseil international des infirmières (2022) rapporte qu'il manquait 5,9 millions d'infirmières en 2020; ce nombre est passé à 13 millions après la pandémie. Cela alourdit le fardeau des infirmières en poste qui côtoient déjà quotidiennement la souffrance, des symptômes aigus et la mort.

## CONTEXTE

C'est en 1992 que le concept de fatigue de compassion est apparu dans la recherche en sciences infirmières, après l'observation par Carla Joinson, infirmière en soins d'urgence, d'une forme d'épuisement professionnel bien distincte chez ses collègues. Reprenant les observations de Joinson, Figley (2002) a défini la fatigue de compassion comme le « prix de la bienveillance », résultat d'une exposition répétée aux traumatismes d'autrui qui mène à l'épuisement. Les facteurs prédisposant à la fatigue de compassion sont : 1) l'exposition chronique à la souffrance, 2) la compassion, 3) le manque de distance professionnelle, 4) le don de soi, 5) l'exposition au stress et 6) l'absence de mesures d'autosoins (Peters, 2018). Connaître les signes précurseurs de la fatigue de compassion est une étape essentielle pour la prévenir, en réduire le risque et élaborer des interventions. Il est ardu de reconnaître la fatigue de compassion chez soi ou ses collègues, car les signes et les symptômes peuvent être insidieux et se confondre avec ceux d'autres affections (Todaro-Franceschi, 2019). L'évitement, la perte de motivation, la perte de la raison d'être, le désengagement, la consommation d'alcool ou de drogues et les difficultés de concentration sont liés à la fatigue de compassion (Todaro-Franceschi, 2019). Ces symptômes peuvent même entraîner des changements physiques, émotionnels, spirituels et comportementaux chez la personne et nuire grandement à sa qualité de vie (Sinclair et al., 2017). Parmi les facteurs prédisposant à la fatigue de compassion, notons la proximité physique et affective avec les patients, le travail dans des milieux à haut risque (comme l'oncologie ou les soins intensifs), l'exposition aux traumatismes, la lourde charge de travail et l'engagement empathique continu auprès des patients (Todaro-Franceschi, 2019). Coetzee et Klopper (2010), dans leur analyse conceptuelle originale, définissent la fatigue de compassion ainsi :

Résultat d'un processus graduel et cumulatif engendré par le contact prolongé, continu et intense avec les patients, par le don de soi et l'exposition au stress. Tout commence par un

## AUTEURES



Jodi Collier, inf. aut., B.Sc.inf., M.Sc.inf., CSIO(C), Alberta Health Services, 3942-50A Avenue, Red Deer (Alberta) T4N 6R2, [jodi.collier@ahs.ca](mailto:jodi.collier@ahs.ca)



Tania Bergen, inf. aut., B.Sc.inf., M.Sc.inf., Enseignante, Collège des sciences infirmières, Université de la Saskatchewan



Hua Li, inf. aut., maîtrise en santé publique, Ph.D., Professeure adjointe, Collège des sciences infirmières, Université de la Saskatchewan

Auteure-ressource : Jodi Collier, [Jodi.Collier@ahs.ca](mailto:Jodi.Collier@ahs.ca)

DOI:10.5737/2368807634138

état de malaise compassionnel qui ne s'estompe pas après un repos adéquat, ce qui mène à un stress de compassion dépassant la capacité d'endurance de l'infirmière et se transformant en fatigue de compassion (p. 237).

### Épuisement professionnel

L'épuisement professionnel procède de la relation entre l'employé et l'employeur, et est causé par une lourde charge de travail, une mauvaise gestion et un manque d'effectifs (Todaro-Franceschi, 2019). Il peut toucher n'importe qui, pas seulement les infirmières. La fatigue de compassion diffère de l'épuisement professionnel au sens où elle découle plutôt de la relation entre l'infirmière et le patient (Peters, 2018). L'épuisement professionnel est généralement un processus graduel et prévisible, alors que la fatigue de compassion survient plus soudainement et de manière moins prévisible (Figley, 2002).

### Traumatisme secondaire et traumatisme vicariant

Le traumatisme secondaire est une forme de stress post-traumatique qui résulte d'une relation empathique avec des patients ayant vécu un traumatisme (Arnold, 2020). Du diagnostic à l'intervention chirurgicale, en passant entre autres par les effets secondaires destructeurs de la chimiothérapie, les patients atteints de cancer subissent une multitude de traumatismes. Pour Figley (2002), le traumatisme secondaire et la fatigue de compassion sont des concepts interchangeables, mais l'étiquette de « fatigue de compassion » est plus acceptable parce qu'elle ne dit pas que la personne est « traumatisée », contrairement au traumatisme secondaire. Tirant ses origines de la psychologie, le concept de traumatisme vicariant est défini comme la modification de la vision du monde d'une personne et de son sentiment de contrôle et de sécurité résultant du stress empathique provoqué par l'accompagnement d'un patient ayant subi un traumatisme personnel (Arnold, 2020). Bien que le traumatisme vicariant et le traumatisme secondaire soient étroitement reliés, le traumatisme vicariant peut être vu comme l'exposition au traumatisme, et le traumatisme secondaire comme la réponse naturelle de stress au traumatisme vicariant (Arnold, 2020).

### Satisfaction de compassion

La satisfaction de compassion fait référence aux émotions positives que ressent l'infirmière en soignant des patients dans le besoin (Stamm, 2010). La satisfaction de compassion se définit par les moments d'affirmation, de responsabilisation et d'encouragement qui améliorent la qualité de vie professionnelle d'une infirmière et confirment sa décision et son désir d'exercer sa profession. La satisfaction de compassion protège les infirmières à risque de fatigue de compassion (Stamm, 2010).

Bien que la fatigue de compassion soit un concept relativement nouveau dans la recherche en sciences infirmières, il est probable que la complexité des termes et concepts ait empêché d'étudier plus en détail ce phénomène qui subsiste depuis des décennies. L'épuisement professionnel, la fatigue de compassion, le traumatisme secondaire et le traumatisme vicariant, bien que distincts, sont étroitement liés et souvent coexistants,

ce qui brouille la recherche et le discours. Le fait que les infirmières aient été sous les projecteurs pendant la pandémie de COVID-19 peut avoir eu un effet catalysant, révélant au grand jour le fardeau émotionnel de cette profession.

## OBJECTIF

La présente revue intégrative a pour but de trouver dans la littérature publiée entre 2013 et 2023 des stratégies vérifiées pour prévenir et traiter la fatigue de compassion chez les infirmières en oncologie. La présente revue est motivée par le fait que les infirmières vivant de la fatigue de compassion sont davantage portées à vouloir quitter la profession, font plus d'erreurs professionnelles et présentent un jugement altéré (Peters, 2018). En fonction des résultats obtenus, l'objectif sera de formuler des recommandations afin d'orienter les recherches à venir et de sensibiliser la profession aux données actuelles sur les interventions en cas de fatigue de compassion chez les infirmières en oncologie.

## MÉTHODOLOGIE

Les revues intégratives permettent de faire le point sur l'état actuel de la science sur un sujet particulier pour ensuite influencer la pratique et contribuer aux avancées théoriques (Whittemore et Knafl, 2005). Guidée par la méthodologie de Whittemore et Knafl (2005), la présente revue couvre autant la recherche expérimentale que non expérimentale afin de dévoiler la pertinence des stratégies actuelles visant à prévenir et à soigner la fatigue de compassion chez les infirmières en oncologie.

À l'aide d'opérateurs booléens, une recherche exhaustive des bases de données CINAHL, PubMed, Google Scholar et Web of Science a été réalisée pour trouver les articles intégraux évalués par les pairs publiés entre 2013 et 2023. Les mots-clés suivants ont été employés (en anglais pour la recherche) : "compassion fatigue" OR "secondary traumatic stress" OR "burnout" AND "nursing" AND "oncology" AND "intervention" OR "strategy". Au total, 860 publications sont ressorties, ainsi que quatre articles supplémentaires trouvés grâce à une revue individuelle de la bibliographie des premiers articles, pour un grand total de 864.

Les titres et résumés d'articles ont été passés en revue par une personne. Cette première étape a permis de réduire le nombre de publications à 468. Les articles ont ensuite été examinés en fonction des critères suivants : 1) l'article, quel qu'en soit le type, présentait une recherche originale (ex. qualitative, quantitative, devis mixte); 2) l'article portait explicitement sur les soins infirmiers oncologiques; 3) l'article intégral avait été évalué par les pairs et publié en anglais, entre le 1<sup>er</sup> janvier 2013 et le 31 décembre 2022; 4) il était question dans l'article d'une intervention ciblant la fatigue de compassion. Après application des critères, le nombre de publications est passé à 41. L'étape finale prévoyait la lecture du texte intégral des 41 articles restants. Étaient exclues les publications qui : 1) ne constituaient pas une recherche originale, 2) ne présentaient aucune intervention ciblant la fatigue de compassion, et 3) ne rapportaient pas la réalité du milieu oncologique ou dont au moins de la moitié des participantes étaient des

infirmières. Après cette étape, il restait 18 publications [voir le diagramme du système PRISMA à la figure 1, annexe A.] Les données extraites ont été placées dans un tableau simple listant les caractéristiques suivantes : l'auteur (année), le pays, le devis de recherche, l'objectif de l'étude, la taille et la portée de l'échantillon, et les principaux constats. Le tableau résumé des articles se trouve à l'annexe B.

## RÉSULTATS

Au total, 18 articles ont été retenus pour la revue. De ce nombre, 12 études ont été réalisées aux États-Unis, 2 au Canada, 2 en Turquie, 1 au Portugal et 1 au Royaume-Uni. Le devis de type pré-test/post-test était le plus courant; 2 études faisaient appel à des méthodes mixtes et une autre consistait en un essai clinique randomisé. Les échantillons regroupaient de 13 à 189 sujets, pour une moyenne de 65,9. En tout, 1 253 infirmières en oncologie, traitant des patients en milieux ambulatoires et hospitaliers, en pédiatrie et en unité de greffe de cellules souches, ont pris part à ces études. L'expérience professionnelle allait de moins de 5 ans d'expérience (Jakel et al., 2016) à 17,7 ans en moyenne (Esplen et al., 2022). Après un examen approfondi des 18 études retenues, trois types d'interventions en lien avec la fatigue de compassion ont été relevées : les mesures axées sur la pleine conscience (4 publications : Delaney, 2018; Duarte et Pinto-Gouveia, 2016; Hevezi, 2016; Qualls et al., 2022), les autosoins (5 publications : Anderson et Gustavson, 2016; Hand et al., 2019; Phillips et al., 2020; Sullivan et al., 2019; Yilmaz et al., 2018) et la résilience (9 publications : Blackburn et al., 2020; Esplen et al., 2022; Jakel et al., 2016; Klein et al., 2017; Pehlivan et Guner, 2020; Pfaff et al., 2017; Potter et al., 2013; Schuster, 2021; Zajac et al., 2017). Voir l'annexe B pour les détails. Chaque type d'intervention sera examiné dans les paragraphes qui suivent.

### Interventions axées sur la pleine conscience

La pleine conscience est l'art de se concentrer, intentionnellement et sans jugement, sur l'état du corps et des pensées, dans le moment présent (Hevezi, 2016). Issue de la tradition bouddhiste, la pleine conscience est reconnue comme une stratégie utile pour affronter les situations stressantes. Les interventions de réduction du stress par la pleine conscience proposent des séances hebdomadaires de deux à trois heures pendant huit semaines, en plus de séances quotidiennes de méditation (Delaney, 2018). Puisque les interventions de pleine conscience nécessitent beaucoup de temps, il n'est pas étonnant que les études qui font l'objet de la présente revue aient plutôt recours à une formule d'intervention modifiée sur quatre semaines (Hevezi, 2016; Qualls et al., 2022) ou six semaines (Duarte et Pinto-Gouveia, 2016) et qu'une seule étude ait conservé le calendrier de huit semaines (Delaney, 2018). Les quatre études sur ce sujet ont été menées auprès d'un seul échantillon non randomisé; seule l'étude de Duarte et Pinto-Gouveia (2016) a procédé à des comparaisons avec un groupe témoin. Cette étude rapporte une diminution importante de la fatigue de compassion dans le groupe expérimental d'infirmières comparativement au groupe témoin, ainsi qu'une diminution marquée des cas d'épuisement professionnel. Il

est à noter que toutes les interventions ont été réalisées dans le milieu professionnel, pendant les heures de travail.

### Interventions axées sur les autosoins

Les stratégies d'autosoins s'appuient sur les fondements de la santé et du bien-être, de l'alimentation, de l'exercice, du sommeil, des stratégies d'adaptation, de l'éducation et des arts créatifs. Les stratégies faisant l'objet de la présente revue comprennent notamment le tricot, les réunions permettant de faire le point, les séances de massage, la mise en récit, la composition de chansons, l'enseignement des autosoins, les chambres de répit, le counseling et le soutien aux personnes en deuil (Anderson et al., 2016; Hand et al., 2019; Phillips et al., 2020; Sullivan et al., 2019; Yilmaz et al., 2018). Yilmaz et collaborateurs (2018) ont montré que ce type d'interventions, lorsqu'elles sont dirigées par des infirmières, peuvent augmenter la satisfaction de compassion, et diminuer l'épuisement professionnel et la fatigue de compassion. La complexité de l'intervention de mise en récit et de composition de chansons employée par Phillips et collaborateurs (2020) soulève des questionnements quant à la reproductibilité puisque l'animatrice, une infirmière en oncologie, était également auteure-compositrice-interprète.

### Interventions axées sur la résilience

La personne résiliente fait preuve d'adaptabilité, de tolérance et de débrouillardise dans les situations difficiles (Merriam-Webster, 2020). La résilience englobe des composantes individuelles et environnementales, et tient compte de la capacité à grandir en tirant des leçons des expériences difficiles. Il s'agit d'une importante stratégie pour gérer le stress occasionné par le travail en oncologie (Pehlivan et Guner, 2020). Les interventions axées sur la résilience ont prouvé leur efficacité à l'échelle individuelle auprès des infirmières, mais aussi à l'échelle des organisations en favorisant le maintien en poste des effectifs, en augmentant la productivité et en diminuant le roulement de personnel (Blackburn et al., 2020).

Blackburn et collaborateurs (2020) ont mis en place le programme THRIVE®, qui propose une retraite de huit heures, une étude de groupe de six semaines sur les médias sociaux encadrée par un animateur ou une animatrice, et une séance récapitulative de deux heures. Le programme THRIVE® montre une hausse statistiquement significative de la résilience ( $p = 0,0268$ ), ainsi qu'une diminution des cas d'épuisement professionnel ( $p = 0,005$ ) et des traumatismes secondaires ( $p = 0,004$ ); ces résultats se maintenaient 2, 4 et 6 mois après l'intervention. Blackburn et collaborateurs (2020) ont également constaté que le taux de roulement chez les infirmières ayant participé au programme THRIVE® était de 6,1 %, comparativement à la moyenne nationale de 17,1 %, ce qui montre des bénéfices à la fois pour les personnes et les organisations. Dans l'intervention d'éducation continue d'Esplen et collaborateurs (2022), les participants ont admis que c'était la première fois, en 17,7 années d'expérience (en moyenne) qu'on leur parlait de fatigue de compassion et des facteurs de risque personnels. Dans ce même échantillon ( $n = 189$ ), 88 % ont dit que les questions du bien-être au travail et de la qualité de vie n'étaient pas abordées lors des évaluations annuelles de rendement.

## DISCUSSION

Les interventions axées sur la pleine conscience ont prouvé leur grande efficacité comme stratégie permettant de contrer la fatigue de compassion chez les infirmières en oncologie. Les organisations auront besoin d'autres renseignements sur la durée et la composition exactes des interventions de pleine conscience pour déterminer la faisabilité et l'engagement personnel envers le programme. Les recherches à ce sujet doivent se poursuivre afin d'évaluer la faisabilité et l'efficacité d'interventions plus courtes, comparativement aux interventions de plus longue durée. Dans l'ensemble, les interventions axées sur la pleine conscience semblent elles aussi très prometteuses pour amenuiser la fatigue de compassion. Les déclarations des participants faites dans le cadre de l'étude à méthodes mixtes (Delaney, 2018) et les questionnaires post-intervention (Duarte et Pinto-Gouveia, 2016) traduisent une acceptation générale des interventions axées sur la pleine conscience par les participants. La diminution importante des cas d'épuisement professionnel et de fatigue de compassion associée à ce type d'intervention renforce l'utilité de l'approche.

Les études incluses dans la présente revue révèlent une efficacité mitigée des stratégies d'autosoins pour soigner la fatigue de compassion; l'une des explications possibles est que ces stratégies sont plus efficaces en prévention qu'en traitement. Les autosoins pourraient mieux s'intégrer aux soins de suivi qu'au traitement, moment où la personne est déjà touchée par la fatigue de compassion et peine à prendre soin d'elle-même. Un autre problème des stratégies d'autosoins est qu'on place souvent la responsabilité d'aller mieux sur la personne qui souffre. Il est difficile de jauger s'il est convenable de suggérer à une infirmière de faire du yoga après avoir vécu un traumatisme douloureux. Le yoga, l'art et l'écriture d'un journal sont d'excellentes approches favorisant la santé et le bien-être, pour autant qu'elles soient appliquées au bon moment. Peut-être le réflexe médical, qui met l'accent sur le diagnostic et le traitement, influence-t-il les approches actuelles et la compréhension des autosoins.

Les études portant sur la résilience utilisaient un devis longitudinal, les mesures étant réalisées à des intervalles variés (ex. entre 3 et 12 mois post-test). Dans les études qui n'ont pas réussi à montrer d'améliorations statistiquement significatives après l'intervention, on note que les symptômes d'épuisement professionnel et de fatigue de compassion n'étaient pas très intenses lorsqu'ont été administrés les questionnaires établissant les mesures de référence avant les interventions. Cela laissait donc peu de place au changement, quelle que soit l'intervention choisie (Jakel et al., 2017; Pfaff et al., 2017). Dans les études à venir, les critères d'inclusion devraient viser les personnes présentant au moins des signes modérés de fatigue de compassion ou d'épuisement professionnel.

Dans toutes les études, il ressort un thème récurrent : les commentaires positifs sur les interventions qu'expriment les participants en réponse aux questions ouvertes posées à la suite des interventions. Dans l'essai clinique randomisé de Pehlivan et Guner (2020), les scores de fatigue de compassion augmentaient immédiatement après l'intervention,

comparativement aux mesures de départ. Bien que cette conclusion étonne, elle donne possiblement suite aux résultats d'Espen et collaborateurs (2022); selon eux, malgré de nombreuses années d'expérience, les infirmières demeurent peu sensibilisées et formées au sujet de la fatigue de compassion. Les infirmières considèrent que le manque de temps est l'un des principaux obstacles à leur participation aux interventions axées sur les autosoins et la résilience. Le soutien et la coopération des organisations sont donc essentiels au succès et à la mise en œuvre des interventions ciblant la fatigue de compassion (Pehlivan et Guner, 2020; Pfaff et al., 2017; Schuster, 2020).

## LIMITES

Parmi les limites de la présente revue, le fait de n'avoir qu'un seul examinateur augmente le risque d'erreur humaine. De plus, un seul essai clinique randomisé a été recensé et intégré à la revue, et la majorité des articles proviennent des États-Unis. Les différents systèmes de santé peuvent poser des difficultés propres. Les infirmières ayant participé à ces études sont principalement des femmes blanches de 22 à 65 ans. À l'heure où la population d'infirmières se diversifie, il sera primordial de constituer un échantillon plus représentatif pour orienter la pratique actuelle.

### Limites des articles recensés

Concernant les 18 publications faisant l'objet de la présente revue, plusieurs limites ont été notées, dont l'autosélection des participants. Ainsi, il est possible que certains d'entre eux se soient portés volontaires parce qu'ils s'intéressaient à l'intervention et désiraient en bénéficier. Par exemple, les participants du groupe ayant reçu un massage ont pris part à la conception et à la mise en œuvre du projet, et ont rapporté eux-mêmes toutes les données. Leur souhait de voir le projet réussir pourrait avoir introduit un biais (Hand et al., 2019). Dans l'ensemble, en raison des petits échantillons et du suivi longitudinal limité dans les études sélectionnées pour la présente revue, il est difficile de déterminer si les interventions ont des effets durables ou à court terme seulement. Les prochaines études devront prévoir un groupe témoin ainsi qu'un suivi au-delà de 6 mois après l'intervention. Il serait utile pour les organisations d'avoir des données permettant de déterminer la durée idéale de l'intervention, ce qui permettrait de mesurer la faisabilité et le coût de ces approches. Dans l'étude réalisée par Zajac et collaborateurs (2017), les données pré-test/post-test n'étaient pas appariées et sept personnes différentes ont dirigé l'intervention, ce qui soulève la question de la cohérence. Dans l'étude de Jakel et collaborateurs (2016), la formation sur la fatigue de compassion a été offerte à la fois au groupe expérimental et au groupe témoin, ce qui pourrait avoir embrouillé les résultats. À ce jour, un seul essai clinique randomisé a évalué la pertinence d'une intervention visant à atténuer la fatigue de compassion chez les infirmières en oncologie. D'autres essais cliniques randomisés sont donc nécessaires.

## RECOMMANDATIONS

Pour éviter la fatigue de compassion, le premier pas consiste à sensibiliser les cliniciens (Todaro-Franceschi, 2019).

En effet, reconnaître la fatigue de compassion permet de valider la réalité des gens qui en souffrent et de déceler les personnes à risque. Le fait que des infirmières ayant en moyenne 17,7 années d'expérience en soins oncologiques n'aient jamais entendu parler de la fatigue de compassion ou des facteurs de risque personnels révèle le besoin urgent d'éducation sur le sujet (Esplen et al., 2022). Outre les efforts de sensibilisation, il faut aussi mettre en place des interventions non uniquement ponctuelles; c'est ce qu'ont conclu Kein et collaborateurs (2017) lorsque les bienfaits de l'intervention étudiée ne se faisaient plus sentir six mois plus tard. Les organisations et les infirmières devraient considérer les interventions axées sur la pleine conscience et la résilience comme des outils utiles tout au long du parcours professionnel. En comprenant la fatigue de compassion et en sachant reconnaître les facteurs de risque, les infirmières et les organisations sauront alors bien employer et évaluer les interventions.

La présente revue met en lumière l'existence de diverses stratégies axées sur la pleine conscience, les autosoins et la résilience pour soulager la fatigue de compassion, mais elle révèle aussi l'absence d'une approche scientifique reconnue en la matière. Heureusement, il semble que les interventions complexes et de longue durée ne soient pas nécessairement meilleures que les interventions plus courtes (Pehlivan et Guner, 2020). Selon la présente revue, les interventions menées par des infirmières ont été bien accueillies (Hand et al., 2019; Schuster, 2021; Yilmaz et al. 2018), les commentaires des participants ont été extrêmement positifs quel que soit le type d'intervention, et la formation sur la résilience aurait favorisé le maintien en poste des infirmières (Blackburn et al., 2020). Pour dépister la fatigue de compassion et sensibiliser les professionnels à cette question, des stratégies simples, comme le fait de répondre annuellement à l'auto-questionnaire Échelle de qualité de vie professionnelle

– Version 5 (ProQOL-5) dans le cadre d'une formation ou d'une évaluation de rendement pourrait permettre de détecter des cas de fatigue de compassion qui seraient autrement passés inaperçus (Esplen et al., 2022). La consolidation continue des stratégies d'autosoins fait partie des approches préventives à ne pas négliger. On a constaté que les interventions visant la fatigue de compassion réduisent par près de trois le roulement de personnel, un argument qui devrait convaincre les organisations d'adopter cette approche (Blackburn et al. 2020).

### Modèle d'intervention sur la fatigue de compassion

Les résultats de la présente revue ont permis d'élaborer un modèle d'intervention qui englobe les recommandations et les conclusions sur la fatigue de compassion. Le modèle, illustré à l'annexe C, souligne le besoin primordial de sensibiliser les milieux à haut risque à ce phénomène; c'est là le principal constat de la revue. Le modèle insiste sur l'importance des interventions tout au long du parcours professionnel des infirmières; compte tenu du peu de recherches actuelles sur la fatigue de compassion, les suggestions demeurent générales et n'entrent pas dans les détails.

## CONCLUSION

De par la nature de leur travail, les infirmières en oncologie sont exposées à la fatigue de compassion (Stamm, 2010). Les interventions axées sur la pleine conscience, les autosoins et la résilience s'annoncent prometteuses pour y remédier. D'autres recherches sont nécessaires afin de déterminer exactement le type et la durée des interventions qui seront les plus efficaces. Depuis la pandémie, l'état des infirmières est préoccupant; il faut passer à l'action. La reconnaissance de la fatigue de compassion par les organisations confirme le traumatisme vécu par les infirmières et dévoile une réalité encore peu connue des soins de santé.

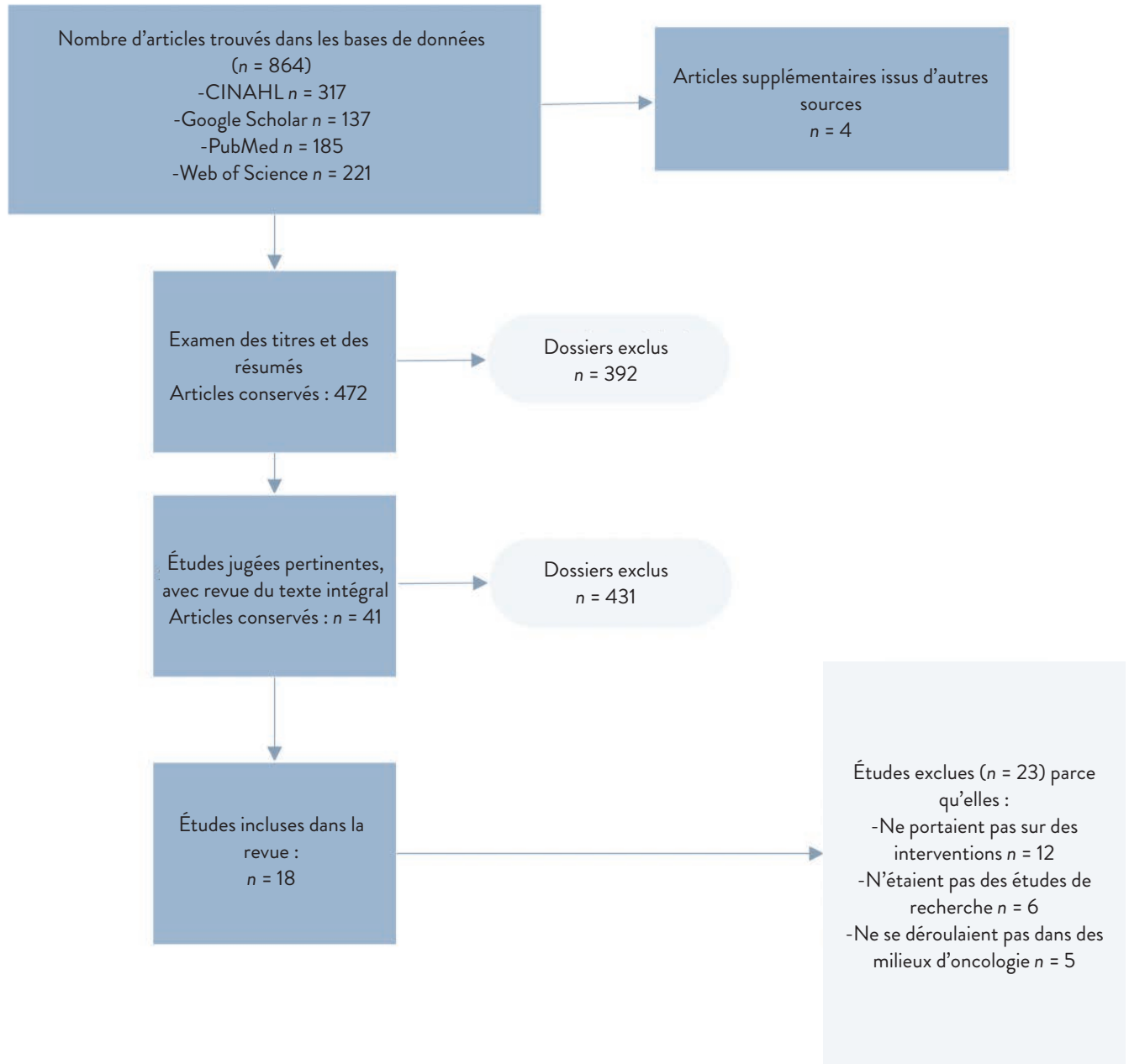
## RÉFÉRENCES

- Anderson, L., & Gustavson, C. (2016). The impact of a knitting intervention on compassion fatigue in oncology nurses. *Clinical Journal of Oncology Nursing*, 20(1), 102–104. <https://doi.org/10.1188/16.CJON.102-104>
- Arnold, T. (2020). An evolutionary concept analysis of secondary traumatic stress in nurses. *Nursing Forum*, 55(2), 149–156. <https://doi.org/10.1111/nuf.12409>
- Blackburn, L., Thompson, K., Frankenfield, R., Harding, A., & Lindsey, A. (2020). The THRIVE© Program: Building oncology nurse resilience through self-care strategies. *Oncology Nursing Forum*, 47(1), 25–34. <https://doi.org/10.1188/20.ONF.E25-E34>
- Coetzee, S. & Klopper, H. (2010). Compassion fatigue within nursing practice: A concept analysis. *Nursing and Health Sciences*, 12(2), 235–243. <https://doi.org/10.1111/j.1442-2018.2010.00526.x>
- Delaney, M. (2018). Caring for the caregivers: Evaluation of the effect of an eight-week pilot mindful self-compassion (MSC) training program on nurses' compassion fatigue and resilience. *Public Library of Science One*, 13(11), 1–20. <https://doi.org/10.1371/journal.pone.0207261>
- Duarte, J., & Pinto-Gouveia, J. (2016). Effectiveness of a mindfulness-based intervention on oncology nurses' burnout and compassion fatigue symptoms: A non-randomized study. *International Journal of Nursing Studies*, 64, 98–107. <http://dx.doi.org/10.1016/j.ijnurstu.2016.10.002>
- Esplen, M., Wong, J., Vachon, M., & Leung, Y. (2022). A continuing educational program supporting health professionals to manage grief and loss. *Current Oncology*, 29(3), 1461–1474. <https://doi.org/10.3390/currncol29030123>
- Figley, C. (1995). The transmission of trauma. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. (pp. 248–254). Brunner-Routledge.
- Figley, C. (Ed.). (2002). *Treating compassion fatigue*. Brunner-Routledge. <https://doi-org.cyber.usask.ca/10.4324/9780203890318>
- Hand, M., Margolis, J., & Staffileno, B. (2019). Massage chair sessions: Favorable effects on ambulatory cancer center nurses' perceived level of stress, blood pressure, and heart rate. *Clinical Journal of Oncology Nursing*, 23(4), 375–381. <https://doi.org/10.1188/19.CJON.375-381>
- Hevezi, J. (2016). Evaluation of a mediation intervention to reduce the effects of stressors associated with compassion fatigue among nurses. *Journal of Holistic Nursing*, 34(4), 343–350. <https://doi.org/10.1177/0898010115615981>
- International Council of Nurses. (2022). *The global nursing shortage and nurse retention*. <https://www.icn.ch/sites/default/files/>

- inline-files/ICN%20Policy%20Brief\_Nurse%20Shortage%20and%20Retention\_0.pdf
- Jakel, P., Kenney, J., Ludan, N., Miller, P., McNair, N., & Matesic, E. (2016). Effects of the use of the provider resilience mobile application in reducing compassion fatigue in oncology nursing. *Clinical Journal of Oncology Nursing*, 20(6), 611–616. <https://doi.org/10.1188/16.CJON.611-616>
- Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, 22(4), 116.
- Kennedy, S., & Booth, R. (2022). Vicarious trauma in nursing professionals: A concept analysis. *Nursing Forum*, 57(5), 893–897. <https://doi.org/10.1111/nuf.12734>
- Klein, C., Rigenback-Hays, J., Sollenberger, L., Harney, D., & McGarvey, J. (2018). Quality of life and compassion satisfaction in clinicians: A pilot intervention study for reducing compassion fatigue. *American Journal of Hospice & Palliative Medicine*, 35(6), 882–888. <https://doi.org/10.1177/1049909117740848>
- McEwen, M. (2019). Theory analysis and evaluation. In M. McEwen & E.M. Wills (Eds.), *Theoretical basis for nursing*, (5<sup>th</sup> ed., pp. 94–113). Lippincott, Williams, & Wilkins.
- Merriam-Webster. (2020). Resiliency. *Merriam-Webster.com dictionary*. <https://www.merriam-webster.com/dictionary/resiliency>
- Pehlivan, T., & Guner, P. (2020). Effect of a compassion fatigue resiliency program on nurses' professional quality of life, perceived stress, resilience: A randomized controlled trial. *Journal of Advanced Nursing*, 76(12), 3584–3596. <https://doi.org/10.1111/jan.14568>
- Peters, E. (2018). Compassion fatigue in nursing: A concept analysis. *Nursing Forum*, 53(4), 466–480. <https://doi.org/10.1111/nuf.12274>
- Pfaff, K., Freeman-Gibb, L., Patrick, L., DiBiase, R., & Moretti, O. (2017). Reducing the “cost of caring” in cancer care: Evaluation of a pilot interprofessional compassion fatigue resiliency programme. *Journal of Interprofessional Care*, 31(4), 512–519. <http://dx.doi.org/10.1080/13561820.2017.1309364>
- Phillips, C., Volker, D., Davidson, K., & Becker, H. (2020). Storytelling through music: A multidimensional expressive arts intervention to improve emotional well-being of oncology nurses. *Journal of Clinical Oncology*, 16(4), 405–413. <https://doi.org/10.1200/JOP.19.00748>
- Potter, P., Deshields, T., Berger, J., Clarke, M., Olsen, S., & Chen, L. (2013). Evaluation of a compassion fatigue resiliency program for oncology nurses. *Oncology Nursing Forum*, 40(2), 180–187. <https://doi.org/10.1188/13.ONF.180-187>
- Qualls, B., Payton, E., Aikens, L., & Carey, M. (2022). Mindfulness for outpatient oncology nurses: A pilot study. *Holistic Nursing Practice*, 36(1), 28–36. <https://doi.org/10.1097/HNP.0000000000000487>
- Schuster, M. (2021). Creating the hematology/oncology/stem cell transplant advancing resiliency team: A nurse-led support program for hematology/oncology/stem cell transplant staff. *Journal of Pediatric Oncology Nursing*, 38(5), 331–341. <https://doi.org/10.1177/10434542211011046>
- Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-MacDonald, L. (2017). Compassion fatigue: A meta-narrative review of healthcare literature. *International Journal of Nursing Studies*, 69, 9–24. <http://dx.doi.org/10.1016/j.ijnurstu.2017.01.003>
- Stamm, B. (2010). *The concise ProQOL manual*. <https://ProQOL.org>
- Sullivan, C., King, A., Holdiness, J., Durrell, J., Roberts, K., Spencer, C., Roberts, J., Ogg, S., Moreland, M., Browne, E., Cartwright, C., Crabtree, V., Baker, J., Brown, M., Sykes, A., & Mandrell, B. (2019). Reducing compassion fatigue in pediatric oncology nurses. *Oncology Nursing Forum*, 46(3), 338–347. <http://doi.org/10.1188/19.ONF.338-347>
- Todaro-Franceschi, V. (2019). *Compassion fatigue and burnout in nursing: Enhancing professional quality of life*. (2nd ed.). Springer Publishing Company.
- Whittemore, R. & Knaf, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing*, 52(5), 546–553. <http://doi.org/10.1111/j.13652648.2005.03621.x/pdf>
- Yilmaz, G., Ustun, B., & Gunusen, N. (2018). Effect of a nurse-led intervention programme on professional quality of life and post-traumatic growth in oncology nurses. *International Journal of Nursing Practice*, 24(6), 1–7. <https://doi.org/10.1111/ijn.12687>
- Zajac, L., Moran, K., & Groh, C. (2017). Confronting compassion fatigue: Assessment and intervention in inpatient oncology. *Clinical Journal of Oncology Nursing*, 21(4), 446–453. <https://doi.org/10.1188/17.CJON.446-453>

## Annexe A

Figure 1  
Organigramme PRISMA





## Annexe B

Figure 2

### Sommaire des articles inclus dans la revue de littérature

Pays	Devis de l'étude	Objectif de l'étude	Taille et portée de l'échantillon	Conclusions
Anderson, Gustavson et al. (2016), États-Unis	Étude non randomisée pré/post-intervention	Déterminer les effets du tricot sur la fatigue de compassion des infirmières en oncologie.	n = 39 infirmières en oncologie Échelle de qualité de vie professionnelle-Version 5 (ProQOL-5)	Les données recueillies avant le début du programme et après 6 semaines de tricot montrent une amélioration significative des scores d'épuisement professionnel et de traumatisme secondaire.
Blackburn et al. (2020), États-Unis	Étude quasi expérimentale	Élaborer un programme qui s'appuie sur les données probantes et le principe de résilience pour aider les infirmières et les personnes travaillant en oncologie qui vivent un épuisement professionnel ou un traumatisme secondaire.	n = 164 travailleurs en oncologie (n = 160 infirmières) Échelle de la fatigue de compassion (version courte) et Échelle de résilience de Connor-Davidson	Le programme THRIVE a permis d'améliorer les scores de résilience et de diminuer l'épuisement professionnel. Les effets étaient encore ressentis 6 mois après l'intervention.
Delaney (2018), Royaume-Uni	Étude pilote observationnelle à devis mixte	Obtenir les premières données empiriques concernant l'effet sur la fatigue de compassion et la résilience des infirmières d'une formation de 8 semaines portant sur la pleine conscience et l'autocompassion. Décrire les expériences des personnes ayant suivi la formation.	n = 13 Échelle d'autocompassion de Neff Échelle de pleine conscience de Frieburg (version courte) ProQOL-5 Échelle de résilience de Connor-Davidson	Le programme pilote de 8 semaines de formation à l'autocompassion a amélioré significativement les scores pré/post-intervention d'épuisement professionnel et de traumatisme secondaire. Les scores de résilience et de satisfaction de compassion se sont aussi améliorés.
Duarte et Pinto-Gouveia (2016), Portugal	Étude comparative quasi expérimentale non randomisée	Étudier l'efficacité d'une intervention courte réalisée en milieu de travail fondée sur la pleine conscience pour soulager les symptômes d'épuisement professionnel et la fatigue de compassion chez les infirmières	n = 94 infirmières en oncologie, analyse statistique de variance (ANOVA) et de covariance (ANCOVA)	Les infirmières du groupe expérimental ont rapporté une diminution marquée de la fatigue de compassion, de l'épuisement professionnel et du stress, ainsi qu'une plus grande satisfaction à l'égard de la vie (ampleur de l'effet moyenne à élevée).
Esplen et al. (2022), Canada	Étude non randomisée pré/post-intervention	Accroître les connaissances et la confiance vis-à-vis la compréhension de la fatigue de compassion et de l'épuisement professionnel à l'aide d'un programme de formation continue.	n = 189 travailleurs en soins oncologiques (n = 173 infirmières) Inventaire révisé des expériences de deuil Modèle de Kirkpatrick pour l'évaluation de programmes de formation	Le questionnaire post-intervention révèle une amélioration de la confiance ainsi que des connaissances dans différents domaines. Une grande satisfaction a été rapportée une fois le programme terminé.
Hand et al. (2019), États-Unis	Étude quasi expérimentale	Déterminer les effets d'un massage sur chaise sur le stress perçu, la tension artérielle et la fréquence cardiaque des infirmières.	n = 51 infirmières Analyse faite à l'aide de statistiques descriptives et de tests t pour échantillons appariés.	Pendant 6 mois, les infirmières ont reçu 200 massages sur chaise, ce qui a permis de réduire leur stress, leur tension artérielle et leur fréquence cardiaque.
Hevezi (2016), États-Unis	Non-randomized pre/post intervention study	Étude non randomisée pré/post-intervention Évaluer l'efficacité des méditations courtes pour soulager la fatigue de compassion et augmenter la satisfaction de compassion chez les infirmières en oncologie.	n = 15 infirmières en oncologie ProQOL-5	Après avoir participé à des méditations structurées, les infirmières ont rapporté une augmentation significative de la satisfaction de compassion et une diminution de l'épuisement professionnel et des traumatismes secondaires.

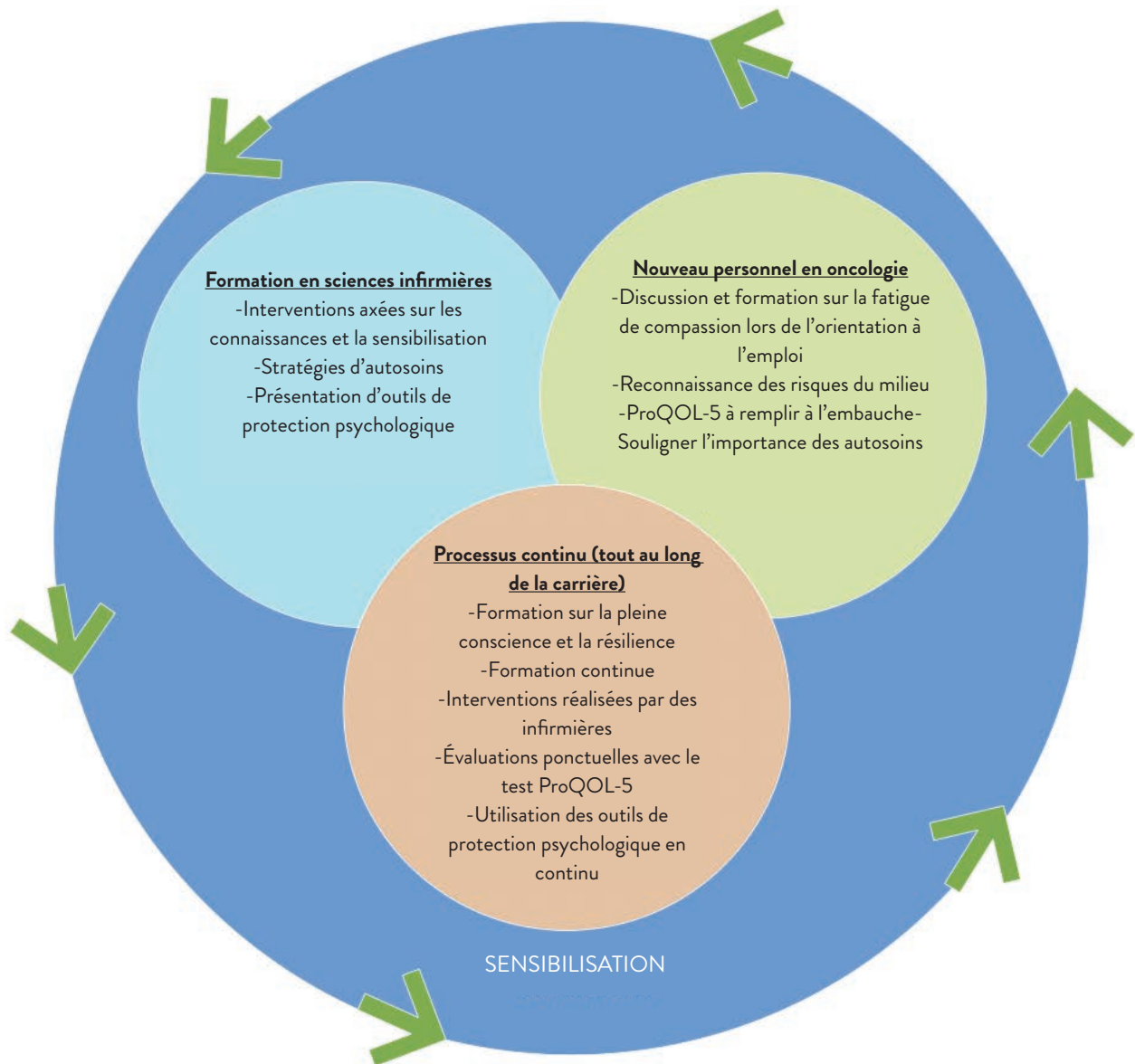
Pays	Devis de l'étude	Objectif de l'étude	Taille et portée de l'échantillon	Conclusions
Jakel et al. (2016), États-Unis	Étude longitudinale quasi expérimentale pré/post-intervention	Déterminer si l'utilisation de l'application mobile <i>Provider Resilience</i> améliore la qualité de vie des infirmières.	n = 25 infirmières en oncologie ProQOL-5, application mobile <i>Provider Resilience</i>	Aucun lien significatif n'a été établi entre le groupe expérimental et le groupe témoin concernant le traumatisme secondaire, l'épuisement professionnel et la satisfaction de compassion.
Klein et al. (2018), États-Unis	Étude pilote exploratoire pré/post-intervention	Déterminer l'efficacité d'un programme de formation sur la satisfaction de compassion, la fatigue de compassion, les traumatismes secondaires, la résilience et la qualité de vie.	n = 18 ProQOL-5	Augmentation marquée de la satisfaction de compassion et légère diminution de l'épuisement professionnel chez les participants.
Pehlivan et Guner (2020), Turquie	Essai clinique randomisé	Mettre en œuvre un programme de résilience pour lutter contre la fatigue de compassion et comparer les effets des versions courtes et longues du programme sur la fatigue de compassion, l'épuisement professionnel, la satisfaction de compassion, le stress perçu et la résilience des infirmières en oncologie.	N = 125 infirmières en oncologie réparties au hasard dans l'un des 2 groupes expérimentaux ou dans le groupe témoin ProQOL-5 Échelle de stress perçu Échelle de résilience pour adultes	Le groupe 1 participait au programme court, le groupe 2, au programme long, et le groupe témoin, à aucun programme. Les résultats ont permis de constater que la durée du programme ne change rien; la satisfaction de compassion s'est améliorée pour tout le monde.
Pfaff et al. (2017), Canada	Étude à méthode mixte	Déterminer l'effet d'un programme pilote de 6 semaines sur la fatigue de compassion, la satisfaction de compassion et le stress clinique du personnel en oncologie.	Étude qualitative n = 12 Étude quantitative n = 32 ProQol-5 Échelle de la satisfaction de compassion Échelle de l'épuisement professionnel Échelle du traumatisme secondaire Indice de stress clinique Échelle des comportements inhibant l'expression de la souffrance (Silencing Response Scale)	Les participants ont dit ressentir moins de stress clinique et avoir une meilleure compréhension de la fatigue de compassion à la fin du programme.
Phillips et al. (2020), États-Unis	Étude pilote quasi expérimentale à deux groupes non randomisés (expérimental et témoin)	Mesurer l'effet d'une intervention multidimensionnelle (récit d'expérience par la musique) combinant les arts créatifs et la capacité à prendre soin de soi sur l'équilibre émotionnel des infirmières en oncologie.	n = 43 infirmières en oncologie ProQol-5 Système d'information sur la mesure des résultats rapportés par les patients Indice de gravité de l'insomnie Échelle de solitude de l'Université de Californie Échelle d'autoréflexion et d'auto-observation Échelle d'autocompassion	Intervention (arts créatifs et capacité à prendre soin de soi) de 6 semaines avec 2 groupes (expérimental et témoin) et collecte de données en 4 points (2 avant et 2 après l'intervention). Amélioration significative au fil du temps pour les 2 groupes, plus importante pour le groupe expérimental.
Potter et al. (2013), États-Unis	Étude pilote descriptive	Évaluer un programme de résilience visant à renseigner les infirmières en oncologie sur la fatigue de compassion	n = 13 infirmières en oncologie ProQOL-5 Test d'inventaire de burnout de Maslach-Questionnaire à l'intention des professionnels des services à la personne (Inventory-Human Services Survey) Échelle révisée d'impact des événements Échelle de satisfaction au travail des infirmières	Le programme de 5 semaines (4 séances de 90 minutes) et retraite de 4 heures entre les séances 4 et 5 pour du faire le point a entraîné une diminution des scores de traumatisme secondaire.

Pays	Devis de l'étude	Objectif de l'étude	Taille et portée de l'échantillon	Conclusions
Qualls et al. (2022), États-Unis	Étude pilote prospective pré/post-test	Évaluer les effets d'une technique de réduction du stress par la pleine conscience sur le stress ressenti et l'épuisement professionnel, la fatigue de compassion et la satisfaction de compassion. Mesurer la fréquence cardiaque, la température corporelle et le rythme respiratoire pré- et post-intervention.	n = 13 infirmières en oncologie ProQOL-5 Questionnaire post-expérience MOON	L'intervention de réduction du stress par la pleine conscience a été efficace pour diminuer la fréquence cardiaque, la température corporelle et le rythme respiratoire. Des améliorations statistiquement significatives ont été notées dans les cas d'épuisement professionnel, de traumatisme secondaire et de fatigue de compassion.
Schuster (2021), États-Unis	Programme pilote	Collecte de données par sondage avant le début du programme et à mi-chemin Évaluer un programme durable de soutien par les pairs en milieu de travail dans le but d'améliorer la culture, le travail d'équipe, le moral et le bien-être du personnel.	N = 92 membres du personnel en oncologie Échelle de Likert avant l'intervention et à mi-parcours.	Thèmes ciblés : l'importance d'être conscient de sa santé et de son bien-être, l'importance pour les organisations d'offrir des programmes de bien-être pour retenir le personnel.
Sullivan et al. (2019), États-Unis	Étude quasi expérimentaux	Élaborer un programme de lutte contre la fatigue de compassion fondé sur des données probantes et en évaluer l'effet sur l'épuisement professionnel, les traumatismes secondaires et la satisfaction de compassion chez les infirmières en oncologie.	N = 59 infirmières en oncologie ProQOL-5 Échelle de résilience de Connor-Davidson-2	Le programme pilote sur l'auto-prise en charge, axé sur la formation, la santé, le deuil et l'aménagement d'une salle de répit a fait augmenter les scores de traumatisme secondaire.
Yilmaz et al. (2018), Turquie	Étude quasi expérimentale	Évaluer les effets sur la fatigue de compassion, la satisfaction de compassion et l'épuisement professionnel d'un programme d'intervention mené par une infirmière à l'intention des infirmières en oncologie.	N = 43 infirmières en oncologie ProQOL-5 Inventaire de croissance post-traumatique	Le programme d'intervention de 5 semaines mené par une infirmière a permis d'améliorer les scores de qualité de vie professionnelle et de croissance post-traumatique.
Zajac et al. (2017), États-Unis	Devis séquentiel mixte	Lutter contre la fatigue de compassion chez les infirmières en élaborant une intervention de soutien au deuil après le décès d'un patient.	N = 91 infirmières en oncologie ProQOL-5 pré/post-intervention.	Les séances de pleine conscience où les infirmières pouvaient faire le point ont permis d'exprimer le deuil et la perte. Les scores post-intervention n'ont pas permis d'établir l'efficacité de la méthode pour soulager la fatigue de compassion.

Annexe C

Figure 3

Modèle d'intervention sur la fatigue de compassion



# Breaking barriers: Indigenous nurse navigator role in oncology care for the Inuit

By Carolyn Roberts

## ABSTRACT

*Individuals who live in the north of Canada face many challenges when they are diagnosed with cancer. Accessing cancer care usually means having to travel to a cancer centre in southern facilities and stay in a city away from family, local community, language and culture. The Indigenous Cancer Program at The Ottawa Hospital was established to assist these individuals in navigating a complex and unfamiliar system of care. The First Nations, Inuit, Métis Nurse Navigator role was designed to collaborate with these patients and develop interventions to meet their unique needs. Recently, a satellite oncology clinic was opened in the territory of Baffin Island Nunavut where patients can be assessed, receive cancer immunotherapy treatment, if required, and be followed after their primary treatment is finished. Holding the clinic in the local setting reduces the travel and time away from home for cancer patients. It is hoped this type of care can be expanded in the remote areas of the country.*

## INTRODUCTION

I want to begin this manuscript with a land acknowledgment. I currently live and work in the Outaouais region, which is the ancestral home of the Anishinaabe Algonquin Peoples. I would also like to acknowledge the First Nations, Inuit and Métis and urban Indigenous who live and work on this unceded Algonquin territory. My hometown of St. Paul's River, Quebec is situated on the ancestral land of the Inuit and Innu Peoples.

It is important for me to begin with a land acknowledgment to respectfully recognize the history, contributions and sacrifices of First Peoples of my home, current community, and country. A history we cannot undo, but I truly believe it is the responsibility of every resident of Canada to learn about our colonial past, to learn about each distinct peoples within the pan indigenous reference and respectfully recognize those differences; for every healthcare institution to have mandatory culturally safe care training; and to acknowledge the First Peoples wherever we place our feet in this vast and diverse country. My commitment to reconciliation is to continue learning, accept the difficult truths of our colonial past, and with that knowledge dispel the many untruths I continuously encounter, and to encourage others to advocate for change until all 94 Calls to Action by the Truth and Reconciliation

## AUTHOR NOTES

Carolyn Roberts, First Nations, Inuit, Métis Nurse Navigator, Indigenous Cancer Program, The Ottawa Hospital – General Campus, Ottawa, ON K1H 8L6

[caroberts@toh.ca](mailto:caroberts@toh.ca)

DOI:10.5737/2368807634149

Committee are met, and we can unite and live in a Canada without the current huge inequities.

July 2023 marks the one-year anniversary of the satellite oncology clinic on Baffin Island, Nunavut. The clinic is predated by years of relationship building heavily supported by medical oncologist Dr. Tim Asmis, and resulting from continuous collaborations between Dr. Marc Gaudet and the Government of Nunavut Qikiqtani General Hospital (QGH). It is the first-ever such clinic in the territory. The original visiting oncology team consists of Dr. Marc Gaudet, Dr. Gad Perry, and me. This article is the story of the design and opening of this clinic, something I only dreamed of in the beginning.

In April 2016, I accepted the position of Indigenous Nurse Navigator for the Aboriginal (now Indigenous) Cancer Program at The Ottawa Hospital. The Indigenous Cancer Program (ICP) is part of Indigenous Cancer Care Unit of Ontario Health, formerly known as Cancer Care Ontario. Every Local Health Integration Network (LHIN) in Ontario has an Indigenous Cancer Program consisting of a navigator, coordinator manager, and regional lead (predominantly a physician). Our small Indigenous Cancer Program (ICP) officially consists of:

Treena Greene, MD, CCFP, FCFP, Regional Indigenous Cancer Lead

Carolyn Roberts, First Nations, Inuit and Métis Patient Nurse Navigator

Gwen Barton, Manager, Indigenous Cancer Program  
Mackenzie Daybutch, Indigenous Cancer Program Coordinator.

Our program supports all First Nations, Inuit and Métis (FNIM) oncology patients and caregivers in the region. However, the needs of the Baffin Island Inuit are the focus of this manuscript.

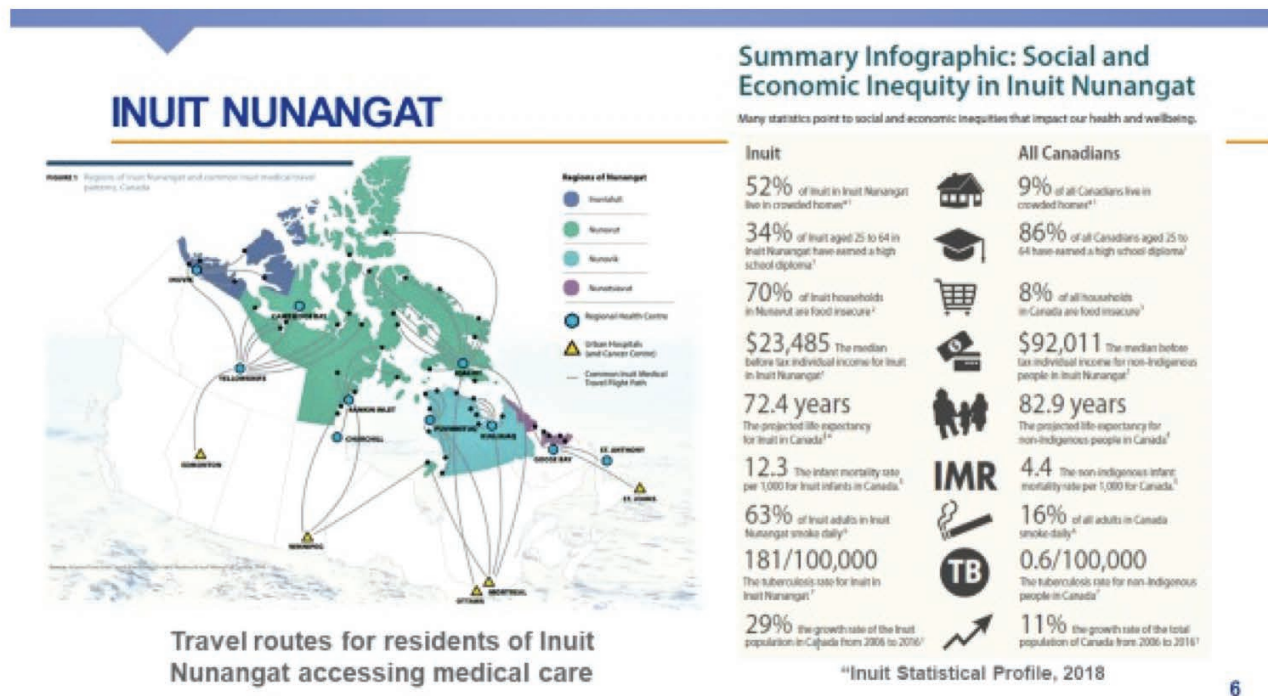
## Photo 1

*New Addition of Qikiqtani General Hospital. Photo by Carolyn Roberts*



Figure 1

Infographic for Inuit Nunangat



## ISSUES FOR BAFFIN ISLAND INUIT FACING CANCER

Historically, there was no Inuktitut word for cancer. When it was created, the Inuktitut word *aaqigunnangituq annia* meant “the disease with no cure.” A cancer diagnosis is arguably one of the most feared diseases. The Inuktitut language reflects this fear.

There are shocking inequities within Canada’s Inuit Nunangat (ITK, 2021; TI, 2017-2018; see Figure 1). Seventy percent of population are food insecure compared to eight percent of mainstream Canada. Annual incomes for Inuit are one quarter of the incomes for non-Inuit. More than half the population live in overcrowded homes with waitlists for housing that can be decades in some communities (CBC News, 2022, 3:24). This is a direct correlation to TB rates being 300 times the national average. This population of 65,000 has the highest lung cancer rates in the world (Lenihan, 2018).

Once diagnosed, the residents of the north endure the extra burden of travel (see map in Figure 1). Separation from family, community, culture, and language has immeasurable impact. Presumably this may contribute to why it is estimated that up to 30% of cancer patients referred to Ottawa might refuse to travel for treatment (Asmis, 2015).

Nunavut has a chronic status of being short staffed, which was increased by the pandemic. It is not unusual for health-care centres to be open for emergencies only (Nunatsiaqnews, 2022). This accentuates an already challenging screening program. Throughout my seven years in this role, I have observed it is not uncommon for patients to be diagnosed at a late stage of disease and, sadly, without treatment options except

end-of-life care. Patients and family members have shared that the health centre turned them away many times, saying their situation was not an emergency.

Baffin Island is a vast land with eight coastal communities. The residents are required to medevac to Iqaluit QGH for x-rays, CT scans, and to be assessed by a physician. In the coastal communities, each community health centre is staffed with nurses and a visiting doctor who may or may not stay the week.

These inequities shone a light on why this role of Indigenous Nurse Navigator had to be unconventional.

## MY BACKGROUND LEARNING

My now 26-year nursing career consists of rural outpost nursing. From 1999 through to 2016, I held full-time and casual positions in northern communities. In 2009, our family returned to Ottawa where I accepted a part-time position in the emergency room (ER) at the Children’s Hospital of Eastern Ontario. Missing the independence of remote nursing, I quickly changed to a casual ER position, so I could accept contacts in northern Cree and Inuit communities.

Those years of nursing gave me insight into the challenges and resiliency of Indigenous communities. It also gave me a personal awakening into my ignorance of FNIM history and communities. As a non-Indigenous person, I was aware of residential schools and some of the atrocities. I was shocked to learn that the last residential school in Canada closed in 1996, and was horrified to learn of children that just disappeared.

I met my first residential school survivor in the community of Mistissini. She was a co-worker. The encounter was one I

will never ever forget. I could not believe what this woman in front of me had experienced in grade school, in high school... I sobbed. She consoled me. I am ashamed to say that, but she did. This remarkable woman consoled me for sharing her life experiences and the experiences of her schoolmates, communities, and People. She consoled my shock and horror. If ever I could retract the words, I would retract asking, 'Why did your parents let you go?' I cringe just writing that. I cannot believe how hurtful, stupid, idiotic, ignorant that was... talk about white privilege.

She explained and I apologized for not knowing, sorry for what happened, for asking more questions. We are alone for hours in a clinic trailer. Appointments were cancelled because of the weather. That afternoon changed the course of not only my career, but my life. I will never ever forget how we ended the conversation. She ended with how some families in the community of the residential school were so nice to them. Bringing them clothes, especially in the winter, cookies, and every Easter these families brought them Easter treats. She ended with positivity. Respect for her is an understatement. It is hard to find the words to express the influence she had on me. How she shared horrific events in her past, and ongoing issues in her family that we now know as intergenerational trauma. In 2009, I certainly had never heard that term. Whenever I meet someone from Mistissini, I always ask if they know her, "How is she?" I think of her often.

Those rural outpost days in Indigenous communities, with the relationships, the friendships, helped foster a keen ear, and a determination for change, to improve care and, consequently, gain a reputation of being 'pushy'!

## HOW THE SPECIFIC TOH ROLE OF INDIGENOUS NURSE NAVIGATOR CAME TO BE

Building the program and the role of Indigenous Nurse Navigator had to overcome a number of obstacles and challenges.

### Obstacle 1

The first obstacle was: How are we going to build the program? Being the first Indigenous Nurse Navigator in the ICP, it was really an empty canvas about how to move forward. Or so I thought.

I quickly discovered that the expectation from patients, family, staff, administration and community partners was that I would be part of the '9 to 5' staff who circulated throughout the hospital to assist Indigenous patients: attending appointments, being present on inpatient units during rounds, submitting NIHB claims. Essentially, I was to be engaged in case management. Albeit an impossible task, given I am the only FNIM Nurse Navigator not just within TOH, but regionally (formally the known as Champlain LHNN). It was unattainable. I have to be clear with all patients/providers that I cannot commit to routinely being present for appointments/all rounds for that reason, otherwise it may fracture the relationship building. With the exception of NIHB claims, I have spent countless hours through the years in building relationships

– collaborating with multidisciplinary teams, advocating, and every day assessing the triage of needs.

However, this type of activity was not how I completely envisioned the role, although it could have gone solely in that conventional direction. I was not going to have the position of Indigenous Nurse Navigator, wear a white labcoat, as per TOH policy, and be similar to current hospital positions. That was the expectation being I am a nurse. Why have that position and be similar to everyone else? With the support of my manager, Gwen Barton, I firmly stood my ground with what is now my 'elevator pitch.'

I am 100% patient centred. I do not replace any service that currently exists. I am not a case manager, social worker, nor affiliated with NIHB. I compliment these positions if need be. I try to support what the patients and family say their needs are, not what the provider says is needed.

Being the only Indigenous Program front-line worker in all of TOH's approximately 15,000 employees, and designated solely for cancer, my rebuttal for opposition was:

*There are Indigenous patients throughout the many departments of TOH without navigators – who fills out their forms? Assists with case management? Why would all services for an Indigenous cancer patient fall to me, and other departments not have the same Indigenous service? Social workers in cancer centre and on units already exist. All patients coming from Nunavut have case managers through Ontario Health Services Network Inc. If case management is needed with Indigenous patients outside of Nunavut, I assist in obtaining a case manager, not be one. That's navigation.*

"Then what do you do?"

### Obstacle 2

My chief objective with all patients and families is to establish a trusting relationship. Trust comes with actions not just words. There have been centuries of horrific mistreatment of FNIM. The Truth and Reconciliation Report (National Centre for Truth and Reconciliation, 2015) highlighted these undisputable truths. We hear over and over in meeting after meeting that we need to regain the trust of our Indigenous peoples. For me in this role, the answer was simple.

Listen, then act on what the patients says their needs are. The obstacle? Acting outside of the confines of the hospital infrastructure.

### Obstacle 3

As healthcare providers, the consensus very likely would be, "Of course. This is what we do." But is it?

Until COVID, there was no form of cancer care in the Baffin Island sector of Nunavut. Telephone consultation had not been common practice and only became routine during the pandemic. At The Ottawa Hospital (TOH), being the tertiary care centre, oncologists physically assessed all Baffin Island residents on one of the three hospital campuses. In order to receive any form of cancer diagnosis, plan, and treatment, patients and their escorts have been required to stay in Ottawa. The common initial cancer investigation is to arrive for MRI and biopsy, remain in Ottawa for results, meet with an oncologist and review

options/plans, then begin treatment. The duration is weeks and months away from family, community, language, culture and employment. Empathically this is an emotionally burden that southern Canadians do not bear to access cancer care. The mental health impact is significant. Care providers at TOH knew/know this, but what actions were implemented to help ease this emotional pain? The colonial standard. Referral to social worker or spiritual care. Both departments had very little knowledge or experience in Inuit culture, and no experience living or working in Inuit communities.

Fear. Diagnosed with *aaqitaugunangituaq aania* disease with no cure. Feeling homesick, lonesome, bored, financial stress, lost, and disconnected were, and continue to be, the substance in recurring conversations I have with patients/families from Nunavut and out of town. How can that be ignored?

### The Ottawa Hospital Vision

*To provide each patient with the world-class care, exceptional service, and compassion we would want for our loved ones.*

Providing positive experiences and improved mental health is a goal of quality of care. Reminding coworkers and superiors of the TOH Vision came in handy to influence the approaches to care and support of individuals from Nunavut.

Living in an urban environment, it can be rather easy to take for granted our independence and mobility. Being from a small remote town of St. Pauls River, Quebec, I could easily relate to feelings of being lost, disconnected, and homesick in an urban environment. Positive experiences were what patients were indirectly saying they needed.

Whenever possible, I take patients and families away from the hospital setting. I try to take them to an environment of nature in the community, giving a sense of where their feet are on the ground. One of my saddest encounters in this role was an interaction with an Inuk man who was admitted to the hospital and facing the end of his life asking me which way was north. It was the only words he ever said to me.

There are no trees in Nunavut. The landscape is dramatically different from what we see around Ottawa. Yet, driving to the Gatineau Park along the Ottawa River, and spending time near Ottawa's landmarks immensely assisted in developing trusting relationships. Implementing actions to meet the needs shared by patients is crucial to truly be an advocate, an ally, or trusted healthcare provider. Barriers can be eased. Staying within the walls of an infrastructure to maintain a professional relationship is a colonial standard, or expectation. We are an Indigenous program and must repeatedly emphasize that our program is not Indigenous in title only. But what was our model of care?

## APPLYING THE SUPPORTIVE CARE FRAMEWORK

Thanks to a colleague, Lynn Kachuik, who shared the *Supportive Care Framework* (Fitch, 2008) with me, and seeing how it was applicable to my position was a 'game changer.' Gwen and I 'ran with it.' Administration had an 'aha moment.' The fog lifted and their understanding about what we were trying to do cleared. Our approach began to be accepted.

First Nations, Métis and Inuit communities may differ in culture, land mass and lifestyle, but what unites them is their shared connection to the land. Both presently and historically, they use resources provided by nature to prosper, grow, heal, and find comfort. Keeping the *Supportive Care Framework* in mind, the approach we developed is aimed at meeting the non-clinical needs of the patients while, at the same time, complementing the care being received from the cancer care staff. What better way to strengthen this connection than being outside of the hospital in a setting of nature where Indigenous patients are most comfortable.

**Table 1**

*Our unofficial team has many champions. It takes a team of devoted providers to build systemic change. Here are examples of comments made by some of our champions.*

"Providing cancer care closer to home for residents of Nunavut should not be considered extraordinary; rather, it is a component of the minimal requirements necessary to provide the kind of care that the rest of Canadians take for granted."

– Garth Nicholas, MD, MSc, Medical Oncologist, The Ottawa Hospital; Associate Professor, University of Ottawa

"The emotional, social, and practical burden on patients traveling from Nunavut for cancer care is immense. Through relationship building and interjurisdictional and interprofessional collaboration, we have been able to offer a few injectable cancer treatments in the territory. Though we encountered many hurdles, the success of these initiatives has opened the door for more treatments and collaboration to follow. Even though there is a long road ahead, we are all in and committed to doing better for our patients."

– Jen Newton (she/her), RN, BScN, MEd, CON(C), Nurse Educator, Cancer Program, The Ottawa Hospital

"As an Indigenous person, providing care closer to home, closer to your community and culture has such a profound impact on improving one's physical, mental, emotional, and spiritual health. As our Elders say, all four components of one's medicine wheel (physical, mental, emotional and spiritual) need to be in balance to live a good life."

– Mackenzie Daybutch, Indigenous Cancer Program Coordinator

"Our goal is to ensure we are providing a culturally safe care environment. How can we do this? By listening and learning from our Indigenous patients and their families, and being respectful of their culture, traditions, and way of life."

– Gwen Barton, Manager, Indigenous Cancer Program

"Inuit connection to the land is deeply rooted in both the past and present. As a physician, I learned quite quickly to honour this connection – take the time to see our similarities and our differences. It will form a much stronger relationship and be fulfilling for both patient and provider."

– Treena Greene, MD, FRCPC, Indigenous Regional Lead

"Collaborating with the Inuit community to break barriers and build a better Nunavut Cancer Care is a journey we strive to improve every day."

– Tim Asmis, MD FRCPC, Medical Oncologist, The Ottawa Hospital; Associate Professor and Fellowship Director, University of Ottawa



Over seven years and through a global pandemic, our program has grown (see Figures 2 and 3). What was once considered a radical approach (i.e., taking patients away from hospital, providing positive mental health experiences to build a trusting relationship) is now recognized as the foundation of

the role. Even though Nunavut has a population of 65,000, it is not uncommon that new patients know of the ICP support through word of mouth, as well as working with other family/community members. This has resulted in new patient connections being eased resulting from the trust earned.

**Figure 2**

*Metrics display an increase in patient and family encounters when a wholistic care model implemented*

## USING A PATIENT - CENTERED APPROACH “SUPPORTIVE CARE FRAMEWORK”

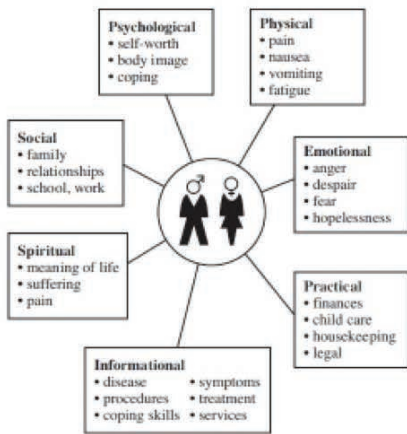
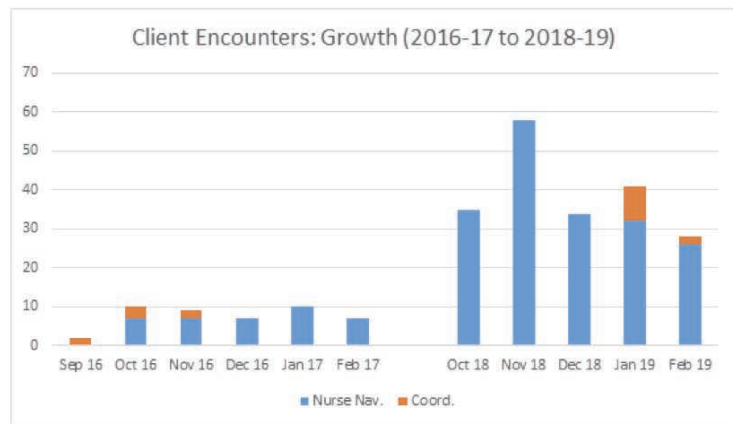


Figure Two. Examples of needs of individuals living with cancer

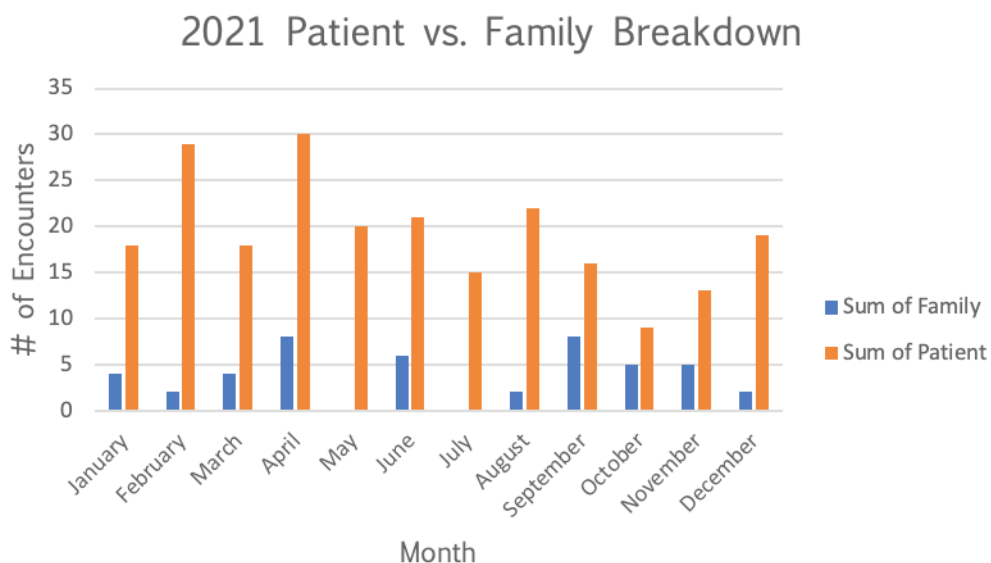
Fitch, 2008



Source: Champlain Regional Indigenous Cancer Program

**Figure 3**

*Metrics for number of encounters with patients and family members*



What we hope for in the future is a corporate-wide Indigenous program. The Wabano report, 'Indigenous-Specific Racism in Healthcare Across the Champlain Region' (2022), highlighted the high needs areas of all hospitals where Indigenous people face the most conflict with providers: emergency rooms, birthing units, and psychiatric wards. Indigenous Navigators would certainly have the potential to improve the healthcare experience of Indigenous people. What I hope is an initial step towards this direction is that TOH and Health Canada have signed a contract for a Health Canada-funded emergency room position at TOH Civic campus to better support Inuit patients seeking care. A pilot. Our team is anxiously awaiting more information.

Oncologist Dr. Tim Asmis has been identifying distinct cancer rates and outcomes of Baffin Island Inuit since 2010. In 2015 he reported the significantly higher cancer rates in the territory and the observation that 30% of patients declined treatment after being diagnosed. He has been the leader in building the relationship between TOH Oncology Department and Qikiqitani General Hospital core medical provider team. Dr. Asmis and Gwen Barton have been the driving force in organizing four onsite oncology team visits to Baffin Island, as well as supporting two QGH team visits to Ottawa. Additionally, in May 2023, he and Gwen Barton were the principal organizers in the Inaugural National Oncology Conference in Iqaluit, Nunavut. This groundbreaking conference was attended by more than 70 healthcare providers from across Canada. The impact of providers being in Nunavut, seeing the territory, experiencing the Inuit culture, engaging with the local community... has increased awareness of the Inuit-specific oncology needs tenfold. Our team has been contacted by numerous attendees offering continued collaboration/support.

## JULY 2022: FIRST SATELLITE ONCOLOGY CLINIC IN THE TERRITORY

In July of 2022, the first Satellite Oncology Clinic in the Territory was opened. This satellite oncology clinic is truly the highlight of my nursing career. To be able to see patients on their own land, in their culture and language is immeasurable. It's incredibly rewarding to see how the ICP has grown and gained the respect of colleagues, multidisciplinary teams. I feel beyond grateful to Dr. Marc Gaudet and Dr. Gad Perry for including me as a part of the Nunavut Oncology Clinic, as well as to my manager Gwen Barton and Director Julie Renaud for being fully supportive that this participation will be part of my role.

The clinic does not offer what we usually think about when we hear 'cancer clinic', such as chemotherapy infusions and radiation therapy. The Nunavut Oncology Clinic occurs approximately every eight weeks to provide follow-up care, new patient consultations, assist the local physicians in the work-up of patients suspicious for cancer, and home care visits. All of which is supported with specialized navigational nursing contribution.

Before July 2022, all patients had to travel to Ottawa for all follow-up appointments after treatment, staying at the Larga Baffin, a boarding house accommodation. These trips often

## Photo 2

*Northern Lights above Iqaluit, Nunavut. Photo by Carolyn Roberts*



involve many days, and sometimes weeks, due to weather or no availability on flights. For example, this month one of our patients from a more northern community of Nunavut spent 13 days in Iqaluit due to weather and no seat availability on a flight to her hometown. This was 13 days after a six-day stay in Ottawa. To not have to travel to Ottawa, now that the satellite clinic is open, can be immeasurable.

The relationships between Dr. Gaudet and Dr. Perry and the patients they see are notably different than how the relationships were experienced in Ottawa. Both oncologists have repeatedly stated how much more engaged the patients are when at home in the north, sharing more about their family, successful hunting trips, or social issues they may be facing. Essentially, there is a sense of a more trusting relationship being built.

Home visits by an oncologist are relatively unheard of in Ottawa. However, they are part of the Nunavut daily schedule and reflect what the community expected. It is not about bringing the ways of providing the southern standard of care to Nunavut, but our team adapting to the needs and expectations of the community when safe to do so.

The oncology team has fostered relationships with the QGH staff and community members. Staff consult with our team and benefit from on-site learning through the expertise of Dr. Gaudet and Dr. Perry. However, the oncology team also learns from our northern colleagues. Ongoing educational exchange is part of the team's mandate.

Since September 2022, immunotherapy infusions are now taking place on a case-by-case basis. They occur both in QGH and the community health centres because of the dedicated collaborations between QGH and TOH Cancer Centre. It is the hope and goal of all staff involved to increase accessibility in the territory and see the Satellite Oncology Program continue to grow. Another two oncologists joined in the fall of 2023. In May 2023, we had a clinic in Pond Inlet, reflecting that providing care in the far north of Nunavut is also possible and a response to the need, given the burden of travel within the territory.

*“From the outside looking in, the numbers of patients seen by our oncology team in Nunavut might seem small. However, the more important piece of this story is the significant impact that this initiative can have on individuals and their families who are able to receive care closer to home with a team who understands and respects the cultural, historical, social, and geographical realities and challenges that Nunavummiut face regarding cancer care.”*

*– Marc Gaudet, MD, MSc, MHA, FRCPC  
Head, Division of Radiation Oncology, The Ottawa  
Hospital*

*“There are so many good reasons to bring cancer care closer to home for Nunavumiut, and so few not to.”*

*– Gad Perry, MD, FRCPC*

## ONGOING FRUSTRATIONS WITH SYSTEMATIC BARRIERS

In a perfect world, all patients would follow a straightforward path from illness to treatment, and to recovery. Unfortunately, that is not the world in which we live. Challenges still remain.

As previously stated, Baffin Island’s Inuit patients and caregivers stay at Larga Baffin when they come to Ottawa for medical appointments. Larga Baffin is a boarding home facility that provides accommodation, food and transportation from/to airport and all medical appointments. Every patient has an oncology case manager from a separate non-profit company, Ontario Health Services Network Inc. (OHSNI). In addition to case manager services, they provide all Inuktituk interpretation/translation services when needed during medical appointments.

In my seven years in the role of FNIM Nurse Navigator, I continue to learn and, yet, be baffled by the complexities of the regulations and qualifications of the Medical Travel Department and the Government of Nunavut (GN). I have seen numerous examples where patients face challenges as a result of these policies; but, for the purpose of this article, I will share only my experiences with my most memorable patients and their caregivers who do not fit into the straightforward path.

### Photo 3

*Northern Lights. Photo by Carolyn Roberts*



### Photo 4

*Northern Lights above Iqaluit, Nunavut. Photo by Carolyn Roberts*



As an example, Larga Baffin has policies that must be followed. If these are not followed, it will result in an eviction from the premises. One of these policies is zero tolerance for alcohol. When a patient is evicted for alcohol consumption, the caregiver has the choice to leave with the patient or stay at Larga Baffin and be returned on the next available flight to Nunavut.

It is this type of patient that ‘falls through the cracks.’ Few, if any, patients have credit cards and they cannot obtain lodging independently without a valid credit card. If evicted on a Friday outside of business hours, the situation is worse. If the hotel where they are residing evicts them outside of business hours, who do they call?

Medical Travel will provide lodging at specific hotels in Ottawa and, from what I can gather, these hotels have an agreement with the Government of Nunavut. Some hotels provide three meals a day at an on-site restaurant, some provide only breakfast, and some offer no food assistance at all. On too many occasions, I have received calls from patients who have no food and have not eaten in two to three days, or have not received taxi vouchers in time to get to their medical appointments.

Remembering the statistic of 70% food insecurity, the first gentlemen I assisted in this situation was on day three following an eviction. I was shocked that a patient from Nunavut in our care, with seemingly great support on a systemic level, was days without food. In response to my dismay, he responded, ‘It was only two days.’ In such cases, our program has repeatedly filled the gap, but it is a band-aid solution.

Another type of challenge occurs when a patient is a GN employee or beneficiary and is not staying at Larga Baffin. The costs they incur are expected to be reimbursed. However, the individuals have low median incomes, low employment rates, and are facing high food prices and overcrowded housing. In my experience throughout my nursing career, I have observed

that when a family/household member is employed, that person could be feeding more than a dozen people. There is little money, if any, to pay upfront and wait weeks for reimbursement. Yet, waiting for reimbursement is often a lengthy process for these individuals. There is a *Hardship Allowance* for emergency funding, but again, it can be a lengthy process to initiate even with advocacy.

Our team is advocating for change, sending numerous emails, requesting meetings with involved parties to identify gaps in the system, and hopefully working to conceptualize improvements. We need to have policies reviewed, updated, and harmonized to fit the needs of patients who are away from home for healthcare in an unfamiliar environment, and ways need to be organized for individuals to have timely assistance with basic needs (e.g., food security) regardless of the day of the week.

## CONCLUDING REMARKS

Being the original front-line healthcare professional, shaping a new program, it is essential to be a strong, well-informed,

empathic advocate. It's comparatively easy to advocate for patients who fit into straightforward pathways, but it is those who fall through the cracks of the system that need you most. They are, I believe, the most vulnerable. They are complex patients who may have a history of intergenerational trauma, untreated or undiagnosed mental illness, or addictions. They may require unconventional assistance from us, as healthcare providers. I believe we all need to be asking ourselves, 'Have the conventional methods worked? What is the outcome if I do nothing? Does what we are doing reflect the values and mission statement of our institution? My own conscience?'

To have programs such as Indigenous Cancer Care is to encompass Indigenous: First Nations, Inuit, Métis and the Urban Indigenous. Encompass their strengths, cultures, teachings, history and what they say their needs are. This, I believe, will need increased unconventional healthcare interactions. Systemic adaptations and changes to healthcare systems that have been in place for decades need revisions with commitments on delivering Truth and Reconciliation Commission Calls to Action in Health 18-24.

## REFERENCES

- Amnesty International. (2023). *Universal Declaration of Human Rights*. <https://www.amnesty.ca/what-you-can-do/youth/start-up-kit/universal-declaration-of-human-rights/>
- Fitch, M. (2008). Supportive care framework. *Canadian Oncology Nursing Journal/Revue canadienne de soins infirmiers en oncologie*, 18(1), 6-14. Pappin Communications.
- Inuit Tapiriit Kanatami. (2018). *Inuit Statistical Profile 2018*. <https://www.itk.ca/wp-content/uploads/2018/08/Inuit-Statistical-Profile.pdf>
- Inuit Tapiriit Kanatami. (2021). *2020-2021 Annual Report*. <https://www.itk.ca/wp-content/uploads/2021/09/20210915-ITK-Annual-Report-EN-final.pdf>
- Lenihan, D. (2018). Stronger voices, better care: Serving the People of Nunavut. *The Ottawa Hospital's New Campus Series: Volume 2*. <https://www.linkedin.com/pulse/engagement-our-latest-ottawa-hospitals-new-campus-series-lenihan/>
- Lochead, D. (2022, June 13). 11 community health centres to shut down this summer. *Nunatsiaq News*. <https://nunatsiaq.com/stories/article/11-community-health-centres-to-shut-down-this->
- MacDonald-Dupuis, N. (2015, Aug. 28). *Some Inuit may be refusing cancer treatment*. CBC News.
- Truth & Reconciliation Commission of Canada. (2015). *Canada's Residential Schools-Missing Children and Unmarked Burials: The Final Report of the Truth and Reconciliation Commission of Canada* (Vol. 4). McGill-Queen's Press-MQUP. <https://www.cbc.ca/news/canada/north/lori-idlout-housing-qp-1.6396607>
- Tungasuvvingat Inuit. (2018). *17/18 Tungasuvvingat Inuit Annual Report*. <https://tiontario.ca/wp-content/uploads/2020/11/2017-2018-Annual-Report-English.pdf>
- United Nations. (2018). *Universal Declaration of Human Rights at 70: 30 Articles on 30 Articles - Article 25*. <https://www.ohchr.org/en/press-releases/2018/12/universal-declaration-human-rights-70-30-articles-30-articles-article-25>
- Wabano Centre for Aboriginal Health in Partnership with the Ottawa Aboriginal Coalition. (2022). *Share Your Story*. <https://wabano.com/wp-content/uploads/2022/05/ShareYourStory-FullReport-EN.pdf>

# Lever les barrières : du rôle de l’infirmière pivot pour les Autochtones dans les soins oncologiques aux Inuits

Par Carolyn Roberts

## RÉSUMÉ

Les personnes qui reçoivent un diagnostic de cancer dans le nord du Canada doivent relever de nombreux défis particuliers. Pour accéder à des soins oncologiques, elles doivent généralement se rendre dans un centre de cancérologie situé dans le sud du pays et séjourner dans une ville loin de leur famille, de leur communauté, de leur langue et de leur culture. Le Programme de cancérologie pour les Autochtones de l’Hôpital d’Ottawa a été créé pour aider ces personnes à s’orienter dans un système de soins oncologiques complexe et peu familier. L’infirmière pivot auprès des Premières Nations, des Inuits et des Métis (PNIM) a pour mission de collaborer avec ces patients et de mettre au point des stratégies d’aide répondant à leurs besoins. Une clinique satellite d’oncologie a récemment été ouverte sur l’île de Baffin, dans le Nunavut, où les patients peuvent être évalués, recevoir un traitement d’immunothérapie anticancéreuse si nécessaire et être suivis après leur traitement primaire. L’ouverture de cette clinique en région éloignée permet aux patients atteints d’un cancer de réduire leurs déplacements et d’éviter de longs séjours loin de chez eux. On espère que ce type de soins pourra être étendu ailleurs au Canada.

## INTRODUCTION

Je tiens à commencer ce manuscrit par une reconnaissance du territoire. J’habite et je travaille actuellement dans la région de l’Outaouais qui est la terre ancestrale des peuples algonquins Anishinaabe. Je tiens à saluer les Premières Nations, les Inuits, les Métis et les Autochtones urbains qui vivent et travaillent sur ce territoire algonquin non cédé. Mon village natal de Rivière-Saint-Paul, au Québec, est situé sur les terres ancestrales des peuples inuits et innus.

Il est important pour moi de commencer par une reconnaissance du territoire afin de témoigner respectueusement de l’histoire, des contributions et des sacrifices des Premières Nations sur ce qui constitue aujourd’hui ma terre d’origine, ma communauté et mon pays. L’histoire est ineffaçable, mais je crois sincèrement qu’il est de la responsabilité de chaque habitant du Canada de connaître notre passé colonial, de savoir que le terme « autochtone » fait référence à des peuples distincts et de reconnaître respectueusement l’histoire et la culture uniques de chaque peuple autochtone, qui imprègnent tous

## AUTEURE

Carolyn Roberts, Infirmière pivot auprès des Premières Nations, des Inuits et des Métis, Indigenous Cancer Program, The Ottawa Hospital – General Campus, Ottawa, ON K1H 8L6

[caroberts@toh.ca](mailto:caroberts@toh.ca)

DOI:10.5737/2368807634157

les lieux où nous posons les pieds dans ce pays si vaste et diversifié. Il faudrait vraiment que chaque établissement de soins ait une formation obligatoire sur les soins respectueux des cultures. Pour œuvrer en faveur de la réconciliation, je m’engage à poursuivre mon apprentissage, à accepter les vérités difficiles de notre passé colonial et, grâce à cette connaissance, à dissiper les nombreuses contre-vérités que je rencontre continuellement ainsi qu’à encourager mes concitoyens à plaider en faveur du changement jusqu’à ce que les 94 appels à l’action du Comité pour la vérité et la réconciliation soient exaucés et que nous puissions unir nos forces pour vivre dans un Canada délesté des immenses inégalités actuelles.

Le mois de juillet 2023 marque le premier anniversaire de la clinique d’oncologie satellite sur l’île de Baffin, dans le Nunavut. Cette clinique est le fruit d’années d’efforts persistants d’établissement de relations par le Dr Tim Asmis, oncologue médical, et de collaborations continues entre le Dr Marc Gaudet et l’Hôpital général Qikiqtani (HGQ) du gouvernement du Nunavut. C’est la première clinique de ce type sur ce territoire. La première équipe d’oncologie en visite était composée du Dr Marc Gaudet, du Dr Gad Perry et de moi-même. Cet article raconte les péripéties de la conception et de l’ouverture de cette clinique, dont j’osais à peine rêver à l’origine.

En avril 2016, j’ai accepté le poste d’infirmière pivot pour les Autochtones au sein du Programme de cancérologie pour les Autochtones (PCA) à l’Hôpital d’Ottawa. Ce programme fait partie de l’Unité des soins de cancérologie chez les peuples autochtones de Santé Ontario, anciennement connu sous le nom d’Action Cancer Ontario. Chaque réseau local d’intégration des services de santé (RLISS) de l’Ontario dispose d’un Programme de cancérologie pour les Autochtones composé

## Photo 1

Agrandissement de l’Hôpital général Qikiqtani. Photo par Carolyn Roberts



d'une infirmière pivot, d'une coordonnatrice et d'un responsable régional (généralement un médecin). Notre petit Programme de cancérologie pour les Autochtones (PCA) est officiellement composé de :

- D<sup>r</sup> Treena Greene, MD, CCMF, FCMF, responsable régionale des services de cancérologie pour les Autochtones
- Carolyn Roberts, infirmière pivot auprès des Premières Nations, des Inuits et des Métis
- Gwen Barton, directrice du Programme de cancérologie pour les Autochtones
- Mackenzie Daybutch, coordonnatrice du Programme de cancérologie pour les Autochtones

Notre programme dessert tous les patients en oncologie des PNIM (Premières Nations, Inuits et Métis) ainsi que les aidants naturels de la région, mais les besoins des Inuits de l'île de Baffin sont au cœur de ce manuscrit.

## PROBLÈMES PROPRES AUX INUITS DE L'ÎLE DE BAFFIN AUX PRISES AVEC LE CANCER

Jusqu'à l'ère moderne, il n'existait pas de mot en inuktitut pour désigner le cancer. À l'origine, le mot inuktitut *aaqigun-nangituq annia* signifiait « la maladie incurable ». Le cancer est sans doute l'une des maladies les plus redoutées. La langue inuktitute a bien illustré cette crainte.

La partie canadienne de l'Inuit Nunangat (ITK 2021; TI, 2018; voir la figure 1) est marquée par des inégalités choquantes. 70 % de la population est en situation d'insécurité alimentaire, contre 8 % dans l'ensemble du Canada. Le revenu annuel des Inuits est quatre fois moins élevé que celui

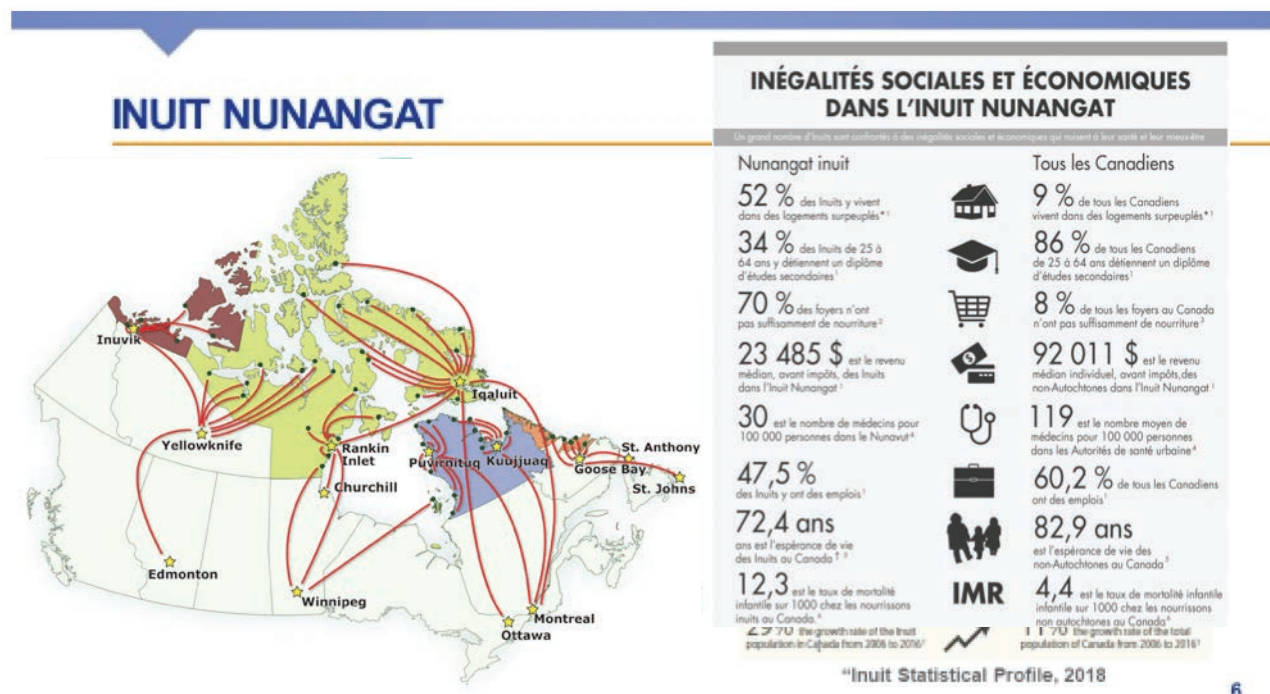
des non-Inuits. Plus de la moitié de la population de l'Inuit Nunangat vit dans des logements surpeuplés et, dans certaines collectivités, les listes d'attente pour un logement sont si longues qu'il faut attendre des décennies avant qu'un logement se libère (CBC News, 2022, 3:24). On observe une corrélation directe avec le taux de tuberculose qui est 300 fois supérieur à la moyenne nationale. L'Inuit Nunangat, dont la population compte quelque 65 000 personnes, présente le taux de cancer du poumon le plus élevé au monde (Lenihan, 2018).

Les habitants du Nord qui obtiennent un diagnostic de cancer se heurtent à de lourdes obligations de déplacement pour recevoir des traitements (voir la carte de la figure 1) et se retrouvent notamment séparés de leur famille, de leur communauté, de leur culture et de leur langue, ce qui a des conséquences incommensurables. On peut supposer que ce facteur contribue à expliquer pourquoi jusqu'à 30 % des patients qui sont aiguillés vers Ottawa refusent de se déplacer pour y recevoir des soins (Asmis, 2015).

Le Nunavut souffre d'un manque chronique de personnel qui a été aggravé par la pandémie. Il n'est pas rare que des centres de santé soient ouverts uniquement pour les urgences (Nunatsiaqnews, 2022), ce qui accentue les difficultés liées au dépistage. Au cours de mes sept années en tant qu'infirmière pivot, j'ai vu trop de patients diagnostiqués très tard, à un stade avancé de la maladie, n'ayant malheureusement plus d'autre possibilité de traitement que les soins de fin de vie. Plusieurs de ces patients et des membres de leur famille ont raconté que leur centre de santé les avait refoulés à maintes reprises parce que leur cas ne correspondait pas à leur définition d'une urgence.

Figure 1

Infographie de l'Inuit Nunangat



L'île de Baffin est un vaste territoire où vivent huit collectivités côtières. Les résidents sont transportés vers l'Hôpital général Qikiqtani d'Iqaluit lorsqu'ils doivent être évalués par un médecin ou passer des radiographies et des tomodensitogrammes. Dans les collectivités côtières, les centres de santé communautaires sont dirigés par une infirmière périodiquement épaulée par un médecin itinérant qui reste souvent moins d'une semaine.

Ces inégalités mettent en lumière les raisons pour lesquelles le travail de l'infirmière pivot pour les Autochtones se doit de déroger du cadre dans lequel les soins sont habituellement prodigués.

## MON APPRENTISSAGE DE BASE

Ma carrière d'infirmière, qui dure maintenant depuis 26 ans, a été en majeure partie consacrée aux soins en milieu rural. De 1999 à 2016, j'ai occupé des postes à temps plein et occasionnels dans divers villages nordiques. En 2009, notre famille est retournée à Ottawa, où j'ai accepté un poste à temps partiel aux urgences du Centre hospitalier pour enfants de l'est de l'Ontario. Comme j'étais désireuse de retrouver l'indépendance dont je jouissais en région éloignée, je suis rapidement passée à un poste occasionnel aux urgences afin de pouvoir accepter des contrats dans les communautés criées et inuites du Nord.

Mes années de carrière en tant qu'infirmière m'ont permis de mieux connaître les défis des communautés autochtones et de voir leur résilience. Elles m'ont également fait prendre conscience de mon ignorance de l'histoire des PNIM et de leurs communautés. En tant que non-Autochtone, j'étais au courant de l'existence des pensionnats et de certaines des atrocités qui y ont été commises. J'ai cependant été choquée d'apprendre que le dernier pensionnat pour Autochtones au Canada avait fermé ses portes en 1996 et j'ai été horrifiée d'apprendre que tant d'enfants avaient tout simplement disparu.

Ma compréhension des pensionnats est toutefois demeurée plutôt abstraite jusqu'à ce que je rencontre une première personne y ayant survécu, dans la collectivité de Mistissini : une collègue. Je n'oublierai jamais cette rencontre. Je n'arrivais pas à croire ce que cette femme devant moi avait vécu à l'école primaire, puis à l'école secondaire... Je sanglotais. Elle m'a consolée. J'ai honte de le dire, mais c'est pourtant ce qu'elle a fait. Cette femme remarquable m'a consolée après m'avoir révélé ses expériences de vie, celles de ses camarades de classe et celles de l'ensemble des communautés autochtones. Elle a pansé les plaies de mes émotions brutales et de mon horreur. Je regrette de lui avoir demandé : « Pourquoi tes parents t'ont-ils laissé partir? ». Le simple fait d'écrire ces mots me donne des frissons. Je n'arrive pas à croire à quel point ces propos étaient blessants, stupides, idiots et ignorants... On pourrait parler des privilèges des Blancs.

Elle m'a expliqué et je me suis montrée désolée de ne pas savoir, de ce qui s'était passé, d'avoir encore d'autres questions à lui poser. Nous avons passé des heures seule à seule dans une roulotte de soins. Les rendez-vous avaient été annulés en raison du mauvais temps. Ces quelques heures ont changé

non seulement le cours de ma carrière, mais aussi celui de ma vie. Je n'oublierai jamais que ma collègue a conclu la conversation sur une note positive, en soulignant la gentillesse de certaines familles du village, qui leur apportaient, à elle et à ses camarades de classe, des vêtements, surtout en hiver, des biscuits et, à chaque Pâques, des friandises. J'ai du mal à trouver des mots pour exprimer l'influence qu'elle a eue sur moi : parler de respect à son égard relèverait de l'euphémisme. Ce jour-là, elle m'a dévoilé non seulement les événements horribles survenus dans son passé, mais aussi les divers problèmes persistants dans sa famille, ce que nous connaissons aujourd'hui sous le nom de « traumatismes intergénérationnels ». En 2009, je n'avais encore jamais entendu ce terme. Chaque fois que je rencontre quelqu'un de Mistissini, je lui demande systématiquement s'il la connaît et s'il est en mesure de me donner de ses nouvelles. Je pense souvent à elle.

Ces journées passées dans les cliniques rurales des communautés autochtones, les personnes que j'y ai côtoyées, les amitiés, m'ont aidé à développer une oreille attentive et une détermination à créer du changement, à améliorer les soins, ce qui m'a valu la réputation d'être insistante et tenace!

## GENÈSE DE LA FONCTION PARTICULIÈRE D'INFIRMIÈRE PIVOT POUR LES AUTOCHTONES À L'HÔPITAL D'OTTAWA

La création du programme et du poste d'infirmière pivot pour les Autochtones ne s'est pas faite sans obstacle ni difficulté.

### Premier obstacle

Le premier obstacle était de taille : sur quelles bases allions-nous édifier le programme? En tant que première infirmière pivot pour les Autochtones au sein du PCA, j'avais carte blanche pour instiguer le changement. C'est du moins ce que je croyais.

J'ai rapidement découvert que les patients, leur famille, le personnel, l'administration et les partenaires communautaires s'attendaient à ce que je fasse partie du personnel « 9 à 5 » qui circule dans l'hôpital pour aider les patients autochtones, notamment en prêtant main-forte durant les rendez-vous et lors des tournées dans les unités d'hospitalisation et en transmettant des demandes de remboursement du Programme des services de santé non assurés (SSNA). Je devais essentiellement faire un travail de gestion de cas. Cette tâche était carrément impossible étant donné que j'étais la seule infirmière pivot pour les Autochtones de l'Hôpital d'Ottawa, mais aussi de la région (anciennement connue sous le nom de RLISS Champlain). C'était infernal. J'ai dû préciser à tous les patients et à tous les fournisseurs que je ne pouvais pas m'engager à être systématiquement présente lors des rendez-vous ou des visites pour cette raison, sous peine de briser la relation que je cherchais à établir. À l'exception du temps consacré aux réclamations du Programme des SSNA, j'ai passé d'innombrables heures, au fil des ans, à établir des relations, à collaborer avec des équipes multidisciplinaires, à défendre les intérêts des patients et à faire chaque jour le triage des besoins.

Toutefois, ce travail ne correspondait pas à l'idée que je me faisais du poste d'infirmière pivot, même s'il aurait pu se limiter à cette fonction conventionnelle. Je ne voulais pas être simplement une autre infirmière en blouse blanche. Sinon, comment justifier la création du poste d'infirmière pivot? Avec le soutien de ma supérieure, Gwen Barton, j'ai fermement défendu mon point de vue en présentant ce qui est aujourd'hui mon « accroche ».

Je suis centrée à 100 % sur les patients. Je ne remplace aucun service existant. Je ne suis ni gestionnaire de cas, ni travailleuse sociale, ni affiliée au Programme des SSNA. J'agis en renfort, selon les besoins. J'essaie de répondre aux besoins exprimés par les patients et leur famille et non aux besoins que les fournisseurs de soins jugent prioritaires.

Pour clarifier mon rôle, je précise que je suis la seule travailleuse de première ligne du Programme autochtone parmi l'ensemble des quelque 15 000 employés de l'Hôpital d'Ottawa avec un mandat limité aux soins de cancérologie. De nombreux patients autochtones répartis dans les différents services de l'Hôpital d'Ottawa n'ont pas accès à une infirmière pivot. Qui les aide à remplir leurs formulaires? Qui les aide à naviguer dans le système? Pourquoi devrais-je fournir une gamme complète de services aux patients autochtones atteints d'un cancer, alors qu'il y a déjà des travailleuses sociales dans le centre de cancérologie et dans les unités de soins et que tous les patients venant du Nunavut sont pris en charge par des gestionnaires de cas chez Ontario Health Services Network Inc.? Au besoin, j'aiguille les patients autochtones venant de l'extérieur du Nunavut vers un gestionnaire de cas, mais je ne suis pas gestionnaire de cas. C'est ça, la mission d'une infirmière pivot.

## Deuxième obstacle

Qu'est-ce que je fais, donc? Mon principal objectif vis-à-vis de tous les patients et de leurs familles est d'établir une relation de confiance. La confiance s'acquiert par des actes, pas seulement par des mots. Pendant des siècles, les PNIM ont subi des atrocités, qui ont indéniablement été mises en lumière dans le rapport sur la vérité et la réconciliation (National Centre for Truth and Reconciliation, 2015). L'Hôpital d'Ottawa nous rappelle, réunion après réunion, que nous devons regagner la confiance des peuples autochtones. Pour moi, dans ma fonction, la marche à suivre était évidente : écouter, puis agir en fonction des besoins exprimés par les patients. Or, pour ce faire, je dois sortir des petites cases de l'infrastructure hospitalière.

## Troisième obstacle

Le consensus dans le milieu de la santé, c'est probablement que les fournisseurs de soins sont à l'écoute des patients. Mais est-ce vraiment le cas?

Avant la COVID, il n'existait aucune forme de soins oncologiques sur l'île de Baffin. Les consultations téléphoniques étaient rares; elles ne sont devenues courantes que durant la pandémie. Il faut rappeler que, comme l'Hôpital d'Ottawa est le centre de soins tertiaires désigné pour l'île de Baffin, pour recevoir un traitement contre le cancer, les habitants de l'île de Baffin doivent séjourner à Ottawa avec leurs accompagnateurs. Lorsqu'ils arrivent à Ottawa, les patients passent généralement une IRM et une biopsie. Ils doivent ensuite rester à Ottawa

pour attendre les résultats et rencontrer un oncologue sur l'un des trois campus de l'Hôpital d'Ottawa afin d'examiner les possibilités et les plans de traitement, avant d'enfin recevoir des soins. Ce processus signifie des semaines et des mois d'éloignement de leur famille, de leur communauté, de leur langue, de leur culture et de leur travail. Si on y réfléchit bien, il s'agit là d'une charge émotionnelle que les Canadiens du Sud ne subissent pas pour avoir accès à des soins oncologiques et qui a de grandes répercussions sur la santé mentale. Cette réalité était et est toujours connue du personnel soignant de l'Hôpital d'Ottawa, mais quelles mesures ont été mises en œuvre pour atténuer la douleur émotionnelle des patients autochtones et de leurs accompagnateurs? On s'en remet à la norme coloniale. Les patients sont dirigés vers le service de travail social ou le service d'aide spirituelle de l'Hôpital d'Ottawa. Or, ces deux services n'ont que très peu de connaissances ou d'expérience de la culture inuite et aucune expérience de vie ou de travail dans les communautés inuites.

La peur de l'*aaqitaugunangituuq aania*, la maladie incurable, est particulièrement palpable chez les Inuits. Le mal du pays, la solitude, l'ennui, le stress financier, le désarroi et le sentiment de déconnexion sont toujours au cœur des conversations que j'ai avec les patients qui viennent du Nunavut ou d'une autre région éloignée pour recevoir des soins à Ottawa, accompagnés par un membre de leur famille. Impossible de passer cette réalité sous silence.

## La vision de l'Hôpital d'Ottawa

*Offrir à chaque patient des soins de calibre mondial et des services exceptionnels avec la compassion digne des personnes qui nous sont chères.*

Comme la prestation de soins de qualité passe notamment par la création d'expériences positives et l'amélioration des services en santé mentale, un rappel de la vision de l'Hôpital d'Ottawa à mes collègues et à mes supérieurs s'est avéré utile pour orienter l'élaboration des approches de soins et de soutien pour les personnes originaires du Nunavut.

Ceux et celles qui vivent en milieu urbain ont tendance à considérer leur indépendance et leur mobilité comme allant de soi. Étant originaire du petit village de Rivière-Saint-Paul, au Québec, je pouvais facilement comprendre le désarroi, le sentiment de déconnexion et le mal du pays que l'on peut éprouver dans un environnement urbain. Les patients nous disent indirectement avoir besoin d'expériences positives.

Dans la mesure du possible, j'invite les patients et les familles à me rencontrer en dehors de l'hôpital. J'essaie de les emmener dans la nature et en ville pour les aider à s'ancrer à la terre. Ma rencontre avec un Inuit admis à l'hôpital en fin de vie, qui m'a demandé où était le nord – les seuls mots qu'il m'ait dits – est l'une des rencontres les plus tristes que j'ai faites en tant qu'infirmière pivot.

Il n'y a pas d'arbres dans le Nunavut. Le paysage y est radicalement différent de celui de la région d'Ottawa. Néanmoins, des promenades dans le parc de la Gatineau, le long de la rivière des Outaouais, et un tour d'horizon des lieux emblématiques d'Ottawa contribuent grandement à l'établissement de relations de confiance. Pour être un fournisseur de soins digne



de confiance et un véritable allié pour les patients, il est essentiel d'être à l'écoute des besoins des patients et de prendre des mesures concrètes pour y répondre. Les obstacles peuvent toujours être aplanis. L'idée de se cantonner aux murs d'une infrastructure pour tisser une relation professionnelle correspond à une norme coloniale. Nous sommes un programme pour les Autochtones, mais notre modèle de soins répond-il vraiment aux besoins des Autochtones?

## INTÉGRATION DU CADRE DE SOINS DE SOUTIEN

J'ai découvert le cadre de soins de soutien (Fitch, 2008) grâce à ma collègue Lynn Kachuik. Ce cadre a complètement changé ma conception du poste d'infirmière pivot. Gwen et moi avons misé sur ce cadre pour aider l'administration à comprendre ce que nous voulions faire : notre approche commençait enfin à être acceptée.

Les Premières Nations, les Inuits et les Métis ont certes une culture, un territoire et un mode de vie distincts, mais ces peuples entretiennent tous une connexion très forte à la terre. Depuis la nuit des temps, ils se servent des ressources de la nature pour grandir, pour s'épanouir, pour guérir et pour trouver du réconfort. Dans l'esprit du cadre de soins de soutien, l'approche que nous avons développée vise à répondre aux besoins non cliniques des patients en complément des soins oncologiques prodigués par le personnel soignant. Quel meilleur moyen d'alimenter le lien qui unit les peuples autochtones à la terre que de sortir de l'hôpital pour aider les patients autochtones à renouer avec la nature?

En sept années d'existence traversées par une pandémie mondiale, notre programme s'est considérablement développé (voir les figures 2 et 3). Ce qui était autrefois considéré comme une approche radicale (c'est-à-dire emmener les patients hors de l'hôpital et cultiver un lien de confiance en créant des expériences positives qui favorisent une bonne santé mentale) constitue aujourd'hui le fondement de la fonction d'infirmière pivot. Bien que le Nunavut ait une population de 65 000 habitants, il n'est pas rare que les nouveaux patients connaissent le PCA grâce au bouche-à-oreille ou aux services rendus à un membre de leur famille ou de leur communauté, ce qui favorise l'établissement d'un lien de confiance.

Nous espérons déployer un programme pour les Autochtones à l'échelle de l'organisation. Le rapport du centre autochtone Wabano, intitulé « Indigenous-Specific Racism in Healthcare Across the Champlain Region » (2022), met en lumière les domaines particulièrement névralgiques où les Autochtones sont le plus susceptibles d'avoir un conflit avec les fournisseurs de soins : les urgences, l'obstétrique et la psychiatrie. Des infirmières pivots pour les Autochtones pourraient certainement améliorer l'expérience des Autochtones dans ces domaines. L'Hôpital d'Ottawa et Santé Canada ont signé un contrat pour la création d'un poste financé par Santé Canada afin de mieux servir les patients inuits dans les urgences du campus Civic de l'Hôpital d'Ottawa. Il s'agit d'un projet pilote qui, je l'espère, nous aidera à étendre la portée de notre programme pour les Autochtones. Notre équipe attend avec impatience de plus amples informations.

### Tableau 1

*Notre équipe officieuse compte de nombreuses personnes phares. Il faut une équipe de professionnels dévoués pour mettre en place un changement systémique. Voici quelques témoignages de nos plus ardents défenseurs*

« La prestation de soins oncologiques à proximité du domicile des habitants du Nunavut ne devrait pas être considérée comme une mesure extraordinaire; il s'agit d'une condition minimale pour offrir aux habitants du Nunavut la qualité de soins que la plupart des Canadiens considèrent comme normale. »

– D<sup>r</sup> Garth Nicholas, MD, M.Sc., oncologue médical à l'Hôpital d'Ottawa et professeur agrégé à l'Université d'Ottawa

« Le fardeau émotionnel, social et logistique qui pèse sur les patients qui se déplacent depuis le Nunavut pour recevoir des soins oncologiques est immense. Grâce à notre réseau de contacts et à des collaborations intergouvernementales et interprofessionnelles, nous avons pu proposer quelques traitements anticancéreux injectables sur le territoire. Bien que nous ayons rencontré de nombreux obstacles, le succès de ces initiatives a ouvert la voie à d'autres traitements et à de nouvelles collaborations. Même si le chemin à parcourir est encore long, nous sommes tous enthousiastes et déterminés à faire mieux pour nos patients. »

– Jen Newton, inf. aut., B.Sc.inf., MEd, CON (C), Infirmière enseignante au sein du programme de cancérologie de l'Hôpital d'Ottawa

« En tant qu'Autochtone, je suis particulièrement consciente du fait que la possibilité de fournir des soins près de chez soi, près de sa communauté et de sa culture, favorise grandement la santé physique, mentale, affective et spirituelle. Comme le disent nos Aînés, pour qu'une personne puisse s'épanouir, les quatre composants de la roue de la médecine (la santé physique, mentale, affective et spirituelle) doivent être en équilibre. »

– Mackenzie Daybutch, coordonnatrice du Programme de cancérologie pour les Autochtones

« Notre objectif est de veiller à ce que les patients bénéficient d'un environnement de soins respectueux de leur culture. La clé pour atteindre cet objectif, c'est d'écouter et d'apprendre de nos patients autochtones et de leurs familles et de respecter leur culture, leurs traditions et leur mode de vie. »

– Gwen Barton, directrice du Programme de cancérologie pour les Autochtones

« Au fil du temps, les Inuits ont su conserver le lien qui les unit à la terre. En tant que médecin, j'ai rapidement appris à respecter ce lien et à honorer les particularités et les similitudes entre mes patients et moi, ce qui m'a permis de tisser des relations mutuellement bénéfiques et enrichissantes avec mes patients. »

– D<sup>r</sup> Treena Greene, MD, FRCPC, responsable régionale des services de cancérologie pour les Autochtones

« Jour après jour, nous levons les obstacles et collaborons avec la communauté inuite pour améliorer les soins oncologiques offerts aux habitants du Nunavut. »

– D<sup>r</sup> Tim Asmis, MD, FRCPC, oncologue médical à l'Hôpital d'Ottawa et professeur agrégé et directeur du programme de surspécialisation en oncologie médicale à l'Université d'Ottawa

Figure 2

Les indicateurs révèlent une augmentation des rencontres avec les patients et les familles grâce à la mise en œuvre d'un modèle de soins holistique

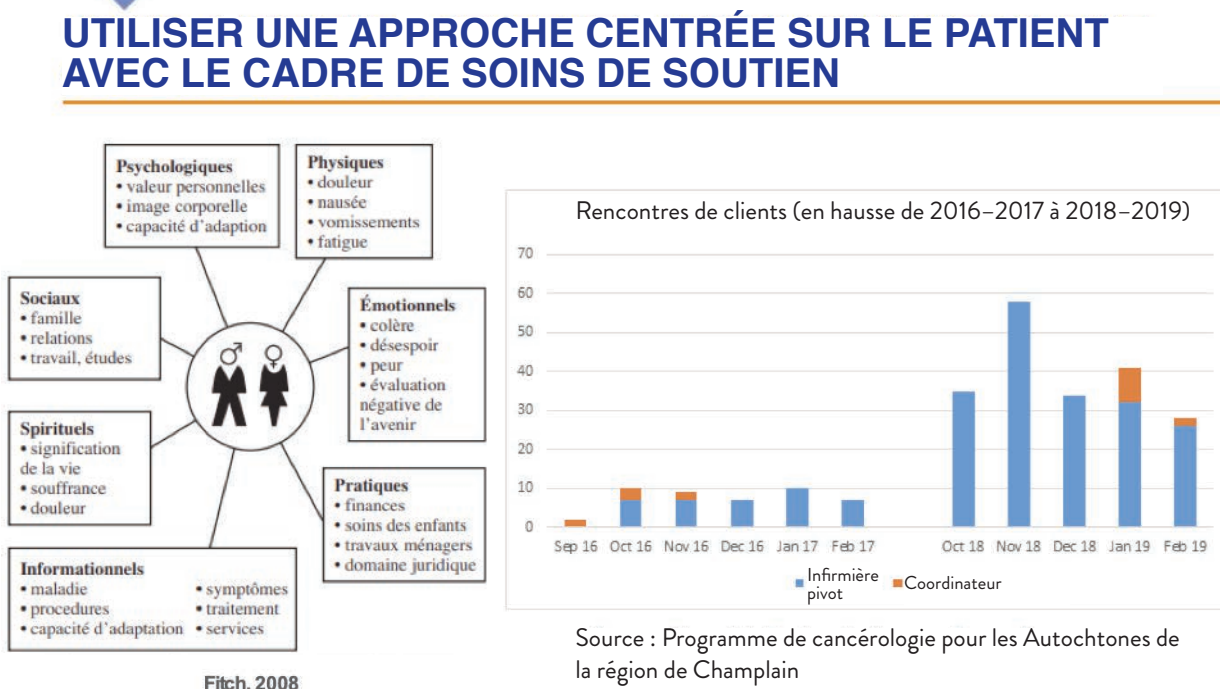
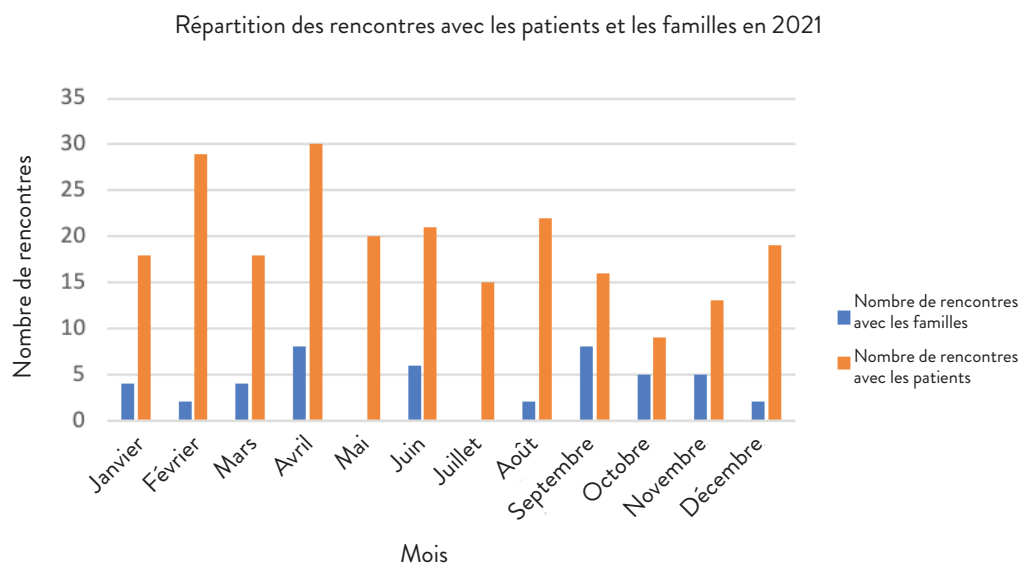


Figure 3

Nombre de rencontres avec les patients et les familles



Le Dr Tim Asmis, oncologue, étudie depuis 2010 les taux de cancer et le devenir des Inuits de l'île de Baffin qui ont un cancer. En 2015, il a signalé des taux de cancer nettement plus élevés sur le territoire et a souligné que 30 % des patients diagnostiqués renonçaient à recevoir des traitements. Il a joué un rôle de premier plan dans l'établissement de relations entre le service d'oncologie de l'Hôpital d'Ottawa et l'équipe médicale de l'Hôpital général Qikiqtani. C'est également en grande partie grâce à lui et à Gwen Barton que l'équipe d'oncologie de l'Hôpital d'Ottawa a pu se rendre sur l'île de Baffin quatre fois et que l'équipe de l'Hôpital général Qikiqtani a pu se rendre à Ottawa deux fois. En outre, en mai 2023, Gwen Barton et lui ont été les principaux organisateurs de la première conférence nationale sur l'oncologie qui s'est tenue à Iqaluit, dans le Nunavut. Plus de 70 professionnels de la santé de l'ensemble du Canada ont participé à cette conférence inédite. La présence de ces professionnels au Nunavut, la découverte du territoire, l'expérience de la culture inuite, le contact avec la communauté locale... ont décuplé la prise de conscience des besoins particuliers des Inuits dans le domaine de l'oncologie. Notre équipe a été approchée par de nombreux participants qui nous ont proposé leur aide et leur collaboration continue.

## OUVERTURE DE LA PREMIÈRE CLINIQUE SATELLITE D'ONCOLOGIE DU NUNAVUT

La première clinique satellite d'oncologie du Nunavut a vu le jour en juillet 2022. L'ouverture de cette clinique où les patients peuvent recevoir des soins sur leur propre territoire, dans leur langue et dans le respect de leur culture est le point culminant de ma carrière d'infirmière. Il est incroyablement gratifiant de constater comment le PCA s'est développé et a gagné le respect de mes collègues et des équipes pluridisciplinaires avec lesquelles nous collaborons. Je suis extrêmement reconnaissante au Dr Marc Gaudet et au Dr Gad Perry de m'avoir invitée à faire partie de la clinique d'oncologie du Nunavut, ainsi qu'à ma supérieure, Gwen Barton, et à la directrice, Julie Renaud, d'avoir appuyé sans réserve cette participation dans le cadre de mes fonctions.

La clinique ne propose pas les soins habituellement prodigués dans les cliniques de cancérologie du « Sud », tels que les perfusions de chimiothérapie et la radiothérapie. Elle est ouverte environ toutes les huit semaines pour offrir des soins de suivi, des consultations initiales pour de nouveaux patients, des services complémentaires à ceux offerts par les médecins locaux aux patients ayant des signes de cancer et des visites à domicile. Tous ces services sont offerts grâce au concours d'une infirmière pivot spécialisée.

Avant juillet 2022, tous les patients devaient se rendre à Ottawa pour tous les rendezvous de suivi de leur traitement et séjournaient à Larga Baffin, une résidence avec pension, souvent durant plusieurs jours, voire semaines, en raison des conditions météorologiques ou de l'absence de vols disponibles. Par exemple, ce mois-ci, une patiente originaire d'une communauté septentrionale du Nunavut a été contrainte de passer 13 jours à Iqaluit en raison du mauvais temps et de l'absence de siège disponible sur un vol à destination de son village natal, après avoir passé 6 jours à Ottawa. Maintenant

que la clinique satellite est ouverte, la possibilité d'éviter des voyages à Ottawa revêt une valeur inestimable.

La clinique satellite offre un climat plus propice à l'établissement de relation de confiance entre fournisseurs de soins et patients que l'Hôpital d'Ottawa, comme l'ont souligné le Dr Gaudet et le Dr Perry. Les deux oncologues ont déclaré à plusieurs reprises que les patients sont beaucoup plus enclins à parler de leur famille, de leurs parties de chasse et de leurs problèmes sociaux lorsqu'ils sont chez eux dans le Nord.

À Ottawa, les oncologues effectuent rarement des visites à domicile. Ces visites font cependant partie intégrante des soins prodigués au Nunavut : plutôt que d'implanter les méthodes de soins du Sud au Nunavut, notre équipe s'adapte aux besoins et aux attentes de la communauté, si elle peut le faire en toute sécurité.

L'équipe d'oncologie a tissé des liens avec le personnel de l'Hôpital général Qikiqtani et la population locale. Le personnel consulte notre équipe et bénéficie de formations sur place données par le Dr Gaudet et le Dr Perry. L'équipe d'oncologie apprend également de ses collègues du Nord et a pour mandat de favoriser les échanges pédagogiques.

Depuis septembre 2022, des perfusions d'immunothérapie sont désormais organisées au cas par cas. Elles ont lieu à la fois à l'Hôpital général Qikiqtani et dans les centres de santé locaux grâce aux ententes conclues entre l'Hôpital général Qikiqtani et le centre de cancérologie de l'Hôpital d'Ottawa. Tout le personnel du programme de la clinique satellite d'oncologie espère et souhaite accroître l'accessibilité aux soins dans le territoire, notamment grâce à la création d'autres cliniques satellites. Deux autres oncologues se joindront à l'équipe de la clinique satellite du Nunavut à l'automne 2023. En mai 2023, nous avons organisé une clinique à Pond Inlet, ce qui montre qu'il est également possible de fournir des soins dans l'extrême nord du Nunavut pour alléger le fardeau des déplacements requis pour recevoir des soins à l'intérieur du territoire.

*« A priori, le nombre de patients de notre clinique satellite d'oncologie au Nunavut peut sembler faible. Il ne faut cependant pas perdre de vue l'incidence considérable que cette initiative peut avoir sur les patients qui reçoivent des soins plus près de chez eux, fournis par une équipe qui connaît et respecte les réalités culturelles, historiques, sociales et géographiques ainsi que les défis auxquels les habitants du Nunavut sont confrontés pour bénéficier de soins oncologiques. »*

*– Dr Marc Gaudet, MD, M.Sc., M.G.S.S., FRCPC  
Chef de la division de radio-oncologie, Hôpital d'Ottawa*

*« Il y a tant de bonnes raisons de rapprocher les soins oncologiques du domicile des habitants du Nunavut, et si peu de ne pas le faire. »*

*– Dr Gad Perry, MD, FRCPC*

## FRUSTRATIONS PERMANENTES LIÉES À DES OBSTACLES SYSTÉMATIQUES

Dans un monde idéal, tous les patients suivraient un parcours linéaire jusqu'à la guérison. Malheureusement, ce n'est pas le monde dans lequel nous vivons. Il reste encore des défis à relever.

Comme mentionné précédemment, les patients et les aidants inuits de l'île de Baffin séjournent à la résidence Larga Baffin lorsqu'ils vont à Ottawa pour des rendez-vous médicaux. Cet établissement fournit l'hébergement, la nourriture et le transport pour l'aéroport ainsi qu'à tous les rendez-vous médicaux. Chaque patient bénéficie des services d'un gestionnaire de cas en oncologie d'Ontario Health Services Network Inc. (OHSNI), une entreprise indépendante sans but lucratif. En plus des services de gestion de cas, l'entreprise offre des services d'interprétation et de traduction en inuktitut lors des rendez-vous médicaux.

J'occupe le poste d'infirmière pivot auprès des PNIM depuis maintenant sept ans, et je continue d'apprendre au quotidien. Je demeure toutefois déconcertée par la complexité des règlements et des exigences du service de déplacement pour raisons médicales et du gouvernement du Nunavut. J'ai vu de nombreux patients être confrontés à des difficultés en raison de ces politiques, mais pour les besoins de cet article, je ne me pencherai que sur mes expériences les plus mémorables avec des patients et leurs aidants qui n'ont pas un parcours linéaire.

La résidence Larga Baffin a des politiques qu'il faut absolument respecter, sous peine d'expulsion. L'une de ces politiques impose une tolérance zéro envers l'alcool. Si un patient est expulsé pour consommation d'alcool, son proche aidant a le choix de partir avec le patient ou de rester à Larga Baffin et d'être renvoyé au Nunavut à bord du prochain vol disponible.

Les patients qui se font expulser « passent entre les mailles du filet ». Dans la plupart des cas, voire dans la totalité des cas, les patients ne possèdent pas de carte de crédit. Or, on sait qu'il est impossible de se loger dans un établissement commercial sans une carte de crédit valide. Si l'expulsion a lieu un vendredi en dehors des heures de bureau, la situation est encore pire. Vers qui peuvent-ils se tourner?

Le service de déplacements pour raison médicale offre l'hébergement dans des hôtels à Ottawa et, d'après ce que j'ai pu comprendre, ces hôtels ont conclu un accord avec le gouvernement du Nunavut. Certains hôtels offrent trois repas par jour dans un restaurant sur place, d'autres n'offrent que le déjeuner, mais d'autres n'offrent aucun repas. Trop souvent, j'ai reçu des appels de patients qui n'avaient pas de nourriture

### Photo 2

*Aurores boréales. Photo par Carolyn Roberts*



### Photo 3

*Aurores boréales dans le ciel d'Iqaluit, au Nunavut. Photo par Carolyn Roberts*



et n'avaient pas mangé depuis deux ou trois jours, ou qui n'avaient pas reçu de bons de taxi à temps pour se rendre à leurs rendez-vous médicaux.

Le premier patient que j'ai aidé dans cette situation avait été expulsé trois jours plus tôt. J'ai été choquée qu'un patient du Nunavut sous notre responsabilité, bénéficiant apparemment d'un excellent soutien du système de santé, soit privé de nourriture pendant plusieurs jours. Voyant mon désarroi, il m'a dit : « Ça ne fait que deux jours. » Une réponse qui ne semble plus aussi étonnante si on se rappelle que 70 % des habitants du Nunavut vivent dans l'insécurité alimentaire. Notre programme a permis de combler des lacunes systémiques à plusieurs reprises, mais l'aide que nous offrons est seulement une solution de fortune.

Nous avons aussi des cas délicats d'employés ou de bénéficiaires du gouvernement du Nunavut qui ne séjournent pas à Larga Baffin et qui devraient normalement pouvoir demander un remboursement de leurs frais. Cependant, ces personnes ont des revenus très faibles, sont souvent sans emploi, vivent dans des logements surpeuplés et doivent payer leurs denrées alimentaires au prix fort. Mon expérience de travail m'a permis de constater qu'en région éloignée, le salaire d'une personne est souvent mis à contribution pour nourrir plus d'une dizaine d'autres personnes. Il n'y a donc pas beaucoup d'argent, voire pas du tout, pour payer des frais puis attendre un remboursement qui n'arrivera que des semaines plus tard. Or, l'attente d'un remboursement représente souvent un long processus pour ces personnes. Il y a bien une *indemnité de précarité* pour les besoins urgents, mais là encore, la procédure peut être longue à mettre en place, même avec l'aide d'une intervenante.

Notre équipe revendique des changements, envoie de nombreux courriels et demande des réunions avec les parties concernées afin de mettre le doigt sur les lacunes du système avec l'espoir de pouvoir conceptualiser des améliorations. Plusieurs politiques doivent être remises en cause, modifiées et harmonisées afin de répondre aux besoins des patients qui se déplacent loin de chez eux pour recevoir des soins dans un environnement qui ne leur est pas familier. Ces personnes devraient avoir accès à une aide rapide pour combler leurs besoins de base (comme la nourriture), quel que soit le jour de la semaine.

#### Photo 4

Aurores boréales dans le ciel d'Iqaluit, au Nunavut. Photo par Carolyn Roberts



## REMARQUES FINALES

Pour créer un programme de santé de première ligne, il faut impérativement connaître la réalité sur le terrain et savoir défendre ses idées avec énergie et empathie. Il est relativement

facile de défendre les intérêts des patients dont le parcours est linéaire : les patients qui passent à travers les mailles du filet du système sont ceux qui ont le plus besoin de nous. Ce sont, à mes yeux, les plus vulnérables. Ce sont souvent des patients qui ont des antécédents de traumatismes intergénérationnels, de dépendances ou de maladies mentales non traitées ou non diagnostiquées. Ces personnes ont sans doute besoin d'une aide non conventionnelle de la part des professionnels de la santé que nous sommes. Je crois que nous devons tous nous poser les questions suivantes : « A-t-on réussi à traiter le patient en ayant recours aux méthodes conventionnelles? Que se passera-t-il si je n'interviens pas? Mes actions et celles de mes collègues sont-elles fidèles aux valeurs et à la mission de notre organisation? Que me dicte ma conscience? »

Les initiatives comme le Programme de cancérologie pour les Autochtones sont essentielles pour créer une société inclusive et respectueuse des Premières Nations, des Inuits, des Métis et des Autochtones en milieu urbain. Ces initiatives doivent tenir compte des besoins exprimés par les Autochtones et honorer la culture, les enseignements, l'histoire et l'unicité de chaque peuple autochtone. Je pense que, pour transformer la prestation de soins de santé, il faudra intégrer de plus en plus d'interactions non conventionnelles. Le système de santé n'a pas changé depuis des décennies et doit être remodelé à la lumière des appels à l'action 18 à 24 de la Commission Vérité et Réconciliation, qui visent le domaine de la santé.

## RÉFÉRENCES

- Amnesty International. (2023). *Universal Declaration of Human Rights*. <https://www.amnesty.ca/what-you-can-do/youth/start-up-kit/universal-declaration-of-human-rights/Lohead>, D. (2022, June 13). 11 community health centres to shut down this summer. *Nunatsiaq News*. <https://nunatsiaq.com/stories/article/11-community-health-centres-to-shut-down-this>
- Fitch, M. (2008). Supportive care framework. *Canadian Oncology Nursing Journal/Revue canadienne de soins infirmiers en oncologie*, 18(1), 6-14. Pappin Communications.
- Inuit Tapiriit Kanatami. (2018). *Inuit Statistical Profile 2018*. <https://www.itk.ca/wp-content/uploads/2018/08/Inuit-Statistical-Profile.pdf>
- Inuit Tapiriit Kanatami. (2021). *2020-2021 Annual Report*. <https://www.itk.ca/wp-content/uploads/2021/09/20210915-ITK-Annual-Report-EN-final.pdf>
- Lenihan, D. (2018). Stronger voices, better care: Serving the People of Nunavut. *The Ottawa Hospital's New Campus Series: Volume 2*. <https://www.linkedin.com/pulse/engagement-our-latest-ottawa-hospitals-new-campus-series-lenihan/>
- MacDonald-Dupuis, N. (2015, Aug. 28). *Some Inuit may be refusing cancer treatment*. CBC News.
- Truth & Reconciliation Commission of Canada. (2015). *Canada's Residential Schools-Missing Children and Unmarked Burials: The Final Report of the Truth and Reconciliation Commission of Canada* (Vol. 4). McGill-Queen's Press-MQUP. <https://www.cbc.ca/news/canada/north/lori-idlout-housing-qp-1.6396607>
- Tungasuvvingat Inuit. (2018). *17/18 Tungasuvvingat Inuit Annual Report*. <https://tiontario.ca/wp-content/uploads/2020/11/2017-2018-Annual-Report-English.pdf>
- United Nations. (2018). *Universal Declaration of Human Rights at 70: 30 Articles on 30 Articles - Article 25*. <https://www.ohchr.org/en/press-releases/2018/12/universal-declaration-human-rights-70-30-articles-30-articles-article-25>
- Wabano Centre for Aboriginal Health in Partnership with the Ottawa Aboriginal Coalition. (2022). *Share Your Story*. <https://wabano.com/wp-content/uploads/2022/05/ShareYourStory-FullReport-EN.pdf>

# CAPO and CANO joining forces to advance a national psychosocial oncology advocacy agenda

By Carmen G. Loiselle, Samar Attieh, Lorelei Newton

## ABSTRACT

*Patient advocacy remains a key priority within the Canadian Association of Psychosocial Oncology (CAPO) and the Canadian Association of Nurses in Oncology (CANO). Optimizing collaboration across advocacy organizations, institutions, and other stakeholders is timely as we enter an era where patients and their caregivers' voices are front and centre. In this paper, we report on ongoing efforts to advance patient advocacy – broadly defined as processes and behaviours related to proactively supporting a cause – herein specific to cancer care. Through active partnering, both organizations are well positioned to push for a representative and inclusive national psychosocial oncology advocacy agenda.*

## BACKGROUND

Prior approaches to cancer care were often construed as “downstream,” whereby practices tended to be top-down with decisions, recommendations, and actions taken at institutional and/or executive levels (Van Beers et al., 2021). Upstream (or bottom-up) approaches, on the other hand,

are increasingly seen as promising in ensuring that individuals facing health threats such as cancer and their close network are actively involved and heard (Loiselle, 2023). Whereas changes initiated mainly through top-down approaches often limit implementation and outreach of promising supportive initiatives, a commitment to engaging individuals affected by cancer as service co-designers and users (e.g., patients, family members, friends) can more positively impact care processes and outcomes (Bombard et al., 2018; Loiselle, 2023). Moreover, collaboratively, stakeholders can revisit and fine-tune best practices through blended approaches that combine both top-down and bottom-up approaches (Austin et al., 2023; Bombard et al., 2018; Luo et al., 2021; Ogunlayi & Britton, 2017; Vermond et al., 2022).

Through their respective vision and mission, the Canadian Association of Psychosocial Oncology (CAPO) (<https://www.ca-po.ca/about/mission>) and the Canadian Association of Nurses in Oncology/Association canadienne des infirmières en oncologie (CANO/ACIO) ([https://www.cano-acio.ca/page/mission\\_and\\_vision](https://www.cano-acio.ca/page/mission_and_vision)) seek to actively integrate the diverse voices of patient representatives into blended upstream and downstream approach that pushes for patient advocacy to publicly recommend and defend the rights of individuals (International Council of Nurses, 2021). In 2022, in the context of CANO's 34th annual conference held in Victoria, British Columbia under the theme “Together again: Connection, reflection, celebration”, a joint CAPO/CANO symposium delivery underscored ongoing efforts to advance patient advocacy. Key points from this symposium are presented herein.

## PSYCHOSOCIAL ONCOLOGY ADVOCACY WITHIN THE CANADIAN ASSOCIATION OF PSYCHOSOCIAL ONCOLOGY (CAPO)

CAPO identifies psychosocial oncology (PSO) advocacy for individuals affected by cancer as one of its highest priorities. PSO advocacy seeks to identify common advocacy priorities and foster collaboration by bringing communities together to facilitate networking, exchanges of ideas and concrete actions to enhance access to supportive resources (American Psychosocial Oncology Society, 2020; Cancer Care Ontario, 2018; Loiselle & Brown, 2020). To achieve its vision, CAPO developed a five-year strategic plan highlighting four key pillars: 1) Innovation and education, 2) Research and knowledge translation, 3) Clinical and community care and 4) Leadership and advocacy (CAPO strategic plan, 2022). Within each pillar, CAPO underscores person-centred strategies that are co-designed with an active inclusion of patient and informal caregiver voices. The Advocacy Committee plays a key role in advising the CAPO Board of Directors in the development and implementation of patient advocacy initiatives. With ongoing efforts to increase the diversity of its members, the advocacy committee's work is anchored in the overarching principle that the voice of equity-seeking groups is present. One of CAPO's recent initiatives is the co-creation of a national agenda for psychosocial oncology advocacy. By bringing together various stakeholders, including healthcare professionals, researchers, patient representatives, and advocacy organizations, a co-designed national agenda fosters a coordinated and collaborative approach. This initiative aims to provide a roadmap for enhancing

## AUTHOR NOTES

Carmen G. Loiselle\*, RN, PhD, Department of Oncology and Ingram School of Nursing, Faculty of Medicine and Health Sciences, McGill University, Montreal, QC  
Email: [carmen.g.loiselle@mcgill.ca](mailto:carmen.g.loiselle@mcgill.ca)

Mailing address: Dialogue McGill, 550 Sherbrooke St West, West Towers, Suite 775, Montréal, QC H3A 1B9

\*Senior and corresponding author

Samar Attieh, MSc, MPH, Experimental Medicine Division, Faculty of Medicine and Health Sciences, McGill University, Montreal, QC

Lorelei Newton, PhD, RN, CGNC, School of Nursing, University of Victoria, Victoria, BC

psychosocial well-being of individuals facing or surviving cancer by identifying key priorities in psychosocial oncology while devoting concrete advocacy efforts where they are most needed.

Developing a national PSO advocacy agenda requires thoughtful and large-scale collaborative efforts. As we enter an era of renewed focus on innovation and cancer care co-design, CAPO works on two interrelated objectives: 1) Creating a repository of advocacy organizations working to enhance

access to psychosocial oncology support, and 2) Co-designing strategic advocacy actions involving all relevant stakeholders.

Initially, CAPO relied on a three-phase process to identify potential Canadian organizations advocating for PSO (Figure 1). An extensive literature search (i.e., Medline Ovid, social media, grey literature, and informal feedback) was conducted to identify documented cancer advocacy initiatives. Thorough in-depth screening, organizations without an explicit

PSO advocacy mandate were excluded. Retained organizations were then invited to complete a brief survey to confirm their PSO advocacy and organization status (e.g., non-profit, charitable, etc.).

Fifty-two Canadian organizations advocating for psychosocial oncology were identified across provinces. Most reported being non-profit ( $n = 37$ ; 71.2%) and/or charitable ( $n = 28$ ; 53.8%), as these categories are not mutually exclusive. Figure 2 displays the status of retained advocacy organizations.

Out of the 52 organizations, 90.4% ( $n = 47$ ) identified raising awareness about cancer supportive needs as their main PSO advocacy activity (Table 1). The second was promoting initiatives that support person-centred psychosocial care (88.5%).

A larger CAPO survey, co-created with various stakeholders including patient representatives, is underway to identify key advocacy priorities, challenges, gaps, successful advocacy strategies, and future advocacy directions of the identified organizations. Findings from this second survey will inform the proposed comprehensive national advocacy agenda with key action items. Provincial and national endorsements from are therefore critical for effective implementation and dissemination across jurisdictions.

Figure 1

Summary of phases to identify Canadian organizations involved in psychosocial oncology advocacy

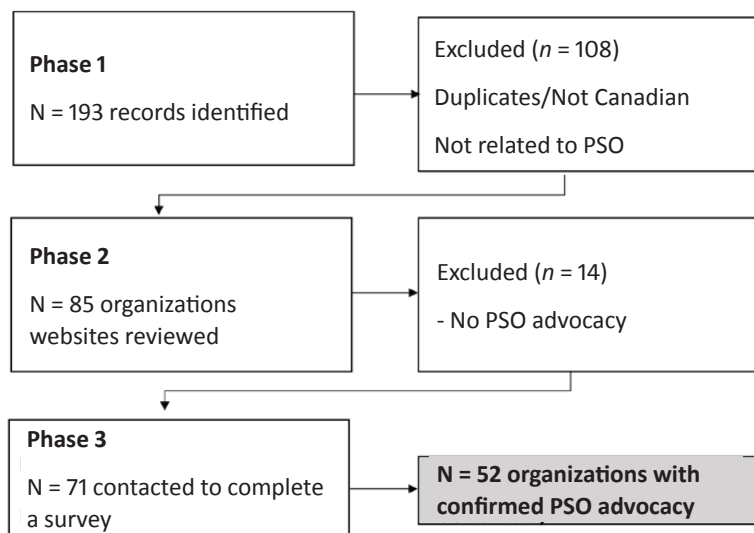
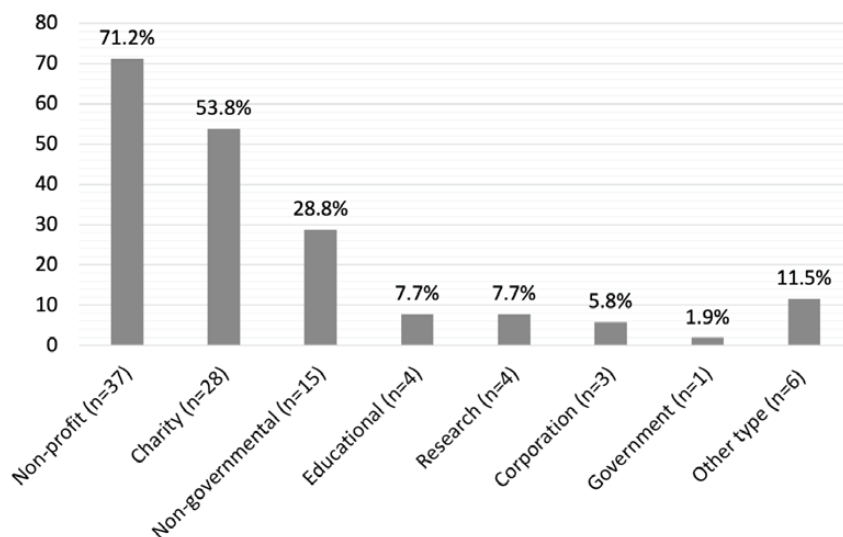


Figure 2

Status of Canadian organizations involved in PSO advocacy (N = 52). Categories are not mutually exclusive



## ADVOCACY WITHIN THE CANADIAN ASSOCIATION OF NURSES IN ONCOLOGY (CANO)

CANO is a recognized leader in pursuing cancer care nursing excellence and enhancing services access and equity, nationally and internationally. Through advocacy, collaboration, provision of practice resources, education, research, and leadership, CANO's aims to advance cancer care nursing for all affected people living in Canada (CANO, 2022). Its updated mission and vision reflect the views and goals of its membership.

The ongoing commitment to advocate for patients and their families, particularly post-pandemic, came through loud and clear in the recent membership survey. CANO members reported

**Table 1**

Main advocacy activities reported by the surveyed organizations (N = 52)

Main PSO advocacy activities	n	%
Raising public awareness about cancer supportive needs	47	90.4
Promoting initiatives that support person-centred psychosocial care for patients and caregivers	46	88.5
Liaising with representatives from various cancer agencies on psychosocial oncology issues	32	61.5
Informing legislators (e.g., access to information, support, services)	27	51.9
Lobbying (i.e., sensitizing government officials to the effects of certain policies on patients and caregivers)	23	44.2
Designing and implementing research projects related to psychosocial oncology	18	34.6
Working with government to establish cancer care policies related to psychosocial oncology	14	26.9

many challenges they are facing, such as lack of recognition of oncology nursing as a speciality, staff recruitment and retention, staff skill requirements in specialty settings, post-pandemic fiscal cuts, burnout, and Canadian healthcare system chaos. These concerns informed CANO’s strategic planning and helped to identify three main advocacy goals: 1) Adopting an advocacy policy that delineates roles and responsibilities as it relates to advocacy activities, 2) Developing advocacy positions and undertaking annual advocacy activities related to at least one key issue affecting people with cancer and at least one issue pertaining to the oncology nursing profession, and 3) Advocating in support of climate change-related initiatives within healthcare (Booker & Newton, 2022).

CANO is recognized as a leader in advocating for nurses and patients, positive supportive work environments, social justice issues (e.g., health services equity), and climate change. Through a strong national and international network, CANO is well positioned to advocate for more actionable advocacy strategies. For instance, ongoing national initiatives that include a new underserved populations working group, best practices resources that are vital for nurses advocating in their workplaces, position statements, expanded membership categories to include nurses practicing in low-and middle-income countries,

and the *Canadian Oncology Nursing Journal* to disseminate advocacy works. An advocacy task force is also underway to begin structuring a policy that best suits the identified goals. Through healthcare policies, funding, resources, and recognition of oncology nursing, CANO is establishing a solid foundation for being the voice for oncology nurses and people with cancer. CANO is also well connected to national and international advocacy groups (e.g., CAPO, Global Power of Oncology Nursing, The International Society of Nurses in Cancer Care, the International Psycho-Oncology Society [IPOS]) and is continuously looking to leverage the synergy that comes with deliberate collaborations across cancer advocacy organizations.

### JOINING FORCES

Whereas advocacy within organizations is invaluable, working in partnership with other organizations allows for more synergistic and impactful outcomes (Shah, 2023; Junk, 2019). CAPO and CANO recognize the importance of collaboration to advocate for comprehensive and person-centred cancer care and to promote the integration of psychosocial support and nursing expertise into cancer care policies, guidelines, and best practices. Both organizations bring unique and complementary oncology perspectives and expertise, allowing for

a more comprehensive understanding of patient advocacy barriers and enabling the development of well-rounded advocacy strategies. By joining forces, CAPO and CANO can have a significant influence by building stronger networks and more effectively advocating for positive changes to enhance access to psychosocial oncology support. The combined resources of the two organizations translate into a broader reach and the ability to engage with a wider audience, including policymakers, media outlets, and the public.

### CONCLUSION

Through collaborative advocacy, aligned goals, policy influence, timely information, and patient/family engagement, CAPO and CANO are well positioned to address the diverse needs of individuals affected by cancer and ensure that psychosocial oncology and nursing care are recognized, prioritized, and made more accessible. By coordinating joint advocacy strategies, CAPO and CANO can readily identify gaps, avoid overlapping campaigns, and focus on complementary areas of expertise. This streamlined advocacy process maximizes efficiency and impact of such timely collective actions for the benefit of those who require psychosocial oncology support the most.



## REFERENCES

- American psychosocial oncology society (APOS). (2020). *What is psychosocial oncology?* <https://apos-society.org/people-affected-by-cancer/what-is-psychosocial-oncology/>
- Austin, J., Drossaert, C. H., van Dijk, J., Sanderman, R., Børøsd, E., Mirkovic, J., ... & Bohlmeijer, E. T. (2022). Integrating top-down and bottom-up requirements in eHealth development: The case of a mobile self-compassion intervention for people with newly diagnosed cancer. *JMIR cancer*, 8(3), e37502.
- Bombard, Y., Baker, G. R., Orlando, E., Fancott, C., Bhatia, P., Casalino, S., ... & Pomey, M. P. (2018). Engaging patients to improve quality of care: A systematic review. *Implementation Science*, 13, 1–22.
- Booker, R., & Newton, L. (2022). Forging ahead: CANO/ACIO's Strategic Plan for 2022-2024. *Canadian Oncology Nursing Journal*, 32(2), 158.
- Canadian Association of Nurses in Oncology. (2022). *Mission & Vision*. [https://www.cano-acio.ca/page/mission\\_and\\_vision](https://www.cano-acio.ca/page/mission_and_vision)
- Canadian Association of Nurses in Oncology. (2022). *Strategic planning*. CANO/ACIO ([cano-acio.ca](http://cano-acio.ca))
- Canadian Association of Psychosocial Oncology. (2022). *Mission & Vision*. <https://www.capo.ca/about/mission>
- Canadian Association of Psychosocial Oncology. (2022). *Strategic planning*. [https://www.capo.ca/resources/Documents/Strategic%20Objectives%202022-2027%20\(2\).pdf](https://www.capo.ca/resources/Documents/Strategic%20Objectives%202022-2027%20(2).pdf)
- International Council of Nurses (ICN). (2021). *The ICN Code of Ethics for Nurses*. Geneva. ICN\_Code-of-Ethics\_EN\_Web\_0\_0.pdf
- Junk, W. M. (2019). When diversity works: The effects of coalition composition on the success of lobbying coalitions. *American Journal of Political Science*, 63(3), 660–674.
- Loiselle, C. G. (2023). Now, more than ever, timing is right for oncology nurses to champion co-design, and promote value-based and strengths-based cancer care! *Canadian Oncology Nursing Journal / Revue canadienne de soins infirmiers en oncologie*, 33(2), 180–181. <https://canadianoncologynursingjournal.com/index.php/conj/article/view/1368>
- Loiselle, C. G., & Brown, T. L. (2020). Increasing access to psychosocial oncology services means becoming more person-centred and situation-responsive. *Supportive Care in Cancer*, 28(12), 5601–5603.
- Luo, O. D., Carson, J. J. K., Sanderson, V., & Vincent, R. (2021). Training future healthcare sustainability leaders: Lessons learned from a Canadian-wide medical student community of practice. *The Journal of Climate Change and Health*, 4, 100066.
- Ogunlayi, F., & Britton, P. (2017). Achieving a 'top-down' change agenda by driving and supporting a collaborative 'bottom-up' process: Case study of a large-scale enhanced recovery programme. *BMJ open quality*, 6(2), e000008.
- Shah, S. (2023). Going farther by going together: Collaboration as a tool in advocacy. *Pediatric Clinics*, 70(1), 181–191.
- Van Beers, J. C., van Dun, D. H., & Wilderom, C. P. (2021). Effective hospital-wide lean implementation: top-down, bottom-up or through co-creative role modeling? *International Journal of Lean Six Sigma*, 13(1), 46–66.
- Vermond, D., de Groot, E., de Wit, N., & Zwart, D. (2022). A delicate balance: How physicians manage change towards collaborative care within their institutions. *Journal of Integrated Care*, 30(5), 125–137.

# L'ACOP et l'ACIO joignent leurs forces pour faire valoir l'oncologie psychosociale à l'échelle nationale

Par Carmen G. Loiselle, Samar Attieh, Lorelei Newton

## RÉSUMÉ

*La défense des intérêts des patients demeure une grande priorité de l'Association canadienne d'oncologie psychosociale (ACOP) et de l'Association canadienne des infirmières en oncologie (ACIO). À l'ère où nous accordons de plus en plus d'importance à la voix des patients et de leurs proches aidants, il devient crucial d'optimiser la collaboration entre les organismes de défense des intérêts, les établissements de santé et les autres parties concernées. Le présent article décrit les efforts en cours de défense des intérêts, un terme qui, en gros, désigne les processus et les comportements relatifs au soutien proactif d'une cause (dans ce cas-ci, les soins oncologiques). Grâce à leurs partenariats actifs avec tous les acteurs concernés, les deux associations sont bien placées pour revendiquer un programme national d'oncologie psychosociale à la fois inclusif et représentatif.*

## CONTEXTE

Par le passé, les approches des soins oncologiques étaient souvent qualifiées de descendantes, c'est-à-dire que les décisions, les recommandations et les mesures orientant les

pratiques venaient d'en haut (à l'échelon des cadres ou de la direction de l'établissement) (Van Beers et al., 2021). Les approches ascendantes, quant à elles, partent de la base et sont de plus en plus prometteuses pour veiller à ce que les personnes dont la santé est menacée (par le cancer, par exemple), et leurs proches soient activement consultés et entendus (Loiselle, 2023). Les changements découlant d'approches descendantes limitent souvent la mise en place et la portée des initiatives de soutien prometteuses; en revanche, lorsque les personnes touchées par le cancer (patients, membres de la famille, amis) qui utilisent les services de santé deviennent en plus co-conceptrices de ces mêmes services, les processus de soins et leurs résultats s'en trouvent améliorés (Bombard et al., 2018; Loiselle, 2023). En outre, les parties concernées peuvent revoir et peaufiner ensemble leurs pratiques exemplaires en adoptant une façon de faire qui combine les approches ascendantes et descendantes (Austin et al., 2023; Bombard et al., 2018; Luo et al., 2021; Ogunlayi et Britton, 2017; Vermond et al., 2022).

À travers leur mission et leurs aspirations respectives, l'Association canadienne d'oncologie psychosociale (mission de l'ACOP) et l'Association canadienne des infirmières en oncologie ([https://www.cano-acio.ca/page/mission\\_and\\_vision](https://www.cano-acio.ca/page/mission_and_vision)) cherchent à intégrer activement les diverses voix des représentants des patients dans ce type d'approches à la fois ascendantes et descendantes dont le but est de défendre les intérêts des patients, c'est-à-dire de mettre en place des actions de promotion et de défense des droits des personnes dans l'espace public (Conseil international des infirmières/International Council of Nurse, 2021). En 2022, dans le cadre

du 34<sup>e</sup> congrès annuel de l'ACIO, tenu à Victoria (Colombie-Britannique) sous le thème « À nouveau réunis : connexions, réflexions, célébrations », un symposium conjoint entre l'ACOP et l'ACIO a souligné les efforts en cours pour défendre les intérêts des patients. L'article présente les principaux points abordés lors du symposium.

## PROMOTION DE L'ONCOLOGIE PSYCHOSOCIALE AU SEIN DE L'ASSOCIATION CANADIENNE D'ONCOLOGIE PSYCHOSOCIALE (ACOP)

La promotion de services d'oncologie psychosociale pour les patients atteints de cancer constitue l'une des plus grandes priorités de l'ACOP. Le but est de déterminer les priorités communes et d'encourager la collaboration en rapprochant les différents groupes pour faciliter le réseautage, les échanges d'idées et les actions concrètes et ainsi accroître l'accès aux ressources (American Psychosocial Oncology Society, 2020; Action Cancer Ontario/Cancer Care Ontario, 2018; Loiselle et Brown, 2020). Pour atteindre cet objectif, l'ACOP a conçu un plan stratégique sur cinq ans qui s'articule autour de quatre piliers : 1) l'innovation et l'éducation, 2) la recherche et la vulgarisation de connaissances, 3) les soins cliniques et communautaires et 4) le leadership et la défense des intérêts (plan stratégique de l'ACOP, 2022 – en anglais). Pour chaque pilier, l'ACOP met l'accent sur des stratégies axées sur la personne qui sont conçues en commun dans l'optique d'inclure activement les voix des patients et des proches aidants. Le comité de défense des intérêts de l'ACOP joue aussi un rôle important en conseillant le CA dans la création et la mise en œuvre

## AUTEURES

Carmen G. Loiselle\*, inf. aut., Ph.D., Département d'oncologie et École des sciences infirmières Ingram, Faculté de médecine et des sciences de la santé, Université McGill, Montréal, QC  
Courriel : [carmen.g.loiselle@mcgill.ca](mailto:carmen.g.loiselle@mcgill.ca)

Adresse postale : Dialogue McGill, 550, rue Sherbrooke Ouest, Tours Ouest, Bureau 775, Montréal (Québec) H3A 1B9

\* Auteure principale et auteure-ressource

Samar Attieh, M.Sc., MSP, Division de médecine expérimentale, Faculté de médecine et des sciences de la santé, Université McGill, Montréal, QC

Lorelei Newton, Ph.D., inf. aut., CGNC, École des sciences infirmières, Université de Victoria, Victoria, C.-B.

d'initiatives pour défendre les intérêts des patients. Grâce aux efforts continus déployés pour diversifier la provenance de ses membres, le comité de défense des intérêts s'assure de faire entendre la voix des groupes en quête d'équité, un grand principe fondamental pour l'organisme. Une des initiatives récentes de l'ACOP est la cocréation d'un plan national pour la promotion de l'oncologie psychosociale. Ce programme national, fruit d'un effort commun, met la table pour l'adoption d'une approche coordonnée et

collaborative, puisqu'il rassemble diverses parties prenantes, notamment des professionnels de la santé, des chercheurs, des représentants des patients et des organisations de défense des intérêts. Cette initiative se veut une feuille de route pour améliorer le bien-être psychosocial des personnes atteintes de cancer ou des survivants. Elle permettra d'établir les priorités en oncologie psychosociale tout en déployant des efforts concrets de défense des intérêts concrets là où les besoins se font le plus sentir.

La conception d'un plan national de promotion de l'oncologie psychosociale exige une réflexion et une collaboration à grande échelle. À l'ère où l'on se préoccupe de l'innovation et de la cocréation en soins du cancer, l'ACOP joint ses forces à d'autres organisations du pays pour travailler sur deux objectifs interreliés : 1) monter un répertoire d'organismes de défense des intérêts qui travaillent à améliorer l'accès à l'oncologie psychosociale, et 2) cocréer des actions de défense des intérêts stratégiques faisant intervenir toutes les parties prenantes concernées.

L'ACOP a recours à un processus en trois étapes pour trouver les potentielles organisations canadiennes faisant la promotion de l'oncologie psychosociale (figure 1). Une revue de la littérature exhaustive (dans Medline Ovid, réseaux sociaux, littérature grise et commentaires informels) a été menée pour documenter les initiatives de défense des intérêts des patients en oncologie. À la suite d'un triage minutieux, les organismes sans mandat explicite de promotion de l'oncologie psychosociale ont été exclus. Les organismes retenus ont été invités à remplir un court sondage pour confirmer leur mission de promotion de l'oncologie psychosociale et leur statut (sans but lucratif, de bienfaisance, etc.).

Cinquante-deux organismes canadiens promouvant l'oncologie psychosociale ont été trouvés parmi les provinces. La plupart étaient des organisations sans but lucratif ( $n = 37$ ; 71,2 %) ou de bienfaisance ( $n = 28$ ; 53,8 %) (ces catégories ne s'excluent pas mutuellement). La figure 2 montre le statut des organismes retenus.

Parmi les 52 organismes, 90,4 % ( $n = 47$ ) ont nommé la sensibilisation sur les besoins en soutien contre le cancer comme leur principale activité de défense des intérêts en oncologie psychosociale (Tableau 1). La deuxième activité était la promotion d'initiatives qui soutiennent les soins psychosociaux axés sur la personne (88,5 %).

Un sondage plus vaste de l'ACOP, cocréé avec plusieurs parties prenantes (dont des représentants des patients), est en cours pour déterminer les priorités, les difficultés, les lacunes, les

Figure 1

Résumé des étapes de repérage des organisations canadiennes faisant la promotion de l'oncologie psychosociale

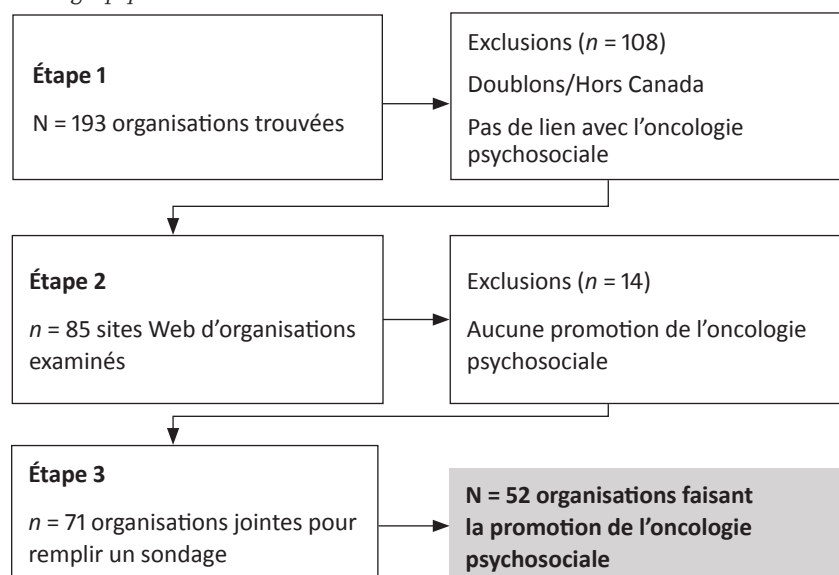


Figure 2

Statut des organisations canadiennes faisant la promotion de l'oncologie psychosociale ( $n = 52$ ). Les catégories ne s'excluent pas mutuellement.

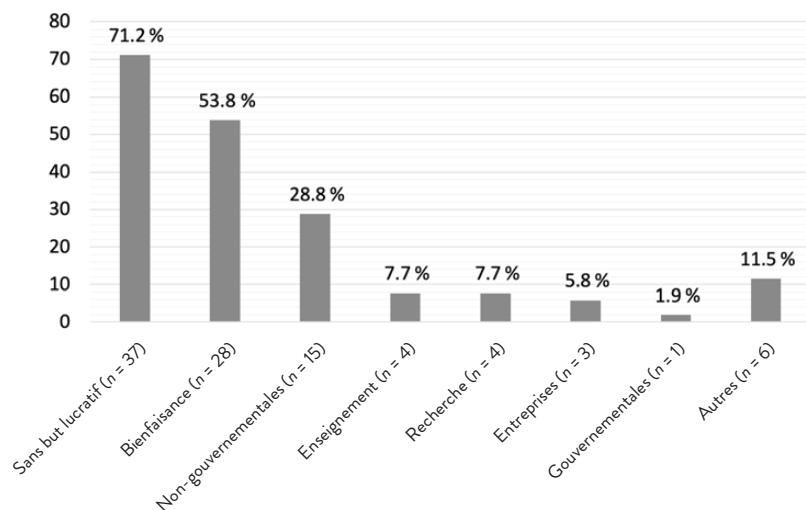


Tableau 1

Principales activités de promotion de l'oncologie psychosociale	n	%
Sensibiliser la population aux besoins en soutien des personnes atteintes de cancer	47	90,4
Promouvoir les initiatives qui appuient les soins psychosociaux axés sur la personne pour les patients et proches aidants	46	88,5
Assurer la liaison avec les représentants de divers organismes en oncologie sur les enjeux d'oncologie psychosociale	32	61,5
Informers les législateurs (ex. accès à l'information, soutien, services)	27	51,9
Faire du lobby (ex. sensibiliser les représentants du gouvernement aux effets de certaines politiques sur les patients et les proches aidants)	23	44,2
Concevoir et mettre en œuvre des projets de recherche liés à l'oncologie psychosociale	18	34,6
Travailler avec le gouvernement pour établir des politiques de soins oncologiques intégrant l'oncologie psychosociale	14	26,9

stratégies de promotion efficaces, et la direction à venir que prendront les organismes retenus dans leur défense des droits des patients. Les résultats de ce deuxième sondage d'auto-évaluation éclaireront le plan national de défense des intérêts proposé en suggérant des actions clés. Les approbations provinciales et nationales des organismes et ministères actifs dans le domaine de l'oncologie seront essentielles à une mise en œuvre efficace et à une diffusion à grande échelle dans toutes les provinces.

## DÉFENSE DES INTÉRÊTS AU SEIN DE L'ASSOCIATION CANADIENNE DES INFIRMIÈRES EN ONCOLOGIE (ACIO)

L'ACIO est un leader reconnu qui encourage l'excellence des soins infirmiers oncologiques et améliore ici comme ailleurs l'accès et l'équité. L'ACIO fait progresser les soins infirmiers en oncologie par la représentation, la collaboration, la publication de ressources pratiques, la formation, la recherche et le leadership, pour le bénéfice de tous les Canadiens (CANO, 2022). La mission et la vision revampées de l'ACIO reflètent les opinions et les objectifs de ses membres.

L'engagement continu à défendre les intérêts des patients et de leur famille, particulièrement après la pandémie, était manifeste dans un récent

sondage mené auprès des membres. Ces derniers ont dit rencontrer plusieurs difficultés, comme le manque de reconnaissance des soins infirmiers en oncologie en tant que spécialité, le recrutement et la rétention du personnel, les exigences en matière de compétences du personnel en milieu spécialisé, les compressions budgétaires postpandémie, l'épuisement professionnel, et le chaos du système de santé canadien. Dans sa planification stratégique, l'ACIO a tenu compte de ces difficultés pour déterminer trois grands objectifs de défense des intérêts : 1) adopter une politique en la matière qui décrit les rôles et les responsabilités relatives aux activités de défense des intérêts; 2) élaborer les positions de l'organisme et entreprendre des activités annuelles de défense des intérêts liées à au moins un problème important qui touche les personnes atteintes du cancer, et un autre qui touche la profession des infirmières en oncologie; 3) se mobiliser en appui aux initiatives de lutte contre les changements climatiques dans le milieu de la santé (Booker et Newton, 2022).

L'ACIO est un leader reconnu pour défendre les intérêts des infirmières et des patients, favoriser la création de milieux de travail positifs et accueillants, prendre fait et cause pour la justice sociale (ex. l'équité dans les services de santé) et participer à la lutte aux changements climatiques. Grâce à un solide réseau national et international,

l'ACIO est bien placée pour promouvoir des stratégies concrètes. Notons, en guise d'exemples, les initiatives nationales en cours qui prévoient la création d'un nouveau groupe de travail sur les populations moins bien desservies, les ressources sur les pratiques exemplaires essentielles pour les infirmières qui se mobilisent dans leur milieu de travail, les énoncés de position, les nouvelles catégories de membres pour accueillir les infirmières qui travaillent dans des pays à revenu faible ou moyen, et la *Revue canadienne de soins infirmiers en oncologie* pour faire connaître les efforts de défense des intérêts. Un groupe d'étude sur le sujet est en cours de formation; son but sera de poser les bases d'une politique adaptée aux objectifs visés. Au moyen de politiques en santé, de financement, de ressources et de mesures de reconnaissance des soins infirmiers oncologiques, l'ACIO établit une fondation solide pour porter la voix des infirmières en oncologie et des personnes atteintes de cancer. L'Association entretient aussi de bonnes relations avec d'autres groupes nationaux et internationaux de défense des intérêts (ex. ACOP, Global Power of Oncology Nursing, International Society of Nurses in Cancer Care, International Psycho-Oncology Society) et cherche continuellement à profiter de la synergie qui émerge d'une collaboration volontaire entre les différentes organisations de défense des droits dans le domaine de l'oncologie.

## JOINDRE NOS FORCES

Si la défense des intérêts au sein des organisations est essentielle, le travail en partenariat avec les autres organisations permet d'atteindre une meilleure synergie et d'accroître la force des résultats ainsi produits (Shah, 2023; Junk, 2019). L'ACOP et l'ACIO reconnaissent l'importance de collaborer pour défendre l'accès à des soins oncologiques complets et centrés sur la personne, et pour favoriser l'intégration du soutien psychosocial et de l'expertise infirmière dans les politiques, les lignes directrices et les pratiques exemplaires en oncologie. Les deux organisations apportent chacune des perspectives uniques et complémentaires, ce qui permet une compréhension globale

des freins à la défense des intérêts des patients, et rend possible l'élaboration de stratégies cohérentes. En joignant leurs forces, l'ACOP et l'ACIO peuvent avoir une influence déterminante sur l'amélioration de l'accès aux services d'oncologie psychosociale en tissant des réseaux solides et en prônant efficacement des changements positifs. La mise en commun des ressources des deux organisations se traduit par une portée accrue de leur travail et une capacité de rejoindre un plus vaste auditoire, notamment les décideurs politiques, les médias et le grand public.

## CONCLUSION

De par leur collaboration en matière de défense des intérêts, l'harmonisation de leurs objectifs, leur influence sur les

politiques, l'information qu'elles transmettent au bon moment et la mobilisation des patients et des familles, l'ACOP et l'ACIO sont bien placées pour répondre aux divers besoins des personnes atteintes de cancer et veiller à ce que les soins psychosociaux et les soins infirmiers en oncologie soient reconnus, prioritaires et accessibles. En coordonnant leurs stratégies de défense des droits, l'ACOP et l'ACIO peuvent rapidement déceler les lacunes, éviter les campagnes qui se recoupent, et se concentrer sur leurs sphères d'expertise respectives, mais complémentaires. Ce processus unifié de défense des droits maximise l'efficacité et la force des actions collectives au bénéfice de ceux et celles qui ont le plus besoin de soutien psychosocial en oncologie.

## RÉFÉRENCES

- American psychosocial oncology society (APOS). (2020). *What is psychosocial oncology?* <https://apos-society.org/people-affected-by-cancer/what-is-psychosocial-oncology/>
- Austin, J., Drossaert, C. H., van Dijk, J., Sanderman, R., Børøsund, E., Mirkovic, J., ... & Bohlmeijer, E. T. (2022). Integrating top-down and bottom-up requirements in eHealth development: The case of a mobile self-compassion intervention for people with newly diagnosed cancer. *JMIR cancer*, 8(3), e37502.
- Bombard, Y., Baker, G. R., Orlando, E., Fancott, C., Bhatia, P., Casalino, S., ... & Pomey, M. P. (2018). Engaging patients to improve quality of care: A systematic review. *Implementation Science*, 13, 1–22.
- Booker, R., & Newton, L. (2022). Forging ahead: CANO/ACIO's Strategic Plan for 2022-2024. *Canadian Oncology Nursing Journal*, 32(2), 158.
- Canadian Association of Nurses in Oncology. (2022). *Mission & Vision*. [https://www.cano-acio.ca/page/mission\\_and\\_vision](https://www.cano-acio.ca/page/mission_and_vision)
- Canadian Association of Nurses in Oncology. (2022). *Strategic planning*. CANO/ACIO (cano-acio.ca)
- Canadian Association of Psychosocial Oncology. (2022). *Mission & Vision*. <https://www.capo.ca/about/mission>
- Canadian Association of Psychosocial Oncology. (2022). *Strategic planning*. [https://www.capo.ca/resources/Documents/Strategic%20Objectives%202022-2027%20\(2\).pdf](https://www.capo.ca/resources/Documents/Strategic%20Objectives%202022-2027%20(2).pdf)
- International Council of Nurses (ICN). (2021). *The ICN Code of Ethics for Nurses*. Geneva. [https://www.icn-nurses.org/ICN\\_Code-of-Ethics\\_EN\\_Web\\_0\\_0.pdf](https://www.icn-nurses.org/ICN_Code-of-Ethics_EN_Web_0_0.pdf)
- Junk, W. M. (2019). When diversity works: The effects of coalition composition on the success of lobbying coalitions. *American Journal of Political Science*, 63(3), 660–674.
- Loiselle, C. G. (2023). Now, more than ever, timing is right for oncology nurses to champion co-design, and promote value-based and strengths-based cancer care! *Canadian Oncology Nursing Journal / Revue canadienne de soins infirmiers en oncologie*, 33(2), 180-181. <https://canadianoncologynursingjournal.com/index.php/conj/article/view/1368>
- Loiselle, C. G., & Brown, T. L. (2020). Increasing access to psychosocial oncology services means becoming more person-centred and situation-responsive. *Supportive Care in Cancer*, 28(12), 5601–5603.
- Luo, O. D., Carson, J. J. K., Sanderson, V., & Vincent, R. (2021). Training future healthcare sustainability leaders: Lessons learned from a Canadian-wide medical student community of practice. *The Journal of Climate Change and Health*, 4, 100066.
- Ogunlayi, F., & Britton, P. (2017). Achieving a 'top-down' change agenda by driving and supporting a collaborative 'bottom-up' process: Case study of a large-scale enhanced recovery programme. *BMJ open quality*, 6(2), e000008.
- Shah, S. (2023). Going farther by going together: Collaboration as a tool in advocacy. *Pediatric Clinics*, 70(1), 181-191.
- Van Beers, J. C., van Dun, D. H., & Wilderom, C. P. (2021). Effective hospital-wide lean implementation: top-down, bottom-up or through co-creative role modeling? *International Journal of Lean Six Sigma*, 13(1), 46–66.
- Vermond, D., de Groot, E., de Wit, N., & Zwart, D. (2022). A delicate balance: How physicians manage change towards collaborative care within their institutions. *Journal of Integrated Care*, 30(5), 125–137.

## PRACTICE REFLECTIONS

## Ethical considerations for nurses working in rare cancer care: Focus on sarcoma

Sarah J. Quinn

*Keywords:* cancer, ethics, rare cancer types, oncology nursing care

## INTRODUCTION

Is rare cancer management a nursing ethics issue? A rare cancer is commonly defined as occurring in less than six people out of every 100,000 people (Drabbe et al., 2021). Treatment for rare cancer offers numerous challenges for patients such as a likely delay in diagnosis and difficulty finding a specialist (Drabbe et al., 2021). Patients with a rare cancer struggle to access information on their diagnosis, which may cause distress (Blay et al., 2016; Srikanthan et al., 2019). There is also less clinical trial-based evidence available in treating rare cancers (Drabbe et al., 2021; Van Der Graaf et al., 2022). In addition, it is difficult for these patients to find clinical trials in which to participate (Blay et al., 2016). Thus, there are fewer drugs for rare cancer, which likely contributes to the shorter overall survival for these patients (Kondo, 2021).

Woven throughout these practice challenges, numerous ethical concerns arise. In this paper, I will exhibit these ethical challenges by using sarcoma as an example of a rare cancer. From my perspective as a registered nurse working in the sarcoma setting at the Calgary, Alberta, Tom Baker Cancer Centre, I will also discuss how some of these issues have presented in my practice. I believe, nurses working in the sarcoma setting should be informed of, and act on ethical issues impacting their patients that may arise from difficulties including clinical trial access, drug approval, uncertainty about genomic

testing, and lack of information for decision making. Nurses have the opportunity to create positive change to help mitigate these difficulties, and specific suggestions to do so will be discussed.

## WHAT IS SARCOMA?

Sarcoma is a rare cancer that originates in the mesenchymal tissue, which forms connective tissue (Srikanthan et al., 2019). The most common sarcomas develop in cartilage, bone, fat, muscle or blood vessels (Lee, n.d.). When looking at all adult solid cancer tumours, only about 1% are sarcoma (Burningham et al., 2012). There are more than 100 different subtypes of sarcoma, and many of these occur in less than one in every 1,000,000 people, thus are often referred to as ultrarare sarcomas (Kasper, 2021). The rarity of sarcoma creates numerous ethical considerations, which I will explore in the next section.

## ETHICAL CONSIDERATIONS FOR PATIENTS WITH SARCOMA

The clinical difficulties when caring for a patient with a rare cancer are arguably obvious, but what makes these ethical issues? Nash and Wells (2020) describe ethics in healthcare as the process of searching for the more ideal option in each scenario using a “moral gradient” (p. 20). Consideration of the four ethical principles of beneficence, nonmaleficence, autonomy and justice, does not offer solutions but, rather, suggests potential action (Nash & Wells, 2020). I argue that sarcoma treatment brings forward numerous issues related to these ethical principles, which nurses in rare cancer settings should have the skills to navigate. In this section, I will explore the ethical implications of selected components of sarcoma patient

treatment. This is not an exhaustive list and is intended to be an introduction to each issue.

## Clinical Trials

*Patient Participation in Clinical Trials*

A clinical trial is a research study where researchers use humans to test the safety or impact of a health intervention, such as a drug (Canadian Institutes of Health Research, 2022). Clinical trials have four phases: A Phase I study is used by researchers to test the safety and dosing of a drug; in a Phase II study, they test how well the drug works for certain diagnoses and for side effects; in Phase III studies, they test the benefit of the drug; and in Phase IV studies, researchers test drugs that are federally approved for further efficacy and safety (Nielsen & Berthelsen, 2019). Patients recruited into Phase I and II trials do so without knowing if the drug will have any benefit, thus participants in these trials typically have no other treatment options (Nielsen & Berthelsen, 2019). Nielsen and Berthelsen (2019), in their meta-synthesis regarding what influenced cancer patients' decisions to participate in clinic trials, found that when patients had other treatment options available, their decisions to participate in the clinical trials involved more intensive risk-benefit analysis and consideration of quality of life. Alternatively, patients with no other treatment options were described as making the decision “intuitively,” sometimes in a matter of minutes, and often before hearing about the details of the clinical trial (Nielsen & Berthelsen, 2019, p. 2457). This finding brings forward concerns related to informed consent, under the umbrella of the ethical principle of autonomy. How can healthcare providers ensure that a patient is agreeing to a trial in their own best interest and not just

## AUTHOR NOTES

Sarah J. Quinn, School of Nursing, University of Victoria

Address for correspondence: Sarah J. Quinn  
sqquinn@uvic.ca

because it is their last treatment option? This demonstrates the “therapeutic misconception” when patients see clinical trial participation as a means to obtain treatment (Heynemann et al., 2023, p. 272; Strzebonska & Waligora, 2019). If this misconception is present, it is concerning because the true goal of clinical trials is to generate new knowledge, not to benefit individual participants (Heynemann et al., 2023). The therapeutic misconception is further exacerbated if the patient believes that their care during the clinical trial will be personalized, as opposed to protocolled (Heynemann et al., 2023). Not only is deciding to participate in a clinical trial difficult, but so is obtaining enough trial evidence for sarcoma treatment.

### Quantity and Quality of Clinical Trial Data

There is an additional ethics issue in the lack of clinical trial data available for treating sarcoma patients. Strzebonska and Waligora (2019) wrote an article debating the ethics of master protocols, a new research process that may offer some hope for patients with rare cancers. Master protocols are either a basket trial or umbrella trial, and each is more flexible than clinical trials where researchers can test targeted therapies on patient cohorts. In a basket trial, patients with different cancer types can be enrolled if all patients share one genetic mutation. In an umbrella trial, patients all have the same cancer, but different mutations. Strzebonska and Waligora (2019) argue that ethical challenges in master protocols include, “scientific validity, the risk-to-benefit ratio, and informed consent” (pp. 1-2). Even though master protocols create the opportunity for patients with rare cancer and rare mutations to participate, they may risk reliability due to small accrual of patients, thus potentially being unethical. Another concern is that since recruitment of these patients may have to occur over a long period of time to gain enough participants, this delays findings and publication of results to help patients (Strzebonska & Waligora, 2019).

The ethics of basket and umbrella trials is further discussed by Strzebonska

and Waligora (2019) because these trials often test for what is referred to as surrogate endpoints to expedite findings. Surrogate endpoints refer to testing outcomes, such as progression-free survival and tumour shrinkage, not overall survival or quality of life. The latter outcomes are more patient-centred outcomes, thus, lessening the overall possibility of achieved benefit of trial participation. Another concern with these trials is that if they are designed to test one drug against one genetic mutation, they may not benefit patients with multiple genetic mutations and may lead to disease progression. Strzebonska and Waligora argue that including a patient with multiple mutations in a trial testing a singular mutation, likely poses more risk than benefit, thus failing to uphold beneficence and non-maleficence (Strzebonska & Waligora, 2019).

Ashley et al. (2015) offered an alternative perspective stating that adaptive trials are necessary in the treatment of rare cancers, because these patient cohorts just simply do not have the time or numbers to obtain results using traditional research methods. They even recommended changing the statistical significance required for studying rare cancer to allow for smaller sample sizes. Ashley et al. (2015) wrote, “In the setting of rare cancers, a new balance needs to be made between risk and benefit in securing scientific truth” (p. e192). Overall, upholding the ethics of research whilst navigating to what degree modifications to rigor and validity can be made in the setting of rare cancer is undoubtedly an ethical issue. In addition to expediting research on rare cancer drugs, expediting the drug approval process is also controversial.

### Drug Approval

A drug shown to have clinical trial benefit can be submitted to Health Canada (HC) to ensure, “safety, efficacy, and quality” of the drug (Health Canada, 2006, p. 4). In a study conducted by Canadian oncologists, HC approval of oncology drugs was identified as taking about three months longer than obtaining the US Food and Drug Administration (FDA) approval

(Ezeife et al., 2015). Also, once a drug is approved, it is up to each individual province in Canada whether or not to fund it (Ezeife et al., 2015). Time from FDA approval to provincial funding in Alberta of cancer drugs was found to be about 30.1 months (Ezeife et al., 2015, p. 1691). This timeframe is concerning in the sarcoma setting. For context, the five-year survival rate for stage IV soft tissue sarcoma is only 15% (Canadian Cancer Society, 2015). Once a drug is approved by the province, patients who meet prespecified HC indications can access these drugs (Ezeife et al., 2015). In our sarcoma clinic, we have encountered situations where patients may benefit from a medication, but their sarcoma sub-type is not a HC approved indication, so there is no funding for the drug. There are other ways for patients to access non-approved medications, such as special access programs, patients own health insurance, clinical trials, or patients paying for them (Ezeife et al., 2015). Often in our setting, compassionate access programs are used if the patient’s sarcoma has progressed on all other approved drugs, and they are accessing the unapproved drug as a last treatment option. Compassionate drug access brings forward concerns regarding autonomy and informed consent, especially since the drug has no proven benefit for the patient, and the drug information is minimal for decision-making and risk-benefit analysis (Fountzilias et al., 2018). Fountzilias et al. (2018) also noted that compassionate drug access is an equity issue, as the programs tend to be utilized by those with the right oncology connections and higher socioeconomic status. Most concerning, is the potential benefit to the patient requires risking patient safety (Fountzilias et al., 2018). If patients are not going through a compassionate access program, then cost is a concern. Another ethical debate with drug costs is whether drug companies should accept lower rates of return for drugs to treat rare cancers (Ashley et al., 2015). In my experience, the process of obtaining access to treatment drugs that are not HC approved is often very time consuming for oncologists, and emotionally distressing and confusing

for patients. Thus, patients place their trust in their care team's guidance and advice, which brings forward other ethical considerations.

### Clinical Decision Making: A Patient and Provider Issue

As previously acknowledged, lack of information in treating sarcoma is twofold, not only do providers have less scientific evidence for treating the disease, but patients also have less information to affirm decisions. I asked the Tom Baker Cancer Centre Clinical Lead for Sarcoma oncologist if they feel it is ethically challenging to treat sarcoma. They expressed that there is a lack of evidence-based practice guidelines for making treatment decisions for certain sarcoma types (personal communication, July 2023). Clinical practice guidelines are a summary of the scientific evidence and patient outcomes to guide care (Phillips et al., 2023). Lack of guidelines provides more margins to experiment with treatment options. However, this then forces patients to accept their oncologist's decisions with no scientific evidence (personal communication, July 2023). I have observed this shift in the power dynamic between patient and provider, where patients seem to put their full trust in their oncologist, because they think they have no other option. Jordens and Montgomery (2018) argue that a critical component of autonomy is the healthcare provider's ability to educate patients on the expected outcomes of a treatment. However, without the likely outcomes being known, how can patients exercise this aspect of their autonomy in treatment decisions? It seems that sarcoma patients face certain disadvantages to exercising their full autonomy in decision making. Uncertainty in sarcoma is also expressed in genomic testing.

### Tumour Genomic Profiling

Tumour genomic profiling occurs when tissue from a patient is studied in the laboratory to identify the driver mutations of the tumour (Best et al., 2018). Driver mutations are changes to a gene DNA sequence that allow cancer cells to grow. Identifying these mutations enables the development of drugs to inhibit them (National Cancer

Institute). This profiling creates a concerning categorization within oncology where smaller and smaller groups of cancer types are identified and, thus, fewer patient groups share molecular mutations to study in clinical trials and for targeted therapies to treat (Ashley et al., 2015). Interestingly, Ashley et al. (2015) described this issue as evidence that technology is advancing at a faster pace than the ability to create new drugs, due to the lengthy traditional research and development process. Thus, the issue of tumour genomic profiling also relates back to the ethics of using alternative research processes for faster scientific evidence.

Newson et al. (2016) argued that any form of genomic testing in healthcare creates an ethics issue regarding patient uncertainty. Despite genomic testing being solicited as something to provide answers, it typically creates more questions (Newson et al., 2016). Patient uncertainty is deemed an ethical issue, as recognizing the uncertainty of outcomes in decision making is essential for autonomy (Newson et al., 2016). Thus, the existence of uncertainty in genomic profiling needs to be well acknowledged between patient and provider prior to testing. I have observed patients expressing their surprise in finding out that their genomic testing showed mutations that no existing targeted drugs treat. Thus, it is important to ensure that patients are aware that tumour genomic profiling will not automatically yield benefits for them.

## IMPLICATIONS FOR NURSING PRACTICE AND RECOMMENDATIONS

The ethical considerations in treating sarcoma may appear to be prescriber issues. However, Starzomski et al. (2023) argue that for nurses to practice from an ethical perspective, they have a responsibility to understand, "what is happening, what ought to happen, and how to navigate the difference" (p. 17). My first suggestion for nurses in rare cancer settings would be to utilize their resources. As noted by Starzomski et al. (2023), nurses have their, "codes of ethics, standards for nursing practice, and health care regulatory guidelines," to

understand their role in navigating the is-ought gap (p. 17). Below, I will offer suggestions for nurses to take action-based approaches to changes at the micro, meso, and macro level.

### Micro

While working with individual patients in the sarcoma setting, nursing knowledge related to clinical trials (including basket and umbrella trials), clinical practice guidelines, and genomic profiling are essential to provide patients with education and support. Awareness and utilization of resources to help patients make treatment decisions in the context of having less available information is also important. For example, nurses ought to know when to refer a patient for consultation with a clinical ethicist for assistance with decision making. Additionally, when interacting with patients, the language used by the nurse is important. For example, Heynemann et al. (2023) suggested that for patients considering clinical trial participation, using words such as "intervention" instead of "treatment", and "experiment" instead of "trial" would decrease the potential for the therapeutic misconception (p. 272).

### Meso

At the organization level, nurses can have impact in sarcoma patient care by gaining an understanding of what clinical practice guidelines exist to guide the care of their patients and how they can contribute to them. For example, in Alberta, the Alberta Provincial Sarcoma Tumour Team includes nurses and works to compile evidence to formulate clinical practice guidelines (Alberta Health Services, 2017). Thus, nurses can be directly involved in the process of creating evidence-based clinical practice guidelines.

Additionally, with increasing pressures on our healthcare system, nurses should advocate for appropriate nurse-led initiatives, such as nurse-run oncology clinics to improve patient access to care. Rajasekaran et al. (2021) found that nurse-led specialist sarcoma clinics helped improve patient follow-up care because, in addition to the holistic aspects of care, these nurses provided extensive psychosocial support.



Additionally, these nurse-run clinics off-loaded the quantity of patients needing to be seen by clinicians (Rajasekaran et al., 2021). Nurses can advocate for these nurse-led initiatives within their organization by seeking and presenting evidence of the benefits of the initiatives. Oncology APNs could refer to Farrell's (2016) book titled, *Advanced Nursing Practice and Nurse-led Clinics in Oncology*.

### Macro

At the macro level, there are numerous opportunities for nurses to educate, advocate, and collaborate to improve sarcoma nursing care systemically. Nurses can join special interest groups or nursing associations to achieve this interaction (e.g., the Canadian Association of Nurses in Oncology [CANO], 2023), to network with nurses across Canada, and to access resources. Nurses can contribute knowledge to the association by hosting a webinar,

speaking at a conference, or joining a committee (CANO, 2023). When searching online, I was unable to find a nursing-focused national sarcoma group or website, therefore a nurse could initiate these to benefit nurses across Canada working in sarcoma care. There is also a need for increased Canadian nursing research in sarcoma. Having an online sarcoma nursing group could potentially aid nurses in the process of recruiting patients for sarcoma studies, especially if they are examining a rarer subtype of the disease.

### CONCLUSION

Rare cancer care is continuously evolving and complex. Patients with rare cancers such as sarcoma face numerous uncertainties in their care that impact their ability to autonomously make decisions. Also, the poor prognosis and multiple sub-types of the disease have led to a complex debate regarding the

ethics of decreasing the time it takes to produce scientific evidence and obtain drug approval. There are additional ethical issues in this area that nurses should also be aware about such as the cost and process of fertility preservation, treating rural patients, pathology misdiagnosis, and cost effectiveness in sarcoma care. Through learning about these issues, oncology nurses will hopefully be inspired to instigate positive change in the context of sarcoma care for patients at the micro, meso, and macro levels. It is a nurse's ethical duty to ensure that each oncology patient receives the highest quality of care possible, regardless of the type of cancer they have.

### ACKNOWLEDGEMENTS

*This manuscript was written based on a course NURS 522: Nursing Ethics for Health System Transformation taught by Dr. Rosalie Starzomski at the School of Nursing, University of Victoria, 2023.*

### REFERENCES

- Alberta Health Services. (2017). *Soft-tissue sarcoma: Management of metastatic disease*. <https://www.albertahealthservices.ca/assets/info/hp/cancer/if-hp-cancer-guide-sar-003-management-soft-tissue-sarcoma.pdf>
- Ashley, D., Thomas, D., Gore, L., Carter, R., Zalberg, J. R., Otmar, R., & Savulescu, J. (2015). Accepting risk in the acceleration of drug development for rare cancers. *The Lancet Oncology*, 16(4), e190–e194. [https://doi.org/10.1016/S1470-2045\(14\)71153-2](https://doi.org/10.1016/S1470-2045(14)71153-2)
- Best, M., Newson, A. J., Meiser, B., Juraskova, I., Goldstein, D., Tucker, K., Ballinger, M. L., Hess, D., Schlub, T. E., Biesecker, B., Vines, R., Vines, K., Thomas, D., Young, M.-A., Savard, J., Jacobs, C., & Butow, P. (2018). The PiGeOn project: Protocol for a longitudinal study examining psychosocial, behavioural and ethical issues and outcomes in cancer tumour genomic profiling. *BMC Cancer*, 18(1), 389–389. <https://doi.org/10.1186/s12885-018-4310-0>
- Blay, J.-Y., Coindre, J.-M., Ducimetière, F., & Ray-Coquard, I. (2016). The value of research collaborations and consortia in rare cancers. *The Lancet Oncology*, 17(2), e62–e69. [https://doi.org/10.1016/S1470-2045\(15\)00388-5](https://doi.org/10.1016/S1470-2045(15)00388-5)
- Burningham, Z., Hashibe, M., Spector, L., & Schiffman, J. D. (2012). The epidemiology of sarcoma. *Clinical Sarcoma Research*, 2, 14. <https://doi.org/10.1186/2045-3329-2-14>
- Canadian Association of Nurses in Oncology. (2023). *Home page*. <https://www.cano-acio.ca/>
- Canadian Cancer Society (2015). *Survival statistics for soft tissue sarcoma*. <https://cancer.ca/en/cancer-information/cancer-types/soft-tissue-sarcoma/prognosis-and-survival/survival-statistics>
- Canadian Institutes of Health Research. (2022). *What are clinical trials?* <https://cihr-irsc.gc.ca/e/52988.html>
- Drabbe, C., Grünhagen, D. J., Van Houdt, W. J., Braam, P. M., Soomers, V. L. M. N., Van Der Hage, J. A., De Haan, J. J., Keymeulen, K. B. M. I., Husson, O., & Van Der Graaf, W. T. A. (2021). Diagnosed with a rare cancer: Experiences of adult sarcoma survivors with the healthcare system—results from the SURVSARC study. *Cancers*, 13(4), 679. <https://doi.org/10.3390/cancers13040679>
- Ezeife, D. A., Truong, T. H., Heng, D. Y. C., Bourque, S., Welch, S. A., & Tang, P. A. (2015). Comparison of oncology drug approval between Health Canada and the US Food and Drug Administration. *Cancer*, 121(10), 1688–1693. <https://doi.org/10.1002/cncr.29246>
- Farrell, C. (2016). *Advanced nursing practice and nurse-led clinics in oncology*. Routledge. <https://doi.org/10.4324/9781315797502>
- Fountzilias, E., Said, R., & Tsimberidou, A. M. (2018). Expanded access to investigational drugs: Balancing patient safety with potential therapeutic benefits. *Expert Opinion on Investigational Drugs*, 27(2), 155–162. <https://doi.org/10.1080/13543784.2018.1430137>
- Heynemann, S., Lipworth, W., McLachlan, S.-A., Philip, J., John, T., & Kerridge, I. (2023). When research becomes practice: The concept of the therapeutic misconception and challenges to consent in clinical trials. *Internal Medicine Journal*, 53(2), 271–274. <https://doi.org/10.1111/imj.16015>
- Jordens, J., & Montgomery, K. (2018). Respecting patient autonomy: Some telling challenges for medical professionals who treat seriously ill patients. In K. Montgomery & W. Lipworth (Eds.) *Medical professionals: Conflicts and quandaries in medical practice* (1<sup>st</sup> ed., pp. 13-27). Routledge. <https://doi.org/10.4324/9780203712221>
- Kasper, B. (2021). The challenge of drug approval in rare cancers. *Cancer*, 127(6), 837–839. <https://doi.org/10.1002/cncr.33314>
- Kondo, T. (2021). Current status and future outlook for patient-derived cancer models from a rare cancer research perspective. *Cancer Science*, 112(3), 953–961. <https://doi.org/10.1111/cas.14669>

- Lee, S. (n.d.). *Sarcoma*. Canadian Cancer Society. <https://cancer.ca/en/cancer-information/resources/glossary/s/sarcoma>
- Nash, R. R., & Wells, M. J. (2020). Ethical principles in the practice of medicine. In K. A. Mazur & S. L. Berg (Eds.), *Ethical issues in pediatric hematology/oncology* (pp. 19–35). Springer International Publishing. [https://doi.org/10.1007/978-3-030-22684-8\\_2](https://doi.org/10.1007/978-3-030-22684-8_2)
- National Cancer Institute. (n.d.). *Driver mutation*. <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/driver-mutation>
- Newson, A. J., Leonard, S. J., Hall, A., & Gaff, C. L. (2016). Known unknowns: Building an ethics of uncertainty into genomic medicine. *BMC Medical Genomics*, 9(1), 57–57. <https://doi.org/10.1186/s12920-016-0219-0>
- Nielsen, Z. E., & Berthelsen, C. B. (2019). Cancer patients' perceptions of factors influencing their decisions on participation in clinical drug trials: A qualitative meta-synthesis. *Journal of Clinical Nursing*, 28(13–14), 2443–2461. <https://doi.org/10.1111/jocn.14785>
- Phillips, R. S., Vaarwerk, B., & Morgan, J. E. (2022). Using evidence-based medicine to support clinical decision-making in RMS. *Cancers*, 15(1), 66. <https://doi.org/10.3390/cancers15010066>
- Srikanthan, A., Leung, B., Shokoohi, A., Smrke, A., Bates, A., & Ho, C. (2019). Psychosocial distress scores and needs among newly diagnosed sarcoma patients: A provincial experience. *Sarcoma*, 2019, 5302639–8. <https://doi.org/10.1155/2019/5302639>
- Starzomski, R., Storch, J. L., Rodney, P., & Nancy, C. (2023). Nursing ethics: Developing a moral compass for leadership. In R. Starzomski, J. L. Storch & P. Rodney (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (3rd. ed., pp. 17-58). University of Victoria Libraries. <https://dspace.library.uvic.ca/handle/1828/14970>
- Strzebonska, K., & Waligora, M. (2019). Umbrella and basket trials in oncology: Ethical challenges. *BMC Medical Ethics*, 20(1), 58–58. <https://doi.org/10.1186/s12910-019-0395-5>
- Van Der Graaf, W. T. A., Tesselaar, M. E. T., McVeigh, T. P., Oyen, W. J. G., & Fröhling, S. (2022). Biology-guided precision medicine in rare cancers: Lessons from sarcomas and neuroendocrine tumours. *Seminars in Cancer Biology*, 84, 228–241. <https://doi.org/10.1016/j.semcancer.2022.05.011>

## RESEARCH REFLECTIONS

# Advancing linguistic and epistemic equity for sex, gender and diversity in oncology care research: Moving forward and together as a community

Billy Vinette, Wing Lam Tock, Ricardo Souza Evangelista Sant'Ana, Christine Cassivi, Manon Lemonde, Christine Maheu

## AUTHOR NOTES

**Billy Vinette**, RN, MSN, PhD candidate <https://orcid.org/0000-0003-0343-0260>

Faculty of Nursing, University of Montreal, Montreal, Canada

Research center of the Centre intégré universitaire de santé et de services sociaux de l'Est-de-l'Île-de-Montréal, Montreal, QC

Email: [Billy.vinette@umontreal.ca](mailto:Billy.vinette@umontreal.ca)

**Wing Lam Tock**, RN, MSN, PhD candidate <https://orcid.org/0000-0003-1614-3770>

Ingram School of Nursing, Faculty of Medicine and Health Sciences, McGill University, Montreal, QC

Email: [Wing.tock@mail.mcgill.ca](mailto:Wing.tock@mail.mcgill.ca)

**Ricardo Souza Evangelista Sant'Ana**, RN, MSN, PhD candidate <https://orcid.org/0000-0003-3762-4362>

School of Nursing of Ribeirão Preto, University of São Paulo, São Paulo, Brasil

Email: [Ricardo.sesantana@usp.br](mailto:Ricardo.sesantana@usp.br)

**Christine Cassivi**, RN, MSN, PhD student <https://orcid.org/0000-0001-7857-159X>

Faculty of Nursing, University of Montreal, Montreal, Canada

The Centre for Public Health Research (CRESP), Montreal, QC

Email: [Christine.cassivi@umontreal.ca](mailto:Christine.cassivi@umontreal.ca)

**Manon Lemonde**, RN, PhD <https://orcid.org/0000-0003-3102-1915>

Faculty of Health Sciences, Ontario Tech University, Oshawa, ON

Email: [Manon.lemonde@ontariotechu.ca](mailto:Manon.lemonde@ontariotechu.ca)

**Christine Maheu**, RN, PhD <https://orcid.org/0000-0001-8704-8207>

Ingram School of Nursing, Faculty of Medicine and Health Sciences, McGill University, Montreal, QC  
McGill University Health Centre, Montreal, Canada

Email: [Christine.maheu@mcgill.ca](mailto:Christine.maheu@mcgill.ca)

**Corresponding author:** Billy Vinette, Faculty of Nursing, University of Montreal, 2375, chemin de la Côte-Ste-Catherine, Montreal, QC H3T 1A8

Email: [billy.vinette@umontreal.ca](mailto:billy.vinette@umontreal.ca)

## BACKGROUND

In recent years, equity issues have taken on great importance, particularly in the field of oncology. Indeed, Canada has faced significant challenges, including global migration, limited resources, and climate changes that have exerted undeniable impacts on equity in cancer care services. Furthermore, the COVID-19 pandemic was a significant milestone that exacerbated many pre-existing health inequities. Despite these challenges, oncology nurse researchers shoulder the responsibility to contribute to health and epistemic equity (i.e., creation, usage, and diffusion of knowledge). This responsibility transcends Canada's official languages (French and English), reflecting Canada's rich linguistic diversity, with more than 4.6 million individuals (12.7%) primarily using languages other than English or French at home, such as Mandarin, Yue, Cree languages, and many more (Statistics Canada, 2022). Numerous researchers, including those featured in this journal, have taken a proactive stance in raising awareness and advocating for improved oncology research on health and epistemic equity (Varcoe et al., 2015; Winkfield et al., 2020). Alongside scholars and researchers, numerous national and international organizations, including the American Society of Clinical Oncology and the Canadian Partnership Against Cancer, have also expressed a commitment to address this crucial issue.

Closer to us, the Canadian Association of Nurses in Oncology explicitly stipulated in its mission the need to improve health equity in cancer care. These collective stances are an important step towards ensuring health equity across the cancer care

continuum. However, it seems fundamental to tackle the problem by acting explicitly on linguistic and epistemic equity and consider how the intersectionality of race, class and gender may affect linguistic diversity. Inspired by our experiences as nurses with linguistic diversity and different backgrounds, this paper proposes actionable strategies to empower oncology nurse researchers in reducing these inequities.

## EMPOWERING CHANGE: TAKE ACTION

We firmly believe oncology nurse researchers can drive meaningful impact on linguistic and epistemic equity by adopting inclusive research practices from the conceptualization of research projects to dissemination of results to knowledge users. Given their pivotal roles, oncology nurse researchers are in a privileged position to act on these elements, since they take an interest in different subjects throughout the cancer care continuum. Moreover, sex and gender continue to influence the delivery of cancer care and are frequently marginalized, receiving insufficient attention in research and in knowledge translation, which may hinder the generalizability of research findings and their uptake in clinical settings (Heidari et al., 2016).

While we acknowledge that not all research endeavours in oncology can systematically integrate linguistic, sex, gender, and diversity (LSGD) aspects, we encourage oncology nurse researchers to improve their research practices and actively consider these elements more often. To this end, Table 1 presents several actionable strategies intended to encourage LSGD within oncology care research projects and reduce epistemic inequity.

Table 1

Strategies to increase equity within oncology care research projects

#### Before starting a research project

- Collaborate with researchers from different linguistic, sex, gender, and diversity (LSGD) backgrounds.
- Design studies with enough power analysis to answer research questions for both sex (Leopold et al 2014).
- Establish partnerships with stakeholders involved in LSGD communities (Winkfield et al., 2020).
- Engage end users from different LSGD backgrounds ahead of research (Baumann et al., 2023).
- Review inclusion criteria and use recruitment strategies to increase LSGD array of participants (Patel et al., 2020).
- Incorporate provisions for engaging LSGD experts, ensuring access to their insights and guidance, and allocate resources for translation and language editing in grant applications.

#### Throughout the research project

- Create an advisory panel with different LSGD backgrounds (Bodicoat et al., 2021).
- Monitor LSGD equity markers through research (e.g., languages) (Baumann et al., 2023).
- Communicate regularly with stakeholders involved in LSGD communities (Winkfield et al., 2020).

#### After the research project

- Develop multilingual and gender-neutral tools and dissemination resources (Murray & Lee, 2021).
- Use non-conventional dissemination strategies (e.g., community workshops) (Murray & Lee, 2021; Patel et al., 2020).
- Support organizations with LSGD communities to implement research results (Patel et al., 2020).
- Use and provide research data using Sex- and Gender-Based Analysis (Leopold et al 2014).

#### Promote comprehensive LSGD equity: ongoing advocacy, education, and engagement

- Become an advocate and lobby stakeholders (e.g., provincial ministers of health) on an ongoing basis, championing the necessity for comprehensive inclusion of LSGD considerations (Patel et al., 2020; Winkfield et al., 2020).
- Educate yourself and your team (e.g., online courses) (Baumann et al., 2023).
- Use alternative language options to communicate with non-English or French speakers (Bodicoat et al., 2021).
- Establish mentorship program with students from different LSGD backgrounds (Baumann et al., 2023; Murray & Lee, 2021).
- Increase workforce LSGD representation (Baumann et al., 2023; Murray & Lee, 2021).
- Consider using a health equity framework that includes LSGD aspects (e.g., Goodridge et al., 2019).

## CONCLUSION

Addressing epistemic and linguistic inequities in cancer care is of paramount importance. Oncology nursing researchers play a crucial role in ensuring that cancer care is accessible and equitable for individuals from LSGD backgrounds. Given the persistent challenges within the landscape of cancer care provisions in Canada and the potential inequities in accessing

and receiving LSGD-sensitive care, it becomes imperative for oncology nursing researchers to adapt and refine their research methodologies while nurturing an intensified sensitivity towards LSGD, and epistemic equity. Through the embrace of more inclusive practices throughout the research process, we can collectively progress and empower the provision of high-quality and equitable cancer care for individuals from

diverse LSGD backgrounds. Together, let's answer the call to action!

## AUTHORS' CONTRIBUTIONS

**BV:** Writing – original draft. **WLT:** Writing – review & editing. **RSESA:** Writing – review & editing. **CC:** Writing – review & editing. **ML:** Writing – review & editing. **CM:** Writing – review & editing, supervision. All authors contributed to conceptualization of this work.

## REFERENCES

- Baumann, A. A., Shelton, R. C., Kumanyka, S., & Haire-Joshu, D. (2023). Advancing healthcare equity through dissemination and implementation science. *Health Services Research*. <https://doi.org/10.1111/1475-6773.14175>
- Goodridge, D., Bandara, T., Marciniuk, D., Hutchinson, S., Crossman, L., Kachur, B., Higgins, D., & Bennett, A. (2019). Promoting chronic disease management in persons with complex social needs: A qualitative descriptive study. *Chronic Respiratory Disease*, 16. <https://doi.org/10.1177/1479973119832025>
- Heidari, S., Babor, T. F., De Castro, P., Tort, S., & Curno, M. (2016). Sex and gender equity in research: Rationale for the SAGER guidelines and recommended use. *Research Integrity and Peer Review*, 1:2. <https://doi.org/10.1186/s41073-016-0007-6>
- Leopold, S.S., Beadling, L., Dobbs, M. B., Gebhart, M. C., Lotke, P. A., Manner, P. A., Rinnac, C. M., & Wongworawat, M. D. (2014). Fairness to all: Gender and sex in scientific reporting. *Clinical Orthopaedics and Related Research*, 472, 391–392. <https://doi.org/10.1007/s11999-013-3397-5>
- Murray, M. S., & Lee, L. H. (2021). The future of oncology care requires integration of patient engagement and equity into practice. *Future Oncology*, 17(28). <https://doi.org/10.2217/fon-2021-0912>

- Patel, M. I., Lopez, A. M., Blackstock, W., Reeder-Hayes, K., Moushey, A., Philipps, J., & Tap, W. (2020). Cancer disparities and health equity: A policy statement from the American Society of Clinical Oncology. *Journal of Clinical Oncology*, 38(29), 3439–3448. <http://ascopubs.org/doi/full/10.1200/JCO.20.00642>
- Statistics Canada. (2022). *While English and French are still the main languages spoken in Canada, the country's linguistic diversity continues to grow*. <https://www150.statcan.gc.ca/n1/daily-quotidien/220817/dq220817a-eng.htm?indid=32989-4&indgeo=0>
- Varcoe, C., Habib, S., Sinding, C., Fitch, M., Gullatte, M. M., & Cummings, G. G. (2015). Health disparities in cancer care: Exploring Canadian, American and international perspectives. *Canadian Oncology Nursing Journal*, 25(1). 10.5737/236880762517381
- Winkfield, K. M., Regnante, J. M., Miller-Sonet, E., González, E. T., Freund, K. M., & Doykos, P. M. (2021). Development of an actionable framework to address cancer care disparities in medically underserved populations in the United States: Expert roundtable recommendations. *JCO Oncology Practice*, 17(3), e278–e293. 10.1200/OP.20.00630

# 2023 CANO/ACIO Annual Conference Abstracts Index

Abstract number	Oral Presentation titles	Page number
W-01-A	Malignant Hematology and Stem Cell Transplant Nursing – Talk Hematology to Me	92
W-02-A	International Results on the Specialty Certification of Advanced Practice Nurses: Implications for Oncology Nurses in Canada	92
W-03-A	Revitalizing and Integrating the CANO/ACIO Oncology Nursing Learning Pathway and Practice Framework: Designing an innovative education resource for nurses caring for persons with cancer	92
W-04-A	Overcoming Challenges in Graduate Education and Research: CANO/ACIO Doctoral Student Network Workshop	93
W-04-B	Learning Together about What's Working to Improve Cancer Diagnoses	93
W-05-A	Strengthening Oncology Nurses' Symptom Support Competencies: A Train-the-Trainer Workshop Using COSTaRS Practice Guides	94
W-05-B	Society for Integrative Oncology-American Society for Clinical Oncology Clinical Practice Guidelines for Pain and Anxiety/Depression	94
W-06-A	Safe Handling of Hazardous Drugs	95
W-06-B	Cancer and Medical Cannabis: Therapeutic 'Pot'ential?	95
W-01-B	LEADS in Action – A Hands on Workshop to Building Leadership Competencies	95
W-02-B	Take a Stab at It: Developing Vascular Access Resources for Oncology Practice	95
W-03-B	Intimacy and Sexuality After Cancer: A Workshop on Nursing Approach to Address Patient Unmet Needs	96
W-04-C	Integrating Geriatric Assessment into Everyday Oncology Nursing Practice: A Hands-on Workshop	96
W-04-D	Developing a Community of Practice to Support Integration of Geriatric Assessment and Management Into Everyday Oncology Nursing Practice: An Interactive Discussion and Workshop	97
W-05-C	How to Foster Safe and Efficient Cannabis Use in Oncology: Tips and Recommendations for Oncology Nurses	97
W-05-D	Using Patient Reported Outcomes (PROs) to Facilitate Serious Illness Conversations: An Interactive Workshop	97
W-06-C	Cancer Patient Navigation – The Creation of a National Orientation Program	98
W-06-D	How Can I Support Cancer Survivorship from the Diagnosis to Discharge? A Workshop for Clinical Oncology Nurses	98
Merck Clinical Lectureship Award	Model of Care – Virtual Oncology in the Northwest Territories – Oncology Clinic RN Role	98
Helene Hudson Memorial Lectureship Award sponsored by Amgen	Compassion Fatigue: Harnessing the Strength Within	99
I-1-A	Supporting Scholarship in Oncology Nursing: Achievements and Lessons Learned in the Development of an Oncology Nursing Research Centre of Excellence	99
I-1-B	Nurse Initiated Protocols and Decision Support Tools in Oncology Nursing Practice	100
I-1-C	Exploring How to Successfully Make a Nursing Practice Change: Frontline Leaders Using the ADKAR Model & The Knowledge Translation Challenge Process	100
I-1-D	Building on Our Strengths- Development of a Joint Foundational Oncology Orientation Program	100
I-2-A	Strengthening Oncology Nursing Partnerships: Development of a Hybrid Oncology Student Learning Pathway	101

Abstract number	Oral Presentation titles	Page number
I-2-B	Growing Oncology Expertise: C3 Development Ladder	101
I-2-C	Barriers, Facilitators and Motivations to Pursue Specialty Certification in Oncology Nursing: The Case of BC Oncology Nurses	101
I-2-D	Crossing the Chasm: Building Relationships Between Clinical Trial and Cancer Care Nurses to Improve Clinical Trial Recruitment in Nova Scotia	102
I-3-A	Implementing New Cervical Brachytherapy Program: Nursing Perspective	102
I-3-B	Managing Infusion Reactions: Optimizing Scope for Timely Intervention	102
I-3-C	Preventing and Managing Complications of High Dose Methotrexate	103
I-3-D	Network Leadership: Lessons Learned	103
I-4-A	The Power of Nursing: Nurse driven decision tool to manage toxicities with Acute promyelocytic leukemia	103
I-4-B	Impact of Obtaining Patient Reported Symptoms from Patients with Metastatic Breast Cancer	104
I-4-C	Improving Sleep Quality After Cancer: What Does the Evidence Tell Us?	104
I-5-A	Developing a Competency-Based Educational Framework for Palliative Care in Home and Community	104
I-5-B	Optimizing the Strength Within: Integrating Palliative Care in Hematologic Oncology	105
I-5-C	Enhancing delivery of Palliative care on an acute care oncology unit through the use of simulation-based learning	105
I-6-A	Recognizing the Needs and Challenges of the Pediatric Cancer Survivor and the Pivotal Role Nursing Plays	105
I-6-B	Addressing Suffering in Children Living with Cancer and Their Families	106
I-6-C	Psychological Distress in Pediatric Cancer: Measuring the Issue in Children and Their Families and Intervening to Improve Quality of Life	106
I-6-D	Working Together to Foster Treatment Innovation for Pediatric Cancer	106
II-1-A	Chemo Smartbook: Strengthening Systemic Therapy Scheduling at BC Cancer	107
II-1-B	Real-World Implementation Barriers and Facilitators of Electronic Patient-Reported Outcomes (PROs) In Oncology in Quebec: A Qualitative Study	107
II-1-C	Introducing MySymptom Report: A Comprehensive Electronic Patient-Reported Outcome Questionnaire to Support Oncology Practice	108
II-1-D	Enhancing Immunotherapy Safety: The Use of Electronic Patient-Reported Outcomes for Detection and Prediction of Immune-Related Adverse Events	108
II-2-A	The Leading Role of Nurses in Providing Patient-Centred Care for Patients with Ambulatory 5-Fluorouracil Infusors	108
II-2-B	Oncology Nurses as Partners in Head & Neck Cancer Treatment Recovery: The Development of a Nurse-led Gastrostomy Tube Removal Clinic	109
II-2-C	Living Well with Pancreatic Cancer. Maintaining Excellence in Oncology Nursing Care for Patients and their Families Living with Pancreatic Cancer	109
II-2-D	The Impact of Peer Support on the Psychosocial Functioning and Social Support of Young Adults with Gynecological Cancer	109
II-3-A	An Overview of Targeted Systemic Cancer Therapy	110
II-3-B	Closed-Loop Medication Management - A QI Initiative	110
II-3-C	Administration of Systemic Therapy for Cancer on Non-Oncology Inpatient Units	111
II-3-D	Levelling up: Defining the Levels of Care for Systemic Therapy Administration in Nova Scotia	111

Abstract number	Oral Presentation titles	Page number
II-4-A	Exploring Oncology Patient Self-Management Support in Baccalaureate Nursing Curriculum: A Case Study Approach	111
II-4-B	Supportive Care Needs Among Adults Affected by Hematological Cancers and their Caregivers	112
II-4-C	Patient education pamphlets and usual care are not enough; what do patient decision aids offer patients facing cancer decisions?	112
II-4-D	Personas and journey maps to illustrate patients' life stories and contextualize patient-reported outcome measures in cancer care	113
II-5-A	Medical Assistance in Dying in Canada: An Update on the Amended Legislation	113
II-5-B	Perspectives of Family Members of MAID Recipients: Considerations for Oncology Nurses	113
II-5-C	End-of-Life Care among Adults with Hematological Malignancies: Implications for Nursing Practice	114
II-6-A	Nurse-Parent Relational Complexity Within Pediatric Oncology Contexts: Navigating Closeness, Conflict, And Online and Offline Communication	114
II-6-B	Understanding the Family Dynamics of Emerging Adults Diagnosed with Blood Cancer and Their Parents and Siblings	114
II-6-C	Developing an Adolescent and Young Adult Program within CancerCare Manitoba – Initial Steps	115
II-6-D	Addressing the Complex Needs of Adolescents and Young Adults (AYAs) Diagnosed with a Hematological Cancer.	115
III-1-A	Primary Nursing Model in Practice: Halifax Cancer Care Program, Ambulatory Oncology	115
III-1-B	Radiation Oncology Team-Based Care: A Post-Implementation Overview of System, Patient, and Nursing Outcomes at BC Cancer – Kelowna	116
III-1-C	Organizing and Carrying Out a Massive Transfer of Oncology Activities to a New Building: The Experience of CHU de Québec-UL	116
III-1-D	How to Priority Safety in The Context of a Major Developmental Project	116
III-2-A	“A Maelstrom of Feelings”: Psychosocial Wellbeing of Female Patients with Hormone Receptor-Positive Breast Cancer and Its Nursing Implications	117
III-2-B	Preferences for Psychoeducational Interventions Among Caregivers of Patients Undergoing Allogeneic Stem Cell Transplant for Hematological Malignancy	117
III-2-C	E-Learning modules for Oncology Nurses to Better Address Psychosocial Issues in Young Adult: A Collaborative Project with the LLSC	117
III-3-A	What Do Cancer Survivors Believe Caused Their Cancer? A Secondary Analysis Using the Causes Subscale of the Illness Perceptions Questionnaire	118
III-3-B	Developing an Evidence- And Experience-Informed Educational Resource for Gynecological Cancer Survivors and Their Caregivers	118
III-3-C	The Unmet Survivorship Needs of Adolescent and Young Adult Cancer Survivors	118
III-3-D	The Strength Within: One Black Oncology Nurse Practitioner's Survival Story	119
III-4-A	Strengthening from Within: Informing Policy to Optimize the Clinical Nurse Specialist Workforce in Oncology	119
III-4-B	Designing Engagement Strategies for Genomics-informed Oncology Nursing: Comparative Prospective Cross-Jurisdictional Policy Analysis [DESIGN: Policy]	120
III-4-C	The Future of HPV Testing in Times of International Transition.	120
III-4-D	Standardizing Pregnancy Testing and Contraceptive Counselling Practices for Patients of Reproductive Potential Undergoing Anticancer Therapies	120



Abstract number	Oral Presentation titles	Page number
III-5-A	The RPM: A Benevolent Tool to Support People Living with Cancer	121
III-5-B	Oncology Nurses' Experiences with Virtual Care in Canada: Preliminary Findings	121
III-5-C	APOLLO: personalized rehAbilitation PrOgram in aLLOgeneic bone marrow transplantation	121
III-5-D	Surgical Transitions Remote Patient Monitoring (RPM) program	122
III-6-A	Measuring the Impact of New Systemic Therapy Treatments	122
III-6-B	Fostering Strength Within: Establishing a Provincial Oncology Educator Community of Practice	123
III-6-C	Between the Lines: How a Book Club Impacted Oncology Nursing Practice and Staff Well-being	123
III-6-D	An Undergraduate Nursing Student Pursuing Cancer Care; Diagnosis, Nursing School, Advocacy	123
IV-1-A	The Power in Empowerment: Development of a Local Peer Support Program	123
IV-1-B	Strength Within: A Nurse-Led Pilot of Remote Patient Monitoring for Immunotherapy Patients	124
IV-1-C	Utilizing a Community Outreach Program to Improve Cancer Health Literacy	124
IV-1-D	Acute Outpatient Management of Immune Effector Cell Therapy: The Pivotal Role of Oncology Nurses	124
IV-2-A	Oncology Clinical Trials Nursing: Helping to Fortify the Strength Within	125
IV-2-B	VIRTUal clinical trials navigation to improve Outcomes for Princess Margaret advanced SOLid tumor patients (VIRTUOSO)	125
IV-2-C	The Nursing Role in the DOvEEgene Study: An Opportunity for Future Innovations to Improve Timely Access to Care for Women with Symptoms of Gynecologic	125
IV-2-D	The Role of a Clinical Nurse Specialist in the Development of an Oncology Nursing Research Centre	126
IV-3-A	Oncology Nurses' Readiness to Provide Person Centered Care Informed by Genomics: A Mixed-Methods Study	126
IV-3-B	Supporting the Transition: Examining a Nurse Practitioner-Led Intervention for Gynecological Cancer Survivors	126
IV-3-C	Understanding How to Better Support Oncology Nurses in Conducting Advanced Care Planning in BC's Cancer Care System	127
IV-4-A	The Genetic Evolution of AML: Implications for Nursing Practice	127
IV-4-B	Exploring the Need for Human Leukocyte Antigen (HLA) Matched Platelets in Patients Diagnosed with a Hematological Cancer	127
IV-4-C	Strategic Collaboration Between Cancer Patient Organizations and Canadian Oncology Nurses: Learning from Myeloma Patient Groups Worldwide	128
IV-4-D	An Overview of Myeloproliferative Neoplasms, Symptom Assessment and the Shared-Care Model at Princess Margaret Cancer Centre	128
IV-5-A	Connect and Exchange for System Transformation- A Workshop for Oncology Practice Leaders	128
IV-5-B	"How to Start That Conversation?": A Simulation About Sexual Health Among Breast Cancer Survivors	129
IV-5-C	Targeting Nurses' Needs and Leveraging Strengths to Accelerate Genomics-Informed Practices: Results From the GGNPS-CA Survey	129
IV-6-A	Intégration d'un dépistage systématique de la fragilité onco-gériatrique par l'infirmière; les retombées d'un projet pilote	129
IV-6-B	Évaluation et gestion de la détresse par les infirmières en oncologie : une revue de la portée	130
IV-6-C	Normes et compétences en radiooncologie : étude temps-mouvement de la pratique infirmière	130
V-1-A	Oncology Nursing at BC Cancer: A Thoughtful Trajectory of Education, Experiences, and Emergence	130

Abstract number	Oral Presentation titles	Page number
V-1-B	Onboarding an Internationally Educated Nurse on a Transplant and Cellular Therapy Inpatient Unit	131
V-1-C	Designing a Specialized Oncology Nursing Transition to Practice Pathway: A Nova Scotia Experience	131
V-2-A	Informing the Role, Onboarding, and Transition to Practice of Nurse Practitioners in Community Oncology: A Pilot Project in Nova Scotia	131
V-2-B	Addressing Gaps in Transitions for Lymphoma / Chronic Lymphocytic Leukemia (CLL) Follow-Up Patients with an NP-Led Model	131
V-2-C	Developing a Nurse Practitioner-led Outpatient CART Follow-up Program at Princess Margaret Cancer Centre	132
V-2-D	Optimizing the Nurse Practitioner Role to Meet Patient and Health Service Needs in Complex Malignant Hematology: A Qualitative Descriptive Study	132
V-3-A	Effectiveness of Cancer Patient Navigation on Diagnostic Resolution and Treatment Initiation in Patients With Primary Lung Cancer in Manitoba	133
V-3-B	Cancer Patient Navigation – A Canadian Perspective to Enhance Oncology Nursing Excellence	133
V-3-C	Patient Reported Outcomes (PROs) In Cancer Care: Leadership and Nursing Strengths	133
V-3-D	Early Palliative Care Across Canada: A Scoping Review	134
V-4-A	Insights into the Relationship between Patient-initiated Telephone Calls and Women Treated for Gynecological Cancer a Retrospective Study.	134
V-4-B	A New Integrated Cancer Center: An Opportunity for an Evolution of Our Nursing Cancer Care Organization	134
V-4-C	The Implementation of a Clinical Resource Nurse in the Ambulatory Care Setting: A Pilot	134
V-4-D	A New Integrated Cancer Center: An Opportunity for an Evolution of Our Nursing Cancer Care Organization	135
V-5-A	The Strength of Oncology Nursing: Building a Nurse-Led Program That Facilitates In-Home Care For Allogeneic Stem Cell Transplant Recipients	135
V-5-B	Developing a Home Parenteral Nutrition Program for Oncology Patients in a Community Hospital: The Expectation vs the Reality	136
V-5-C	Optimization of Workup Pathways to Improve Access to Cancer Care Programs and Patients' Experiences in Rural and Underserved Communities	136
V-5-D	Oncotype by Nurse, a New Process to Identify High Risk Patients and to Expedite Treatment in Early-Stage Breast Cancer	137
V-6-A	Bridging the Knowledge Gap: Development of an E-learning Course on Geriatric Oncology	137
V-6-B	Co-designing a Tailored Self-Management App with Older Adults with Cancer and Multimorbidities	137
V-6-C	Nurse-Led Assessment Using Patient-Reported Outcomes Among Older Adults with Cancer	138
V-6-D	Implementing Geriatric Assessment and Management for Older Canadians With Cancer: Adherence to and Satisfaction With the Intervention, Results of the 5C Trial	138
P-01	The Triggered Referral Program for Acute Leukemia Inpatients	140
P-02	Enhancing the Patient's Understanding of their Oral Anti-cancer Therapy: A Multidisciplinary Approach to Improving Oral Medication Counselling	140
P-03	How Can Nurses Support Health Promotion Following Breast Cancer in Primary Health Care? Scoping Review Protocol	140
P-04	The Ontario Peritoneal Surface Malignancy Program	141
P-05	Team-Based Care: A Pre- and Post-Implementation Journey Map at BC Cancer – Vancouver	141

Abstract number	Oral Presentation titles	Page number
P-06	Stem Cell HVAC Renovation Project	141
P-08	Exploring the Experiences and Influencing Factors of Oncology Advanced Practice Nurses Engagement in Research and Scholarship in a Cancer Centre	141
P-10	Predisposing, Precipitating, Perpetuating, and Protective Factors Related to Distress in Parents of Children with Cancer: A Systematic Review	142
P-11	Use of Patient-Reported Outcomes (PRO)-Based Nurse-Initiated Interventions in Gynecologic Cancer Patients Receiving Systemic Therapy – A Pilot Study	142
P-12	Evaluating the Impact of the Clinical Nurse Specialist Role on Patient Care and in the Myeloproliferative Neoplasm Program	143
P-13	Managing the Care of Uninsured Cancer Patients during COVID-19 Pandemic in Humber River Hospital (HRH) Cancer Clinic	143
P-15	Difficult Conversations in Malignant Hematology: Modifying the Spikes Framework to Support Early Integration of Advanced Care Planning	143
P-16	Development of a Nurse-Led High-Risk Melanoma Surveillance Clinic	144
P-18	The Patient Access Clinic for those Experiencing Symptoms (PACES): Symptom Support for Patients with Uncontrolled Symptoms Related to Cancer Treatment	144
P-19	To Page, or Not to Page: Optimizing the Management of Oncology Drug Reactions in a Large Outpatient Chemotherapy Unit	144
P-20	Enhancing Patient Safety: Implementing Best Practice Guidelines for Specific Blood Product Administration	145
P-21	Clearing the Haze: Heightening Nursing Understanding of the Side Effects of Cannabis Use and Mitigating Negative Outcomes	145
P-22	Navigating Peritoneal Malignancies: A Patient Guide to Ontario's Peritoneal Surface Malignancy Program	145
P-23	Bridging the Gap: Using a Specialized Nursing Role to Mentor New Surgical Oncology Nursing Hires	146
P-25	An Innovative Collaboration: An Artist and a Nurse. Using Art as a Medium for Palliative and End of Life Care	146
P-26	Specialized Oncology Nurses: Optimizing Their Role in Sexual Health Assessment	146
P-27	More Than Just Chemo Teaching: Providing Education to Patients Newly Starting Systemic Therapy	147

<b>A</b>	<b>Author</b>	<b>Abstract number</b>	<b>C</b>	
	Adams, O	II-2-C	Cacao, F	P-13
	Agnew Kazina, E	V-3-A, V-3-B	Caissie, A	V-5-C
	Ahmad, I	I-4-C	Calzone, K	III-4-B
	Aiello, C	I-2-B	Carley, M	II-4-C
	Aksenchuk, S	P-04, P-22	Carlson, L	W-05-B, I-1-A, III-4-B,
	Alibhai, S	V-6-A, V-6-D		IV-2-B, IV-5-C, P-08
	Alqurini, N	V-6-D	Carlson, S S	P-11
	Alsrayheen, E	V-5-C	Carter, N	II-2-A, V-2-D
	Amir, E	V-6-D	Carter, R A	II-2-D
	Arbour, C	I-4-C	Castiglia, L L	III-4-D
	Armstrong, M	P-16	Castro, A	W-04-A
	Arruda, A	P-12	Cerullo, L	V-6-A
	Auro, V	III-2-B	Champ, S	W-03-A, W-06-C, V-3-B
	Avery, A	I-2-D	Chartier, G	I-3-D, V-3-C, V-6-C
	Ayotte, K	P-20	Chen, C	V-2-C
<b>B</b>	Baetz, Dr T	V-2-A	Cheung, V	IV-4-D, P-12
	Baines, K-A	W-06-D	Chisholm, S	V-5-C
	Baker, T	I-5-A	Chiu, C	III-4-A, III-4-B
	Balneaves, L G	W-05-B	Chouinard, M C	P-03
	Balonjan, K	V-2-D	Clarke, S	V-5-A
	Banjar, A	I-2-B	Claudio, J	P-12
	Bankar, A	IV-4-D	Coady, M	II-4-A
	Barnhill, D	I-3-B, II-3-D	Coles, L	V-5-B, P-02
	Baro, I	V-6-B	Collier, Jodi	W-06-C
	Bayne, C	V-5-D	Colville, C	III-1-A
	Beauregard, V	III-5-A	Colwell, B	II-3-D, III-6-A
	Beck, S	I-2-C, III-4-A, P-05	Concepcion Bachynski, J	IV-5-B
	Beland, F	V-6-D	Cooper, L	I-1-A, IV-2-D, P-08
	Bélangier, M -È	IV-6-A, V-4-B	Crosby, M	I-2-C
	Benc, R	V-3-C, V-4-D, V-6-C	Currie, L	V-6-B
	Bergen, T	Helene Hudson	d'Entremont, D	V-2-A
		Memorial Lectureship	Dahl-Steffensen, K	II-4-C
		Award sponsored	Dalgleish, D	III-1-B
		by Amgen	Danzmann, K	P-01
	Berger, A	V-6-A, V-6-D	Darveau, S	III-5-A
	Bergman, S	V-6-D	Dastjerdi, M	II-1-D
	Bhella, S	V-2-C	Datt, A	IV-1-A
	Bigras, C	V-3-C	Datt, L	IV-1-A
	Bilodeau, K	W-06-D, I-4-C, III-2-C,	Davidson, M	IV-4-D
		P-03	Dawes, M	W-04-B
	Binder, L	W-04-B	Dawson, L	IV-3-A
	Blue, M	P-16	Dayyat, A	V-5-C
	Booker, R	W-06-B, I-5-B, II-5-A,	Deering, J	II-2-B
		IV-5-B, V-4-D	DeLure, A	W-05-D, II-1-C
	Borycki, E	III-5-B	deRaad, M	II-1-B
	Bouchard, C	II-1-B	Deraspe, S	III-1-C, III-1-D
	Bourne, L	III-1-A	Desbiens, J-F	IV-6-B
	Bragg, M	I-3-B, II-3-D	Dewell, S	III-4-B
	Brander, H	V-3-B, P-27	Dhaliwal, S	II-6-B
	Branton, S	I-5-C	Di Carlo, C	P-10
	Brenna, A	V-5-C	Dixon, C	W-06-C, Merck Clinical
	Brennenstuhl, S	V-6-D		Lectureship Award,
	Breunis, H	V-6-D	Dosanjh, J	V-3-B
	Brown, E	V-4-D	Doucet, J	V-1-A
	Brown, J	II-5-C, P-25	Doyle, A	II-4-C
	Bryant-Lukosius, D	W-02-A, II-2-A, III-4-A,	Duerksen, N	W-05-B
		V-2-D	El Haddad, N	III-6-B
	Buick, C	W-02-A, II-1-D, III-4-C,	Elias, M	V-3-C, V-6-C
		III-5-B, V-4-A, V-4-D	Elmas, S	IV-4-C
	Bunkso, J	I-2-A, I-4-B	Elser, C	III-4-D
			Emmenegger, U	V-6-D
			Etchegary, H	V-6-D
			Evans, Z	IV-3-A
				V-5-A

<b>F</b>	Faiman, B	IV-4-C	<b>I</b>	Ijaz, T	III-6-D
	Faour, E	V-6-A		Ilagan, C	I-3-D
	Fernandez, N	III-2-C		Irlbacher, G	II-4-D
	Fifield, C	I-3-B, II-3-C, II-3-D, III-6-A, III-6-B, IV-5-A, V-1-C, P-27		Ismaila, N	W-05-B
		III-5-B		Jamieson-Wright, K	W-03-A
		IV-2-B		Jamieson, K	I-3-B, II-3-D, III-6-B, IV-5-A, V-1-C, V-2-A
		IV-2-A			V-6-D
		V-2-D		Jang, R	II-3-B, P-05
		P-27		Janmohamed-Velani, T	II-6-C, III-3-C
		II-3-C		Jansen, M	P-21
<b>G</b>	Fitch, M	III-4-A	Jennings, S	P-10	
	Flores Pereira, L	III-4-A	Jib, L	I-6-C	
	Flynn-Post, M	P-15	Jibb, L	W-04-C, W-04-D, V-6-A	
	Forbes, M	III-3-A, III-3-B, IV-3-B, IV-5-B	Jin, R	IV-6-C	
	Fortune, A	I-3-A	Joannette, S	V-2-C	
	Fraga, C	I-3-A	Jomha, S	V-2-C	
	Francis, J	III-3-D	Joseph, A L	II-4-D	
	French, J	III-2-C	Julien, K J	II-1-B	
	Galica, J	III-1-C	Julius, A	I-1-A, IV-2-D, P-08	
		II-1-B	Kaal, J	II-3-C, IV-5-A	
<b>H</b>	Gallichan, K	I-3-A	<b>K</b>	Kaal, K J	V-2-A
	Garraway, C T	W-01-B		Kaasalainen, S	II-2-A
	Gélinas-Gagné, C	V-4-A		Kaczmariski, E	P-02
	Germain, I	IV-2-C		Kaur, J	W-04-A, I-2-C, III-4-A
	Germeil, F	P-11		Kei, C	II-2-C
	Gibson, B	III-6-C		Kelly, C	II-2-B
	Gidida, R	W-03-B, IV-3-B, IV-5-B		Kennedy, J	III-6-B, P-27
	Gien, L	W-01-A		Kennedy, M	V-4-A
	Gilbert, L	V-4-D		Kenny, C	I-1-C
	Gill, S	P-10		Kilgour, H M	IV-3-C, P-05
Gilpin, E	W-05-B	Killam, A	W-05-A, V-4-D		
Giroux, J	III-4-B	Killam, L	IV-5-B		
Giulione A	IV-6-B	Kirkby, C	V-4-D		
Given, M	V-6-A	Kiss, A	II-4-C		
Gladkikh, M	IV-4-D, P-12	Knox, A	W-02-A, I-2-C, III-4-A		
Greenlee, H	III-5-C	Ko, J J	P-11		
Gretchev, A	V-6-B	Kobekyaa, F	W-04-A, V-6-B		
Griffith, G	IV-6-B	Koneru, R	V-6-D		
Guo, S	IV-4-D, P-12	Kooner, S	II-2-B		
Gupta, V	III-5-C	Korenblum, C	IV-2-A		
Gyenes, G	V-6-B	Kouroukis, Dr T	V-2-D		
<b>H</b>	Haase, K	IV-6-B	Kovac, A	III-5-A	
	Hamidou, F	P-27	Krzyzanowska, M K	V-6-D	
	Harbers, A	II-3-C	Kusi, G	III-2-B	
	Harding, C	III-5-D	Kweon, M A	III-5-B	
	Harsha, P	V-2-A	Kwon, J-Y	II-4-D	
	Hartzell, R	W-04-B	Lace, S	III-6-B, P-27	
	Hayes, A	III-1-B	Ladouceur, M	IV-1-A	
	Hayes, L	III-5-C	Lafreniere, M	I-2-A, V-1-A	
	Haykowsky, M	III-6-B	Lalani, A	P-05	
	Healey, A	V-6-B, P-11	Lamanna, A	II-6-D, III-4-C, IV-4-B, V-4-A	
Hedges, P	I-3-B, III-6-B, V-1-C		I-2-C, II-4-D, III-4-A, IV-3-C		
Heighton, K	W-05-D, II-1-C	Lambert, L K			
Hildebrand, A	II-1-B		Lambert, S		
Hjal, T	III-6-A, IV-5-A, V-2-A		Landry, M		
Hollenhorst, H	W-01-A, I-3-C, I-4-C		Langleben, A		
Holmes L A	V-2-A		Lapointe, S		
Holmes, J	V-6-A		Lau, F		
Holowynch, A	II-4-D		Lau, F		
Horlock, H	II-3-D, III-6-A		Lauck, S		
Houlihan, J	IV-3-C		Laughland, B		
Howard, A F	II-1-D, II-4-A		Lawrynuik, A		
Howell, D	V-6-D		Leadbeater, K		
Hsu, T	II-2-A		Leahey, A		
Huber, T	IV-1-B		LeBlanc, J		
Hudson, N	II-4-D		Lee, C T		
Hung, L	P-10		Lee, R		
Hwang, K	IV-3-A				
Hyde, A	II-3-A				
Hyman, J					

Lee, U  
Leith, E  
Lelond, S  
Lemonde, M  
Lemy Dantica, J  
Leon, N  
Lepage, K  
Leslie, K  
Letourneau, N  
Leung, B

Leung, A  
Li, A  
Li, Hua

Limoges, J  
Lindberg, G  
Ling, H K  
Link, C  
Lloyd, S  
Loewen, S  
Logan, A  
Loiselle, C G  
Lounsbury, J  
Loutichin, G  
Loveless, S  
Luctkar-Flude, M  
Lun, L  
Luo, J (Lois)  
Macartney, G  
MacBride Smith, A  
MacDonald-Liska, C  
MacDonald, A  
MacDonald, C  
MacDonald, T  
MacDougall, A  
MacDougall, M K  
MacInnes, M  
MacKenzie, K  
MacLeod, J  
Maddigan, J  
Maghalaes, M  
Maharaj, G  
Malakian, A  
Malek, J  
Malik, A  
Manion, R  
Mao, J  
Marcelo, K  
Mariano, C  
Marshall, T  
Martin, L  
Martinez, E  
Mattson, R  
Mayo, S J

Mazarello, S  
Maze, D  
McGillion, Dr M  
McIndoo, D C  
McKeever, K  
McKenzie, M  
McMaster, N  
McNamara, K  
McNeely, M  
McNeil, R

P-11  
II-3-C  
V-3-D  
V-6-D  
II-1-B  
V-3-C  
V-3-C, V-6-C  
III-4-B  
III-4-B, IV-5-C  
W-02-A, W-04-A, W-04-C,  
W-04-D  
III-4-D  
V-6-D  
Helene Hudson  
Memorial Lectureship  
Award sponsored  
by Amgen  
III-4-B, IV-5-C  
P-12  
III-3-A  
W-05-D, II-1-C  
V-4-D  
V-4-D  
II-3-C  
V-3-C, V-6-C  
III-5-B, III-5-D, V-2-D  
V-3-C, V-6-C  
P-27  
IV-5-B  
IV-1-A, P-13  
III-2-A  
P-10  
III-6-C  
W-06-D, II-4-A  
V-1-C  
II-4-A, IV-5-A, V-1-C  
III-6-C  
V-4-C  
II-3-C, III-6-B, P-27  
P-16  
V-2-D  
III-6-B, IV-5-A  
IV-3-A  
II-1-B  
I-5-A  
W-04-A, II-5-C  
IV-2-C  
I-5-C, P-20  
W-04-B  
W-05-B  
III-5-B  
V-6-D  
W-04-B  
I-4-B  
V-6-C  
I-4-B  
I-1-A, I-4-C, II-4-B,  
III-2-B, IV-2-D, P-08  
P-10  
IV-4-D, P-12  
III-5-D  
IV-1-A  
V-2-A  
I-4-B, IV-3-C  
IV-5-A  
V-5-A  
III-5-C  
P-27

Mehta, R  
Menjak, I B  
Meyers, A  
Michaud, S  
Miller, A  
Minard, L V  
Mitton, J  
Mohamed, Z  
Monette, J  
Monginot, S  
Montpetit, C  
Moradian, S  
Morrison, M A  
Moules, Dr N  
Moura, Shari  
Moynihan, M  
Mulrooney, L  
Murawsk, M  
Murdoch, J  
Murray, C  
Myers-Harrison, J  
Nadeau, J  
Nagatani, K  
Nancekivell, K-L  
Neville, C  
Newton, J  
Newton, L

Nguyen, P  
Nicholson, M  
Norman, R  
Nugent, V  
Nye, T  
Oliver, G  
Olmi, L  
Ouellette, C  
Oye-Somefun, A  
Page, C  
Pan, Z  
Papadakos, T  
Paquet-Beaupré, A  
Paruch, M  
Patel, A  
Patton, L  
Pelletier, J  
Pelletier, N  
Petrella, J  
Pham, J  
Pike, A  
Pitters, E  
Pituskin, E  
Pivovarova, O  
Poirier, K  
Porcino, A  
Potts, L  
Powell, T  
Power, J  
Prado, C  
Prémont, B  
Prévost, N  
Prica, A  
Proba, J

Puddester, R  
Puts, M

V-6-D  
V-6-D  
IV-5-C  
W-04-B  
V-6-A  
II-3-C  
II-4-A  
V-2-C  
V-6-D  
W-04-C, W-04-D, V-6-A  
I-1-B, V-1-A  
II-1-D, V-4-A  
IV-5-A, V-2-A  
II-6-A  
III-5-B  
II-4-D  
P-10  
P-10  
V-2-A  
W-01-A  
P-13  
III-1-B  
III-5-D  
I-1-D, III-5-D, P-23  
I-2-C  
W-05-A  
W-02-A, III-4-B, III-5-B,  
V-4-D  
V-1-B, P-06  
V-5-C  
V-6-A  
V-5-C  
P-12  
II-6-D  
IV-1-D, V-5-A  
III-5-D  
V-4-A  
W-02-B, I-1-D  
III-3-A  
V-6-A  
III-1-C, III-1-D  
III-6-B, V-1-C  
II-1-A  
V-2-A  
III-2-C  
I-3-B, III-6-B  
II-3-D, III-6-A  
V-5-C  
III-4-B, IV-3-A, IV-5-C  
V-6-D  
III-5-C  
V-1-B  
P-27  
I-4-B  
III-5-D, P-23  
W-04-A, II-5-B  
III-4-D  
III-5-C  
IV-6-C  
I-6-D  
V-6-D  
W-02-B, I-1-D, I-3-A,  
III-5-D, P-23  
W-04-A, III-4-B, IV-3-A,  
IV-5-C  
W-04-D, III-2-B, V-6-B,  
V-6-D

## M

## N

## O

## P



# CANO/ACIO Annual Conference Workshop Abstracts

## W-01-A

### Malignant hematology and stem cell transplant nursing – Talk hematology to me

Laurie Ann Holmes<sup>1</sup>

Anna Giulione<sup>2</sup>

<sup>1</sup> The Ottawa Hospital

<sup>2</sup> Tom Baker Cancer Centre

## AML Maintenance and Standards of Care

Cindy Murray

Princess Margaret Cancer Centre

Nursing in malignant hematology is a diverse and dynamic subspecialty. New and exciting immune therapy advances show promise in treating relapsed B-ALL, relapsed B cell lymphoma and more recently multiple myeloma using adoptive T-cell transfer (CAR T cell therapy) and bispecifics. This workshop will provide education and rationale for specialized nursing care and deepen the understanding of the potential complications to prevent/minimize expected and unexpected toxicities. Acute leukemia has also seen an expansion in treatment options over the past several years; in particular in the area of maintenance therapy to prevent relapsed disease.

Learn updates on standard of care in AML. This workshop will help oncology nurses deliver safe, effective care and, in doing so, improve patient outcomes.

## W-02-A

### International results on the specialty certification of advanced practice nurses: Implications for oncology nurses in Canada

Denise Bryant-Lukosius<sup>1,2</sup>, Lorelei Newton<sup>3,4</sup>, Catriona Buick<sup>3,5</sup>, Andrea Knox<sup>3,6</sup>, Bonnie Leung<sup>3,6</sup>

<sup>1</sup> McMaster University, Hamilton, ON

<sup>2</sup> Juravinski Cancer Centre, Hamilton, ON

<sup>3</sup> Canadian Association of Nurses in Oncology, Vancouver, BC

<sup>4</sup> University of Victoria, Victoria, BC

<sup>5</sup> York University, Toronto, ON

<sup>6</sup> BC Cancer Research Centre, Vancouver, BC

**Introduction:** Canada lacks a cohesive and comprehensive approach to developing the specialty practice of oncology nurses. The lack of attention to specialty nursing practice in health human resource planning is counter-intuitive to the increasing specialization and complexity of healthcare. As a result, many Canadians lack equitable access to specialty services and nursing expertise that could improve the quality of their care and health outcomes. Forthcoming regulatory changes in Canada moving to a generalist entry-to-practice

model for nurse practitioners will further heighten needs to develop specialty practice. To address these issues, a multi-phase study was conducted to develop recommendations about the specialty certification of advanced practice nurses. Study results have significant implications for strengthening the oncology nursing workforce in Canada.

**Aims:** Through presentation and discussion of key study findings and their implications for the education, credentialing, and development of oncology nurses in Canada, this workshop will:

1. Engage oncology nurses to generate strategies and solutions that address current challenges and develop/strengthen specialty nursing practice.
2. Identify the leadership role CANO/ACIO can play to address priorities for strengthening the oncology nursing workforce.

**Format:** Participants will engage in facilitated small group discussions of study findings to generate possible solutions to barriers faced by specialized and advanced practice nurses in Canada in developing the oncology knowledge, skills, and competencies required for practice. CANO/AICO's role to implement these solutions will also be discussed. Small group findings will be shared with the larger group and consensus strategies will be used to prioritize potential solutions to be led by CANO/AICO. Workshop findings will inform CANO/AICO's strategic planning and investments in developing oncology nursing workforce and specialty practice in Canada.

## W-03-A

### Revitalizing and integrating the CANO/ACIO Oncology Nursing Learning Pathway and Practice Framework: Designing an innovative education resource for nurses caring for persons with cancer

Sarah Champ<sup>1</sup>, Kara Jamieson-Wright<sup>2</sup>

<sup>1</sup> Alberta Health Services Cancer Care

<sup>2</sup> Nova Scotia Health Authority

**Background:** In 2017, the CANO/ACIO Education Committee developed the Specialized Oncology Nurse Learning Pathway in partnership with key stakeholders and national nurse leaders. The Learning Pathway reflects CANO/ACIO's Standards of Practice and Competencies for the specialized oncology nurse to provide guidance on topics for foundational oncology knowledge including four areas of specialty practice. The Learning Pathway is designed to assist oncology teams understand how to support novice oncology nurses to achieve and maintain specialized oncology competencies. In 2019, CANO/ACIO launched the Nursing Knowledge and Practice Framework for Cancer Care to identify foundational oncology knowledge for all nurses caring for persons with cancer, regardless of work setting or level of specialization.



**Purpose:** Since the introduction of the Learning Pathway and Practice Framework, oncology teams have expressed challenges to integrate and operationalize these evidence-based CANO/ACIO resources. This led to the collaboration of the CANO/ACIO Education and Professional Practice committees to revitalize the Learning Pathway. The goal of this joint working group is to integrate the Learning Pathway with the Practice Framework, and create a comprehensive education framework for nurse leaders, educators, and frontline staff.

**Implications:** This workshop invites oncology nurses across Canada to brainstorm ideas, engage in discussion, provide feedback, identify gaps, and validate the revitalized Learning Pathway. The Framework will accomplish its aim to outline foundational knowledge for all nurses, distinguish specialty areas of learning, and navigate the career-long learning required for leadership development.

### W-04-A Overcoming challenges in graduate education and research: CANO/ACIO Doctoral Student Network Workshop

Kylie Teggart<sup>1</sup>, Amina Silva<sup>2</sup>, Bonnie Leung<sup>3</sup>, Billy Vinette<sup>4</sup>, Tracy Powell<sup>5</sup>, Rebecca Puddester<sup>6</sup>, Kimberly Shapkin<sup>5</sup>, Francis Kobekyaa<sup>3</sup>, Aimee Castro<sup>7</sup>, Argin Malakian<sup>8</sup>, Jagbir Kaur<sup>3</sup>

<sup>1</sup> McMaster University

<sup>2</sup> Queen's University

<sup>3</sup> University of British Columbia

<sup>4</sup> University of Montreal

<sup>5</sup> University of Victoria

<sup>6</sup> Memorial University

<sup>7</sup> McGill University

<sup>8</sup> University of Toronto

**Background:** Graduate-prepared nurses play an important role in advancing high-quality cancer care. Oncology nurses may face several practical, professional, and psychosocial challenges when pursuing graduate education and research. Maintaining well-being while balancing competing demands between school, work, and personal life can be difficult. Additionally, securing funding, building professional relationships, and overcoming imposter syndrome can be overwhelming for some. There is a need for practical and innovative strategies to support the well-being of oncology nurses pursuing graduate studies.

**Purpose:** Drawing on “strength within”, this interactive workshop and panel discussion (facilitated by the CANO/ACIO Doctoral Student Network) aims to demystify the graduate school experience. Together, we will identify and discuss various strategies to overcome challenges associated with graduate education and research. This workshop is relevant to oncology nurses considering or currently pursuing master's or doctoral education, as well as supervisors, educators, and researchers in mentorship roles. Participants are invited to bring any questions about pursuing and navigating graduate studies with a focus on oncology nursing to the workshop.

### Workshop objectives:

1. Share lived experiences and discuss the potential challenges associated with graduate education and research in oncology nursing.
2. Discuss practical and innovative strategies to manage time, reduce stress, maintain productivity, and sustain motivation as a graduate student.
3. Build supportive networks among oncology nurses who have experience navigating the challenges associated with graduate studies.

### W-04-B

#### Learning together about what's working to improve cancer diagnoses

Leah Stephenson<sup>1</sup>, Aurelia Roman<sup>1</sup>, Taylor Tomko<sup>1</sup>, Amy Rosvold<sup>1</sup>, Rachael Manion<sup>2</sup>, Louise Binder<sup>3</sup>, Suzanne Wait<sup>4</sup>, Martin Dawes<sup>5</sup>, Stephanie Michaud<sup>6</sup>, Jennifer Rayner<sup>7</sup>, Michael Smylie<sup>8</sup>, Amy Hayes<sup>9</sup>, Sara Rauhullah<sup>9</sup>, Natalie Verreault<sup>10</sup>, Tim Marshall<sup>10</sup>

<sup>1</sup> All.Can Canada

<sup>2</sup> Canadian Skin Patient Alliance

<sup>3</sup> Save Your Skin Foundation

<sup>4</sup> Health Policy Partnership

<sup>5</sup> University of British Columbia

<sup>6</sup> BioCanRX

<sup>7</sup> Alliance for Healthier Communities, Toronto, Ontario

<sup>8</sup> Cross Cancer Institute, Edmonton, Alberta

<sup>9</sup> AstraZeneca

<sup>10</sup> Hoffmann-La Roche

Led by patient groups and people with lived experiences of cancer, All.Can Canada (ACC) is a national, multi-stakeholder network for cancer care efficiency, with a preliminary aim of optimizing people's entry into cancer care through swift, accurate, and appropriately delivered diagnosis.

In 2022, ACC members were honoured to present a workshop at the CANO Conference on “Optimizing Diagnosis in Canadian Cancer Care: Findings, Recommendations, Next Steps, and Implications for Key Stakeholders including Oncology Nurses.” Participants shared promising practices, including inter-jurisdictional collaboration towards a Comprehensive Breast Program to better serve residents of the Northwest Territories (NWT) and Quebec's new rapid access clinics. Oncology nurses participating in the breakout groups consistently identified improving communication and information sharing between providers and with patients, as the most important findings.

At CANO's 2023 conference, building on the learnings from 2022, ACC will update participants on our efforts to create case studies that highlight evidence-proven practices in Canada that support achieving outcomes that matter most to patients. Given the importance of communication and information identified in 2022, we will also update on our efforts to improve information for people as they go through cancer diagnosis and to support collaborative implementation of a Pan-Canadian Health Data Strategy (PCHDS).

We will identify and explore additional practices being undertaken by participants that aim to improve cancer diagnoses while providing updates on previously identified initiatives in Quebec and NWT. We will receive feedback from participants on current efforts shared by ACC: case studies, patient-facing information framework, and PCHDS. Finally, a post-workshop summary will be sent to all interested participants.

### W-05-A Strengthening oncology nurses' symptom support competencies: A train-the-trainer workshop using COSTaRS practice guides

Dawn Stacey<sup>1,2</sup>, Amber Killam<sup>3</sup>, Jennifer Newton<sup>3</sup>

<sup>1</sup> School of Nursing, University of Ottawa

<sup>2</sup> Centre for Implementation Research, Ottawa Hospital Research Institute

<sup>3</sup> The Ottawa Hospital

Our 90-minute interactive workshop will enhance nurses' knowledge, skills, and confidence for using COSTaRS practice guides. Participants will also appraise the quality of symptom management and discuss COSTaRS use in clinical practice and continuing professional development.

The pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) practice guides are available for use by oncology nurses when providing guidance to patients experiencing symptoms. The COSTaRS practice guides summarize evidence from clinical practice guidelines in easy-to-use, nurse-friendly formats and can help nurses integrate best practices into their approach to managing symptoms. COSTaRS practice guides (v2020) also include evidence for managing the unique symptoms from immunotherapy.

**Objective:** By the end of this workshop, participants should: a) feel more confident using the COSTaRS practice guides with patients on chemotherapy and/or immunotherapy; b) know how to appraise the quality of symptom management using an assessment tool; and c) describe strategies for incorporating COSTaRS into clinical practice and continuing professional development.

**Description:** A 90-minute interactive workshop is planned. First, we will provide an overview of COSTaRS. We will introduce the content of specific practice guides and a case study to be used for role play exercises among participants. Nurses will use the Symptom Management Assessment Tool to appraise the quality of a symptom management interaction. Next, we will discuss how the practice guides can be used in telephone calls and face-to-face with symptomatic patients. Finally, we will focus on steps for moving the practice guides into clinical practice and discuss strategies for how to address perceived barriers to their use. The workshop will include several interactive activities for engaging participants.

The workshop will be conducted in English with some activities in English or French.

### W-05-B

### The Society for Integrative Oncology-American Society for Clinical Oncology Clinical Practice Guidelines for Pain and Anxiety/Depression

Lynda G. Balneaves<sup>1</sup>, Heather Greenlee<sup>2</sup>, Linda Carlson<sup>3</sup>, Alyson Doyle<sup>2</sup>, Nofisat Ismaila<sup>4</sup>, Richard Lee<sup>5</sup>, Jun Mao<sup>6</sup>, Debu Tripathy<sup>7</sup>, and Suzanne Zick<sup>8</sup>

<sup>1</sup> University of Manitoba

<sup>2</sup> Fred Hutchinson Cancer Research Centre

<sup>3</sup> University of Calgary

<sup>4</sup> American Society for Clinical Oncology

<sup>5</sup> City of Hope Comprehensive Cancer Center

<sup>6</sup> Memorial Sloan Kettering Cancer Center

<sup>7</sup> MD Anderson Cancer Center

<sup>8</sup> University of Michigan

A key priority of the Society for Integrative Oncology (SIO) is to develop actionable clinical practice guidelines on the evidence-based use of integrative medicine in oncology settings. Following a grant from the Samuelli Foundation, SIO developed a collaboration with the American Society of Clinical Oncology (ASCO) to extend the reach of these clinical guidelines across the multidisciplinary oncology healthcare team, including oncology nurses.

In this workshop, we will describe and discuss the clinical recommendations from two recently published SIO-ASCO guidelines focused on integrative approaches to the management of pain and anxiety-depression, as well as future guidelines in development.

The guidelines followed the ASCO guideline development processes and were based upon data from randomized, controlled clinical trials. SIO-ASCO assembled diverse panelist representation across professional disciplines, geography, race and ethnicity, gender, and career stage to inform the development of each guideline. The pain guideline was published in 2022 in the *Journal of Clinical Oncology* and the anxiety and depression guideline will be published in mid-2023.

Beyond reviewing the clinical recommendations, this workshop will also provide an overview of the on-going implementation processes, including the development of education material. Key knowledge translation products for the guidelines will also be shared with the audience.

Developing and disseminating evidence-based clinical practice guidelines for integrative medicine modalities to manage common cancer-related symptoms has the potential to improve uptake where effectiveness and safety are demonstrated. The SIO-ASCO guidelines inform the integration of evidence-based non-pharmacological approaches to cancer-related pain and anxiety-depression, whilst identifying gaps requiring ongoing studies.

## W-06-A

### Safe handling of hazardous drugs

Komal Patel Saini & Jiahui Wong

de Souza Institute

In cancer care, the risk for potential exposure to drugs that may be hazardous to health is high. The main risk factors include the preparation, administration of anticancer regimens, cleaning up hazardous drug spills, or handling body fluids after chemotherapy. The lack of safety practice can potentially put healthcare workers at risk of both short- and long-term health-related harm. Safe handling is an important consideration for healthcare professionals, including nurses administering and providing care for patients receiving hazardous drugs, whether their worksetting is in a hospital, ambulatory clinic or the community. Understanding the principles of safe handling is essential to reduce environmental contamination and exposure for a safer environment of providers, patients and families. The Canadian Association of Nurses in Oncology Standards and Competencies highlight the importance of having the knowledge and skills to safely administer, and to prevent and manage a cytotoxic spill. This 90-minute interactive workshop will review personal protective equipment guidelines and use case studies to highlight common exposure scenarios, as well as strategies to reduce exposure and to keep healthcare workers, patients and families safe.

## W-06-B

### Cancer and medical cannabis: Therapeutic ‘pot’ential?

Reanne Booker<sup>1,2</sup>

<sup>1</sup> Alberta Health Services

<sup>2</sup> School of Nursing, University of Victoria

Medical cannabis has been legal in Canada for more than 20 years and, yet, high-quality research on medical cannabis remains sparse. In 2018, recreational cannabis use was legalized in Canada. Since then, Health Canada has conducted an annual survey, the Canadian Cannabis Survey, to collect data on the use of cannabis in Canada. Canadian statistics have shown that individuals may use cannabis solely for medical reasons, exclusively for recreational reasons, or a combination of both medical and recreational purposes.

This workshop will provide an overview of cannabis including a review of the endocannabinoid system, the different types of cannabis, formulations, and routes of administration. Studies on the use of medical cannabis in the context of cancer care will be discussed. Dosing, side-effects, cautions and contraindications, and safety and practical considerations will be presented. Case studies will be utilized to describe how medical cannabis might fit into cancer care; discussion will be invited.

Specific workshop objectives include review of:

- Cannabis: endocannabinoid system, types and strains of cannabis, formulations, routes of administration
- Current indications for medical cannabis use in cancer care

- Safety and practical conditions, including side effects, cautions, contraindications
- Key teaching points for educating patients on the use of medical cannabis.

## W-01-B

### LEADS in action – A hands-on workshop to building leadership competencies

Joy Tarasuk<sup>1</sup>, Ruby Gidda<sup>2</sup>

<sup>1</sup> Nova Scotia Health

<sup>2</sup> BC Cancer

Leadership skills are pivotal for oncology nursing practice. The leadership skills of an oncology nurse range from being an advocate for high-quality patient care, an excellent communicator, preceptor, mentor, role model, to inspiring others in their nursing practice. Nurses in all areas of oncology practice can benefit from leadership education and support to maximize their leadership potential and help them to become confident leaders. CANO/ACIO is committed to providing its members with meaningful hands-on opportunities for leadership development at our conference.

Our previous CANO/ACIO workshops have focused on the LEADS framework. The LEADS framework highlights a comprehensive approach to leadership development, which contains five domains: 1) Leads self, 2) Engages others, 3) Achieves results 4) Develops coalitions, and 5) Affects system transformation. Informed by the LEADS framework (Canadian College of Health Leaders, 2016), CANO/ACIO recognizes that effective personal leadership can be learned and integrated into practice. At CANO 2022, focus was on the importance of relational leadership in building trusting environments, which was foundational when leading through the chaos of the COVID-19 Pandemic.

The goal of this LEADS in Action Leadership Workshop is to begin development of leadership pathways and a toolkit to support the progression of competencies that can be utilized for all nurses at each level of nursing to support an oncology nurse's ability to deliver excellent care and influence patient, team, organizational and system outcomes.

## W-02-B

### Take a stab at it: Developing vascular access resources for oncology practice

Cheryl Page, Janny Proba

Hamilton Health Sciences

Oncology nurses are present at every part of the cancer continuum and vascular access knowledge is a core practice competency. By applying knowledge to device care, treatment delivery, and continued advocacy and education, oncology nurses are positioned to be experts in vascular access care. Vascular access can influence treatment plans, improve diagnostic and prognostic capabilities, affect the likelihood of complications and this may have life-altering, life-limiting, or life-ending implications. The intersectionality between the

two fields creates unique opportunities for collaboration and knowledge sharing between CANO and CVAA members.

The lack of educational resources and consensus on vascular access care and maintenance are significant risks and can be a barrier to providing evidence-based care – especially if organizations lack the resources to do so. The publication of the CVAA guidelines and toolkits have helped to standardize the selection, care, and maintenance of vascular access devices and therapy in Canada. The guideline implementation toolkit contains resources for educators and policy-makers to help with knowledge translation while standardizing care in organizations. These guidelines help oncology nurses with evidence-based care and practice, and advocate for changes in their organizations while reducing harm indicators such as sepsis and addressing gaps in practice. While the CVAA guideline toolkit provides many resources to use and adapt for organizations, there is an opportunity to create and address oncology-specific topics.

This three-hour workshop will explore existing resources while providing a chance to network with other educators and policy-makers in the creation of oncology-related vascular access resources. Education and resource development are crucial for the continued provision of high-quality oncology care while augmenting oncology nurses' understanding of best practices in vascular access care.

### W-03-B

#### Intimacy and sexuality after cancer: A workshop on nursing approach to address patients' unmet needs

Janet Giroux<sup>1</sup>, Komal Patel Saini<sup>2</sup>

<sup>1</sup> Gynecologic Oncology, Kingston Health Sciences Centre, Kingston General Hospital Site and the Cancer Centre of Southeastern Ontario Oncology Program

<sup>2</sup> de Souza Institute, University Health Network

**Background:** Sexuality is complex and not only involves the physical aspect, but also the psychological, interpersonal, and behavioural aspects of a person. Cancer diagnosis and treatments are often associated with sexual dysfunction, a significant issue affecting the quality of life of cancer patients and their families. Unfortunately, healthcare providers struggle with addressing sexual health, as they report feeling uncomfortable and lack the knowledge and tools to offer support to patients.

**Methods:** This nursing-focused workshop is designed to facilitate communication and offer assessment and interventions that direct care nurses can apply in this area. It will cover commonly reported challenges in sexual health as a result of cancer- and cancer treatment-related side effects. Case studies will be used to demonstrate challenges and best practices to address them.

The workshop will include the following learning objectives: 1) Describe the common sexual health issues and concerns during survivorship care; 2) Explain how surgery, radiation, chemotherapy/biotherapy and other treatments could affect sexuality; 3) Demonstrate the type of patients who are

at higher risk of sexual reproduction dysfunction; 4) Discuss common strategies for assessing and addressing sexual health side effects for female and male cancer patients, including fertility options.

**Conclusions:** As cancer survival rates continue to increase and patients are living longer with their disease, addressing long-term adverse effects such as sexual difficulties becomes increasingly paramount. Nurses can play a key role in raising the topic of female and male sexual dysfunction with their cancer patients and offer recommendations to ease discomfort, and help their healing process post cancer treatment.

### W-04-C

#### Integrating geriatric assessment into everyday oncology nursing practice: A hands-on workshop

Susie Monginot<sup>1</sup>, Rana Jin<sup>1</sup>, Bonnie Leung<sup>2</sup>, Kimberly Shapkin<sup>3,4</sup>, Allison Weins<sup>5</sup>, Fay Strohschein<sup>3</sup>

<sup>1</sup> Princess Margaret Cancer Centre

<sup>2</sup> BC Cancer

<sup>3</sup> Faculty of Nursing, University of Calgary

<sup>4</sup> School of Nursing, University of Victoria

<sup>5</sup> Cancer Care Manitoba

Approximately 60% of all cancers affect people aged 65 years and over. Due to limited research evidence and low oncology practitioner knowledge about age-related concerns, older adults with cancer are at a significant risk of receiving suboptimal care, as can be seen through age-related disparities in cancer and cancer care outcomes. The International Society of Geriatric Oncology has stated that all older adults considering treatment should complete a baseline geriatric assessment to improve their functional status and address vulnerabilities that may compound or worsen side effects associated with cancer treatments. Drawing from strength within, oncology nurses can play a significant role in supporting and enhancing the care of older adults with cancer. In 2023, CANO launched an Oncology & Aging Toolkit to support oncology nurses in assessing and managing age-related concerns. In this workshop, we will provide oncology nurses with the educational opportunity required to enhance their knowledge of the geriatric assessments and interventions within the toolkit.

Nurses will rotate through a series of expert-led stations providing practical knowledge of how to conduct geriatric-focused assessments related to comorbidity, polypharmacy, functional status, cognition, mood, social support, and nutrition. Nurses will collaborate in small groups to develop personalized intervention plans based on their assessment findings. This session will challenge nurses to think in new ways about older adults with cancer, offering solutions to improve quality of life, guide treatment decision-making and optimize outcomes. Nurses will gain practical knowledge and skills to integrate geriatric assessments into their everyday practice and empower them to confidently communicate assessment results and offer solutions. By providing these skills, we hope to strengthen the community of practice across Canada in this vitally important speciality of oncology nursing care.

## W-04-D

### Developing a community of practice to support integration of geriatric assessment and management into everyday oncology nursing practice: An interactive discussion and workshop

Fay Strohschein<sup>1,2</sup>, Allison Wiens<sup>3</sup>, Bonnie Leung<sup>4</sup>, Susie Monginot<sup>5</sup>, Kimberly Shapkin<sup>1,6</sup>, Rana Jin<sup>5</sup>, Martine Puts<sup>7</sup>

<sup>1</sup> Cancer Strategic Clinical Network, Alberta Health Services

<sup>2</sup> Faculty of Nursing, University of Calgary

<sup>3</sup> Cancer Care Manitoba

<sup>4</sup> BC Cancer

<sup>5</sup> Princess Margaret Cancer Centre

<sup>6</sup> School of Nursing, University of Victoria

<sup>7</sup> Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

In Canada, two-thirds of new cancer cases occur among people aged 65+. The number of cancer cases in this age group continues to rise. Older adults experience physical, functional, psychological, social, and existential changes that can impact cancer and cancer treatment. Disparities in research and treatment suggest these age-related changes are inadequately addressed in cancer care, leading to suboptimal outcomes. Oncology nurses are uniquely positioned to identify and address age-related concerns in cancer care, but often lack the tools, resources, and support to do so.

In 2021, the CANO Oncology & Aging Special Interest Group (OASIG) developed a position statement highlighting the key role Canadian oncology nurses play in optimizing care of older Canadians with cancer and their families. Subsequently, in 2023, the OASIG launched an Oncology & Aging Toolkit, as a resource to inform nursing assessment and management of age-related concerns within oncology nursing practice.

In this workshop, we will (1) present a summary of evidence and guidelines to support integration of geriatric assessment and management into care of older adults with cancer; (2) share experiences of integrating geriatric assessment into care of older adults with cancer in various contexts, including ambulatory oncology care, community primary care practice, and specialized geriatric oncology consultation service, to provide equity-focused oncology nursing for older adults; and (3) facilitate a discussion about opportunities and challenges of integrating geriatric assessment into cancer care. Our aim is to develop a community of practice, among oncology nurse leaders, clinical educators, researchers, and frontline providers, and identify needed supports, resources, and initiatives to promote dissemination and implementation of the CANO Oncology & Aging toolkit. Join us in strategizing together on how to strengthen and enhance equitable care of older Canadians with cancer and those close to them.

## W-05-C

### How to foster safe and efficient cannabis use in oncology: Tips and recommendations for oncology nurses

Billy Vinette<sup>1-6</sup>

<sup>1</sup> Faculty of Nursing, University of Montreal

<sup>2</sup> Research Chair in Innovative Nursing Practices

<sup>3</sup> Quebec Network on Nursing Intervention Research

<sup>4</sup> Centre for Innovation in Nursing Education and Professional Learning

<sup>5</sup> Research centre of the Maisonneuve-Rosemont Hospital

<sup>6</sup> Research centre of the Montreal University Hospital Centre

**Background:** To manage some physical symptoms (e.g., nausea and vomiting, pain) between 14 and 52% of people diagnosed with cancer may choose to use cannabis. However, many oncology nurses emphasize that they do not feel sufficiently empowered to deal with various aspects of cannabis use in oncology. Few educative interventions regarding safe and efficient cannabis use exist with nurses. To address this issue, our team developed a digital educational intervention, entitled Cannabis & Cancer, to support oncology nurses regarding safe and efficient cannabis use by young adults (18-39 years) diagnosed with cancer. This workshop aims to increase nurses' knowledge, confidence, and encourage safer practices regarding cannabis use in oncology.

**Method:** The content of this workshop is derived from the Cannabis & Cancer intervention, originally developed in French, using a systematic approach (Intervention Mapping) involving the collaboration of researchers, nurses, patient partners, pharmacist, and a doctor. Various educational activities will be presented to foster oncology nurses' cognitive engagement in their learning process, such as case studies, videos, and quizzes. Different topics related to the safe and efficient cannabis use will be addressed within the workshop (e.g., beneficial effects, potential side effects, nurses responsibilities).

**Discussion:** We expect that our workshop will increase oncology nurses' knowledge and confidence regarding safe and efficient cannabis use, which could influence their practices in this regard. As cannabis use continues to be increasingly present, Cannabis & Cancer is a promising solution to support oncology nurses practices regarding safe and efficient cannabis use.

## W-05-D

### Using patient-reported outcomes (PROs) to facilitate serious illness conversations: An interactive workshop

April Hildebrand<sup>1</sup>, Claire Link<sup>1</sup>, Andrea DeIure<sup>1</sup>, Linda Watson<sup>1,2</sup>

<sup>1</sup> Cancer Care Alberta

<sup>2</sup> University of Calgary Faculty of Nursing

Patients with advanced cancer face distinct challenges throughout their cancer trajectory due to the nature of their condition and the multiple co-occurring symptoms and concerns often experienced. Nurses play a pivotal role in providing symptom management and supportive care to patients with

advanced disease. However, many nurses may find the need to have difficult or serious illness conversations stressful.

Patient-reported outcomes (PROs) present an opportunity for nurses to identify, understand, and support the different concerns of advanced cancer patients. PRO information is an effective communication tool and can aid nurses in having serious illness conversations which, in turn, can improve the quality of care received by patients and their families/caregivers. These conversations may include early discussions about palliative care, goals of care, and sensitive topics such as Medical Assistance in Dying (MAiD). Most nurses are not expected to be experts on these topics. However, all nurses should feel comfortable engaging in these conversations, and should be familiar with relevant referral pathways and know how to connect patients to additional information.

Participants in this workshop will gain an understanding of how PROs can be used to support a person-centred approach to serious illness conversations for patients with advanced cancer, pulling from more than 10 years of experience of utilizing PROs in Cancer Care Alberta. Participants will walk through multiple patient scenarios to create an interactive, dynamic learning experience that discusses an evidence-based, structured approach to serious illness conversations.

## W-06-C

### Cancer patient navigation – The creation of a national orientation program

*Sarah Champ<sup>1</sup>, Catherine Dixon<sup>2</sup>, Michelle L. Rosentreter<sup>3</sup>, Elizabeth Rioux<sup>4</sup>, Jodi Collier<sup>1</sup>*

<sup>1</sup> Alberta Health Services

<sup>2</sup> Northwest Territories Health and Social Services Authority

<sup>3</sup> Interlake-Eastern Regional Health Authority

<sup>4</sup> Horizon Health Network/Réseau de santé Horizon

Receiving a cancer diagnosis can be a stressful and overwhelming time for patients and families, which is compounded by the fragmented and complex nature of the cancer care system. Cancer Patient Navigation (CPN) programs can help patients through this experience by ensuring timely and equitable access to quality cancer care services, improving of person-centred care, and addressing the challenges people living with cancer face. While the model of care for Cancer Patient Navigation may vary, the core intention and outcomes are the same: to facilitate and enhance the delivery of high-quality, person-centred oncology care.

With the emerging trend of CPN programs across Canada and the evolving role of the oncology nurse in navigation, a need to create a CANO Oncology Navigation Special Interest Group (SIG) was identified. Navigators within the SIG shared their difficulties in orienting new staff, which highlighted that there is no Canadian standard for orientation and training of new navigators. The Navigation SIG prioritized the development of creating a standardized national orientation package as their first project.

This workshop will highlight the work completed to date on the navigation orientation. Participants will be able to explore how to work through various sections of the program

to enhance their own learning, or determine how to implement the package into orientation programs. All nurses have a level of navigation in their current roles, so this workshop and the materials provided would be valuable to enhance their level and knowledge of navigation. It would benefit all oncology nurses no matter their current role.

## W-06-D

### How can I support cancer survivorship from diagnosis to discharge? A workshop for clinical oncology nurses

*Carrie MacDonald-Liska<sup>1</sup>, Karine Bilodeau<sup>2</sup>, Kelly-Anne Baines<sup>3</sup>*

<sup>1</sup> St. Francis Xavier University

<sup>2</sup> University of Montreal

<sup>3</sup> The Ottawa Hospital

While two in five Canadians will develop cancer in their lifetime, 64% are expected to survive the disease for five years or longer. It is now understood that cancer survivorship begins at the time of a diagnosis. Moreover, because studies indicate that patients find the end of active treatment to be most difficult, it is critical to start preparing them at the beginning of the cancer care trajectory. Improvement in patient education and self-management engagement is, therefore, required to enhance patients' ability to cope with the effects of cancer and its treatment throughout the cancer trajectory. Oncology nurses are ideally suited and situated to provide clinical care to meet the needs of survivors, support patients to self-manage their chronic disease, and provide leadership in program development, not only at the time of discharge from cancer centers, but throughout the entire trajectory. This interactive workshop will present a case study to serve as an illustrative example of a patient's unique needs at each stage of the cancer trajectory. A discussion will facilitate how the provision of oncology nurse interventions, including self-management support, can assist meeting patients' individual needs from the time of diagnosis to discharge (i.e., diagnosis, surgery, chemotherapy, radiation).

The learning objectives are:

1. To enhance clinical oncology nurses' knowledge about the key opportunities at each phase of the cancer trajectory to prepare patients to cope with their survivorship concerns.
2. To identify self-management strategies at each phase of the cancer trajectory to engage and empower patients to prepare for discharge.
3. To share and discuss the survivorship resources oncology nurses can utilize to facilitate transition.

## Merck Clinical Lectureship Award

### Model of care – Virtual oncology in the Northwest Territories – Oncology clinic RN role

*Catherine Dixon*

*Northwest Territories Health and Social Services Authority*

Within the Northwest Territories (NT) healthcare system, equitable access to cancer healthcare is a major barrier for our First Nations, Inuit, and Métis (FNIM) residents, as the most

rural and remote communities are predominantly indigenous populations. Given the vast geography of the NT, the majority of residents are required to travel long distances to urban centres (Yellowknife, NT and Edmonton, Alberta [AB]) for prolonged periods to access the specialized cancer treatment, care, and services they require.

With an already formalized agreement between the Northwest Territories Health and Social Services Authority (NTHSSA) and Cancer Care Alberta to provide NT residents medical oncology services, the NTHSSA successfully submitted the virtual oncology model of care project to the Canadian Partnership Against Cancer (CPAC). NTHSSA identified the need to create a new and innovative nurse-led virtual model of care coordination to improve equitable access and to meet the growing demands of patients and the healthcare system.

Developing this model of care has allowed an approach to medical oncology service delivery that focuses on virtual nursing care. This model of care allows for increased care closer to home, care coordination, symptom assessment, intervention and management, circle of care communication, increased access, follow-up of diagnostics, diagnostic appointment coordination to minimize unnecessary travel and offer consistent support from a specialized nurse resource trained and experienced in active cancer care.

The project aims to establish a proof of concept that demonstrates FNIM from across the NT have increased access to consistent, coordinated, and high-quality virtual oncology supports that promote equitable access to specialized medical oncology services and ultimately improves NT residents' experience and outcomes.

### Helene Hudson Memorial Lectureship Award sponsored by Amgen

#### Compassion fatigue: Harnessing the strength within

Tania Bergen, Hua Li

University of Saskatchewan

Compassion fatigue, understood more clearly as the combination of burnout and secondary traumatic stress, is a workplace hazard in oncology nursing. Caring for people undergoing the traumatic experience of a cancer diagnosis and treatment comes at a cost. We would never administer chemotherapy without appropriate PPE, yet we expose our souls daily to the trauma of others, often without any protection. Despite being identified as a high-risk group, findings from this study reveal a concerning lack of awareness and understanding of compassion fatigue in oncology nurses. The pandemic has highlighted the extreme stress, burnout, and fatigue within nursing and the implications this has for retention and turnover. This presentation will review what is compassion fatigue, what are the risk factors, and what are the evidence-based interventions that are effective to ensure we maintain the "strength within" ourselves and our profession. Participants will gain valuable awareness and strategies to minimize the damaging effects of compassion fatigue on their personal and professional lives. Frontline nurses must be knowledgeable about compassion fatigue in order to identify risk factors

and ensure their health. Nurses care for patients every day, it is time to pause and carefully consider how we can care for nurses.

### I-1-A

#### Supporting scholarship in oncology nursing: Achievements and lessons learned in the development of an Oncology Nursing Research Centre of Excellence

Anet Julius<sup>1</sup>, Lara Cooper<sup>1</sup>, Lindsay Carlsson<sup>1</sup>, Samantha J Mayo<sup>1,2</sup>

<sup>1</sup> Princess Margaret Cancer Centre, University Health Network

<sup>2</sup> Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

**Background:** Oncology nurses have highly specialized knowledge and expertise related to the clinical and psychosocial care of people affected by cancer. As such, oncology nurses are uniquely positioned to advance research, innovation, and evidence-based quality improvement to improve patient, family, and community outcomes. However, participation in such activities is influenced by the environmental context, including leadership, available resources, and organizational culture.

**Methods:** The Oncology Nursing Research Centre of Excellence (ONRCE) at the Princess Margaret Cancer Centre was established in 2022. With a goal of advancing cancer nursing science that improves patient and family experience of living with and beyond cancer, the centre was formed through consultation with oncology nurses in diverse roles, interprofessional stakeholders, and national and international leaders in nursing research. Goals for the first year were outlined and executed, with oversight from the ONRCE leadership team.

**Results:** In the first year of the centre, efforts have focused on establishing ONRCE governance, branding and visibility, and developing programming to support research goals among nurses at the point of care, Advanced Practice Nurses and emerging nurse scientists. Process evaluation of program deliverables and training opportunities (e.g., workshops, fellowships) has occurred throughout implementation and remains ongoing. Important lessons have been learned regarding the factors that will impact the feasibility, sustainability, and success of the ONRCE in effectively achieving its goals.

**Conclusion:** The ONRCE has contributed to an organizational culture that values and supports oncology nurses' engagement in research and scholarship. Lessons learned in the first year will not only guide refinements to our ongoing priorities, but can also be extrapolated to other organizations committed to developing similar initiatives.

## I-1-B

### Nurse-initiated protocols and decision support tools in oncology nursing practice

*Crystele Montpetit, Theresa Zapach*

*BC Cancer*

Oncology nurses require specialized education and clinical skills to provide quality, evidence-based care. The ongoing challenge of recruitment and retention of nurses within oncology has emphasized the need to develop clinical tools and resources to support new and experienced nurses in their oncology nursing practice. Decision Support Tools (DST) are evidence-based resources that support clinical judgement and decision making when providing patient care. One of the areas where registered nurses may optimize their scope is through maintenance, evaluation of placement and management of occluded central venous access devices (CVADs). This includes peripherally inserted central catheters (PICCs), non-tunneled and tunneled CVADs and implanted vascular access devices (IVADS). In British Columbia, nursing senior practice leaders, created a nurse-initiated protocol and decision support tool in collaboration with medical oncologists to guide registered nurses in autonomously providing maintenance and care of CVADs. The process of development, adoption, and evaluation of these resources in practice has laid the groundwork for nurse leaders within oncology to evaluate other relevant areas of clinical practice where decision support tools can optimize the role of the nurse.

## I-1-C

### Exploring how to successfully make a nursing practice change: Frontline leaders using the ADKAR Model & the Knowledge Translation Challenge Process

*Chelsea Kenny, Shelby Ritchey*

*BC Cancer Abbotsford*

It is difficult to accurately represent “nurse time” in outpatient systemic therapy scheduling. Based on current workflow, nurses do not have additional time for managing infusion reactions. Reactions create a traumatic experience for patients and stress for nurses. This impacts workload and leads to decreased job satisfaction. At BC Cancer Abbotsford, the frontline systemic nurses feel that having diluent primed lines is a hindrance to the ability to predict the timing of reactions. There is a paucity of literature around drug versus diluent primed lines and infusion reactions. Therefore, frontline leaders from Abbotsford submitted a project through the Knowledge Translation Challenge with the aim of exploring the practice of drug primed lines. An environmental scan involving CANO members identified that many sites nationally use drug primed lines (rather than diluent) for titrated infusions. There are different methods (pharmacy priming, nursing “fast” priming and nursing circle priming the line). This practice of drug primed line has been shared from sites in British Columbia, Alberta, Ontario, Nova Scotia, and

Manitoba. The goal of this presentation is to discuss the process of a nursing practice change. Using the ADKAR model and the platform of the Knowledge Translation Challenge, we will describe how to analyze barriers, utilize facilitators (such as patient partners) and engage interested parties demonstrating that frontline nurses have the strength within to create change.

## I-1-D

### Building on our strengths – Development of a joint foundational oncology orientation program

*Cheryl Page, Kelly-Lynn Nancekivell, Janny Proba, Suganya Vadivelu*

*Hamilton Health Sciences*

**Background and purpose:** While utilizing learning pathways for staff orientating to oncology areas at this tertiary care facility, an opportunity for improvement was identified to develop a standardized oncology orientation day focusing on foundational knowledge development. The Canadian Association of Nurses in Oncology (CANO) Practice Standards and Competencies for the Specialized Oncology Nurse was used to guide the curriculum development for this orientation day. This foundational orientation education day focuses on the pathophysiology, treatment modalities, oncologic emergencies, symptom management and palliative care. Integration of demonstrations and case study-based discussions help to augment didactic course content.

**Findings:** Developing a foundational oncology orientation education day fostered collaboration among the educators supporting the individual specialized areas including surgical oncology, hematology, solid tumour care, and outpatient oncology. Enhancing the nurse’s knowledge, skills, and competencies in oncology with this foundational course provided a common baseline for each sub-specialty to advance in their individual learning pathways. Having a standardized foundational knowledge facilitated with smoother transition for staff to transfer between oncology areas and fostered excellence in oncology nursing practice. Joint foundational educational programs strengthen nursing practice and promote strength within the oncology nursing force.

**Recommendations:** Having adequate leadership support for the foundational oncology orientation impacted the success of this program. Incorporating learner feedback will help to improve the foundational orientation education day as we move forward and will strengthen the program.



## I-2-A

### Strengthening oncology nursing partnerships: Development of a hybrid oncology student learning pathway

*Michelle Lafreniere, Joy Bunsko*

*BC Cancer*

Navigating the transition from nursing student to new graduate is challenging. Learning pathways are an educational and transition-to-practice tool that can be used to bridge this gap. The British Columbia Ministry of Health, in collaboration with the Ministry of Post-Secondary Education is working to integrate specialty nursing learning pathways into baccalaureate nursing programs across the province. Recommendations from the Nursing Policy Secretariat outline building on existing assets and collaborative partnerships to create the space for learning and practice consolidation. At this time, focus on intentional, quality student practicum experiences and robust support in transition to practice is crucial to the recruitment and retention of new graduates.

This presentation will discuss the collaborative process between BC Cancer and the University of the Fraser Valley (UFV) in building a unique hybrid learning pathway combining their specialty oncology nursing elective offered to fourth-year students, BC Cancer specific oncology educational activities and a tailored practicum experience. Additionally, the discussion will explore the evaluation of this learning pathway from all perspectives; the nursing student, the post-secondary institution and BC Cancer.

We will discuss the collaboration that led to this unique student experience, challenges that were faced and key successes. Strengthening the partnerships between post-secondary nursing education and specialty nursing practice creates the opportunity for developing an innovative, supportive, and transformative learning experience.

## I-2-B

### Growing oncology expertise: C3 development ladder

*Celia Aiello, Angela Banjar*

*HHS Juravinski Hospital and Cancer Centre*

C3 provides a continuum of care for individuals with solid tumours including active treatment, pain and symptom management and end-of-life care. Nursing in oncology requires unique knowledge and skills, the ability to connect and communicate with patients and families, and a degree of resilience. It is an area of nursing that instills high reward, but also high loss and sadness. Compassion fatigue and burnout are real, and unawareness, unpreparedness and a lack of support and self-care strategies often lead to high turnover rates in this field. Education pathways have traditionally focused on knowledge, skill and leadership building, but have not acknowledged or incorporated the softer side of science and caring. The C3 Development Ladder incorporates these technical components, but is unique in its upfront focus on building formal

support routines, personal awareness and self-care practices. This growth ladder weaves in understanding the stress of transitioning to practice; self-reflection activities on values, attitudes, beliefs, death experiences and the imprints of culture; conflict and communication skill building; and understanding and combating compassion fatigue and moral distress. Further, the ladder outlines scaling development including in unit, quality improvement, organization, advanced oncology, certifications and academic opportunities. Included are supporting resources and a Benner Self-Assessment Competency Review tailored to unit needs for performance assessment and review. As a recruitment strategy, showcasing C3's commitment to staff wellness, it is now incorporated into the unit's job posting.

## I-2-C

### Barriers, facilitators and motivations to pursue specialty certification in oncology nursing: The case of BC oncology nurses

*Jagbir Kaur, Megan Crosby, Scott Beck, Andrea Knox, Charlotte Neville, Sonya Sangha, Leah Lambert*

*BC Cancer*

Specialty nursing certification has been positively associated with improved symptom management, improved patient satisfaction, sense of empowerment, and increased job satisfaction. For nearly two decades, researchers have studied the perceived value and barriers to specialty nursing certification. However, a paucity of empirical evidence remains specific to specialty nursing certification in oncology, and particularly from the perspective of nurses working in the Canadian cancer care system.

This presentation will share findings from a mixed-methods study aimed at generating contextual evidence about the personal, social, and structural factors that influence BC Cancer nurses to pursue – or not to pursue – specialty certification in oncology nursing. This study includes two phases: (1) Quantitative phase, an online survey based on a validated survey instrument (Perceived Value of Certification Tool PVCT-12®) measuring nurse's perceived value of certification in nursing specialties (2) Qualitative phase, a series of focus group interviews with certified and non-certified BC Cancer nurses. We will also share our approach and learnings from a nurse-led analysis process aimed at building research knowledge and capacity amongst direct care nurses. The findings from this mixed-methods study will be used to guide the development, implementation, and evaluation of an organizational strategy to increase the prevalence of CON(C)-certified nurses at BC Cancer.

## I-2-D

### Crossing the chasm: Building relationships between clinical trial and cancer care nurses to improve clinical trial recruitment in Nova Scotia

Alison Avery, Holly Robinson, Victoria Roberts, Donna Sutherland, Lorrie Yunace

Atlantic Clinical Cancer Research Unit

**Background:** Oncology clinical trials are the cornerstone of improving cancer care for patients. The oncology clinical trials (OCT) team functions independently from ambulatory cancer care clinics at the Nova Scotia Cancer Centre (NSCC) in Halifax, Nova Scotia. This has led to a disconnect and lack of awareness of OCT that could be offered to patients. Through new nurse-led, educational initiatives and strategies, the OCT nurses will engage the ambulatory cancer care nursing team to increase knowledge and awareness of OCT.

**Methods:** Phase 1 of the project involved the creation of a needs assessment survey which was electronically distributed to all NSCC ambulatory cancer care and systemic therapy nurses. Questions explored OCT knowledge levels, identified areas for improvement and gathered questions and suggestions about OCT.

**Results:** The survey received responses from 35/58 (60.3%) registered nurses. Thirty respondents (85.7%) indicated only being aware of “some OTC” with 4 (11.7%) indicating being “very aware of OTC” at the NSCC. When asked how the ambulatory cancer care nurses would like to receive education/information about OTC, 28 (82.3%) responded in favour of in-person meetings.

**Conclusions:** The needs-assessment survey highlighted knowledge gaps in OCT. Some of the changes already implemented based on the survey include in person nurse-led educational sessions, nursing specific emails and printed materials. A second follow-up survey will be administered in the future to evaluate any improvements in OCT knowledge amongst NSCC nursing. Recruitment numbers will be evaluated to determine if NSCC nurse engagement will lead to a greater number of patients being offered treatment with OTC in Halifax, Nova Scotia

## I-3-A

### Implementing New Cervical Brachytherapy Program: Nursing Perspective

Kassandra Gallichan, Baillie Gibson, Janny Proba, Maja Tuta

Hamilton Health Sciences Corporation

**Background & purpose:** This level-one tertiary regional cancer facility provides curative brachytherapy to cervical oncological patients. High Dose Rate cervical brachytherapy is part of the standard of care for the treatment of locally advanced cervical cancer requiring planning and coordinating inpatient and outpatient oncology services. Cervical brachytherapy affects both survival and quality of life and is a radiation treatment plan for

those with non-operable, locally advanced gynecologic cancers. Implementation of cervical brachytherapy at this cancer centre creates an opportunity for radiation-oncology and surgical oncology nurse to provide expert care within this treatment plan.

**Findings:** Many oncological nurses are unfamiliar with the role of a nurse with patients receiving cervical brachytherapy. This may impact the nurse’s knowledge and skill in providing best evidence care for these patients from a lack of professional guidelines for the nursing interventions during brachytherapy treatment. Implementing this treatment involves the processes of admission, supporting the timely delivery of treatment, and offering 24/7 nursing support for admitted patients undergoing this treatment. The absence of the educational resources and professional guidelines highlights the demand for nurses to facilitate professional role development plan. The oncological nurses constructed nursing processes to identify practice gaps and developed expected outcomes that reflect competence learning and change.

**Recommendations:** Ongoing collaboration to review content with stakeholders from inpatient and outpatient areas is crucial to implement evidence-based practice. This establishes a need for continued development of further education and resources to support the ongoing expansion of the brachytherapy program at this cancer centre. This includes adequate allocation of human, financial and material resources based on identified needs and goals for the brachytherapy program.

## I-3-B

### Managing infusion reactions: Optimizing scope for timely intervention

Carolyn Fifield<sup>1</sup>, Deb Barnhill<sup>1</sup>, Meghan Bragg<sup>1</sup>, Kate Heighton<sup>2</sup>, Kara Jamieson<sup>2</sup>, Navanna Pelletier<sup>2</sup>, Joy Tarasuk<sup>1</sup>

<sup>1</sup> Nova Scotia Health Cancer Care Program

<sup>2</sup> Nova Scotia Health Interprofessional Practice and Learning

The incidence and severity of Infusion Reactions (IR) during administration of parenteral systemic therapy for cancer (pSTC) drugs can be unpredictable. Although many pSTC drugs may have a reaction incidence rate of less than 1%, they are the 3rd leading cause of fatal drug-induced anaphylaxis and represent the most frequently reported drug class involved in national Adverse Drug Reaction reporting by a wide margin. Regardless of being an allergic (hypersensitivity) or non-allergic immune response (cytokine release syndrome), the clinical manifestations are similar and require prompt, accurate assessment, and management to avoid severe adverse events, including fatality.

The Nova Scotia Health Cancer Care Program has developed a Care Directive that allows the RN with chemotherapy certification (RNCC) to independently (without additional physician order):

1. Provide defined emergency treatments, including the administration of epinephrine, to the adult patient experiencing an (IR) during administration of pSTC drugs and

2. Grade an IR and Re-challenge IV administration of an STC drug when clinically appropriate.

In preparation for implementation of this Care Directive, updated provincial documentation tools were developed that supported the practice changes. In addition, a comprehensive education plan was developed to support RNCC's province wide in learning how to appropriately grade IR, treat an IR according to symptom, and administer epinephrine when required. Learning modules were designed for use with patient simulators for the RNCC to integrate learning and computer-based learning modules were created to further solidify knowledge. Debrief sessions following simulation learning were an integral component of building confidence with new skills.

### I-3-C

#### Preventing and managing complications of high-dose methotrexate

Laurie Ann Holmes

*The Ottawa Hospital*

High-dose methotrexate (HDMTX) is commonly utilized in chemotherapy protocols for acute lymphoblastic leukemia, osteosarcoma and lymphomas. Aggressive monitoring and prompt intervention is a key component in prevention of toxicities from this regime.

Approximately 2–12% of patients receiving HDMTX will experience acute kidney injury. Related to the kidney injury there can be delayed excretion of the drug metabolites. Numerous toxicities can develop because of the prolonged drug exposure; nephrotoxicity, hepatotoxicity, neurotoxicity, mucositis, and myelosuppression.

Many preventative strategies have been implemented to prevent kidney injury, vigorous intravenous hydration with bicarbonate, along with oral bicarbonate tablets are utilized to establish urine alkaline environment decreasing build up or renal acid. Nurses monitor urine pH levels frequently and administer bicarbonate boluses. Methotrexate is not administered until the desired pH level is achieved.

Following administration, nurses monitor methotrexate blood levels to evaluate excretion. Calcium leucovorin is a medication given to aid in the excretion, nurses will adjust the doses based on blood levels following specific protocols.

Prevention of these toxicities is key in enabling our patient to withstand this intensive therapy in hope of curing their cancer.

- Explain the rationale for hydration and pH monitoring
- Identify patients at risk of delayed excretion
- Discuss the importance of monitoring methotrexate blood levels
- Explain the implications of leucovorin rescue
- Review a patient case of delayed excretion and neurological toxicity

### I-3-D

#### Network leadership: Lessons learned

Chelsea Ilagan, Gabrielle Chartier

*Association Québécoise des Infirmières en Oncologie*

The Programme québécois de cancérologie (PQC) has set the objective of achieving greater collaboration and better coordination between the various stakeholders within the cancer teams of the health and social services network. This objective also aims to maintain quality standards and reduce access delays across the stages of the care trajectory (MSSS, 2019). Historically, the organizations have been working in silos and there is now a concerted effort to move towards the use of tumor-based networks. This way a patient will have access to the same care regardless of where they live provincially. To achieve this, collaborative effort, coordination, and dedication are required of all team. Teams at the MUHC and the Jewish General Hospital (CIUSSS Centre-Ouest) were tasked with leading large networks to advance multidisciplinary and multi-site initiatives to optimize the patient trajectory. By holding regular meetings, sharing experiences, and creating tools (Sharepoint, Kaizen), we can advance these goals. This presentation will discuss strategies to create an alliance that better response to organizational mandates, cancer care projects, and ministerial demands. In addition, a co-development process with all the stakeholders involved serves to improve the cancer patient's overall trajectory.

### I-4-A

#### The power of nursing: Nurse driven decision tool to manage toxicities with Acute promyelocytic leukemia

Laurie Ann Holmes

*The Ottawa Hospital*

Acute promyelocytic leukemia (APL) is a unique subtype of acute myeloid leukemia (AML), which accounts for approximately 10% of AML cases in Canada. Because of advances in diagnosis and management, APL is now considered the most curable form of acute leukemia.

In the initial phase of this disease patients are at increased risk of early mortality related to hemorrhage, sepsis or differentiation syndrome.

Standard treatment of APL based on risk stratification typically includes a combination ATRA (all-trans retinoic acid) and arsenic trioxide (ATO). The toxicity profile related to this combination can lead to life threatening complications, therefore nursing assessment and management is cardinal.

At our institution nurses developed and utilize a decision tool to evaluate and direct care daily. Based on the results of electrolyte results -replacements are instituted to decrease cardiac complication from arsenic. Monitoring of CBC and INR leads to implementation of transfusion and sepsis prevention protocols.

This presentation will provide an overview of APL and the recommended treatment. Demonstrate how the nurses utilize the decision tool to detect and prevent toxicities. Share patient related cases with differentiation syndrome.

## I-4-B

### Impact of obtaining patient-reported symptoms from patients with metastatic breast cancer

Joy Bunkso<sup>1</sup>, Savitri Singh-Carlson<sup>1</sup>, Michael McKenzie<sup>1</sup>, Antony Porcino<sup>1</sup>, Frances Wong<sup>1</sup>, LeeAnn Martin<sup>1</sup>, Rebecca Mattson<sup>2</sup>

<sup>1</sup> BC Cancer

<sup>2</sup> San Diego State University

**Purpose:** This study evaluated the impact and acceptance of repeated patient-reported outcomes (PRO) using a combined screening tool (Edmonton Symptom Assessment Scale (ESAS-r) and Canadian Problem Checklist (CPC) (ESAS-r+CPC)) in clinics with metastatic breast cancer patients (MBCP) and patient-identified primary caregivers (PIPC).

**Methods:** Qualitative methodology employed a narrative inquiry approach with demographic data to illustrate participants' stories. Interviews supported data collection with thematic/content methods for analysis.

**Results:** Participants included (23) MBCP, (5) PIPC, (7) nurses, (3) oncologists. Most patients described feelings of empowerment in self-reporting their own symptoms/concerns on paper formats of ESAS-r+CPC. Patients appreciated having time to discuss any concerns with nurses before seeing oncologists. They felt they could engage better with the nurses regarding their symptoms. PIPCs appreciated the screening tool that helped them help patients remember their symptoms. Most nurses had mixed feelings towards utilizing ESAS-r+CPC due to time constraints, but understood the benefits of self-completing ESAS-r+CPC resulting from patients' reflection on each item. They highlighted constipation and diarrhea as the most common side effects. Consistent utility of ESAS-r+CPC within clinical units to enable familiarity with tumour-specific symptoms was suggested. Oncologists' impressions of ESASr varied, ranging from not helpful to helpful since it eased their time spent with patients.

**Conclusion:** Although completing the screening tool at every clinical visit required patients to come earlier, they felt it helped to illustrate all the symptoms/concerns. Most patients appreciated the paper format and shared that completion on iPads would require some education before feeling comfortable with it.

## I-4-C

### Improving sleep quality after cancer: What does the evidence tell us?

Caroline Arbour<sup>1,2</sup>, Karine Bilodeau<sup>1,3</sup>, Samantha Mayo<sup>4,5</sup>, Josée Savard<sup>6</sup>, Imran Ahmad<sup>3</sup>

<sup>1</sup> Faculty of Nursing, Université de Montréal, Montreal, QC

<sup>2</sup> CIUSSS du Nord-de-l'Île-de-Montréal, Montreal, QC

<sup>3</sup> CIUSSS de l'Est-de-l'Île-de-Montréal, Montreal, QC

<sup>4</sup> Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, Toronto, ON

<sup>5</sup> Princess Margaret Cancer Centre, Toronto, ON

<sup>6</sup> School of Psychology, Université Laval, Quebec, QC

Sleep disruptions are commonly reported after blood cancer treatment. Besides its immediate relevance for patients' immunity and response to treatment, poor sleep could also affect their quality of life (QoL). For this reason, blood cancer patients should be provided with personalized tips and support to foster the best possible sleep. However, current sleep hygiene strategies intended for the general population may not be optimal to meet the resting needs of adults who have recently terminated blood cancer treatment. To this end, the ongoing PROSLEEP study provides the first thorough characterization of sleep and sleep hygiene habits in the context of blood cancer. A cohort of 30 adults with a primary blood cancer diagnosis (lymphoma, leukemia) was recruited. Participants' rest-activity cycle was monitored for seven consecutive days/nights at two to four weeks and three months after the end of blood cancer treatment using actigraphy, sleep diaries, and questionnaires, allowing extraction of both quantitative and qualitative aspects of sleep and interaction with fatigue and QoL. Preliminary results suggest that 60% of patients at two to four weeks and 52% at three months do not meet the minimal seven hours per day sleep requirements. Sleep after blood cancer is likely influenced by demographic, psychological, and lifestyle factors including napping habits and natural light exposure during the day. These results will be used to make recommendations for the detection and management of sleep disturbances in this patient group.

## I-5-A

### Developing a competency-based educational framework for palliative care in home and community

Gayatre Maharaj, Tanya Baker

Bayshore HealthCare

A palliative approach to care is aimed at improving QoL and reducing suffering of persons and their families when faced with life-limiting illness. With an aging population, the demand for such an approach to care has grown. Community-based palliative care is a suitable and desirable option for patients, especially when initiated in the early stages of illness. Such an approach enables for equitable access to quality, integrated, patient-centred care to be provided in preferred settings of care, such as the home. Bayshore HealthCare's Clinical Practice Strategy strives to ensure that patients have

access to and receive clinical excellence consistently throughout their care experience. To ensure high-quality patient care experiences, collaboration with patients, family/caregivers, and the interprofessional team is as essential as providing an engaged healthy workplace that supports professional development. Bayshore recognizes that a robust competency-based educational framework is a key strategy to support a high-performing learning organization that enhances sustainable palliative care services by supporting current and new generations of aspiring clinicians. Currently, Pallium Canada's LEAP education is utilized to support the interprofessional team with essential competencies to provide a palliative care approach. However, advanced education and mentorship is not standardized and varies across the organization. Utilizing the Canadian Interdisciplinary Palliative Care Competency Framework and focused interviews/surveys with frontline staff at Ontario branches, Bayshore's palliative educational framework will be revised and implemented. Strategies to evaluate the revised framework will be discussed with emphasis on the impacts on patient, family/caregiver, and care provider experiences.

### **I-5-B** **Optimizing the strength within: Integrating palliative care in hematologic oncology**

Reanne Booker<sup>1,2</sup>

<sup>1</sup> Alberta Health Services

<sup>2</sup> School of Nursing, University of Victoria

Advances in the treatment for hematologic malignancies (HMs), such as targeted therapies, immunotherapies, and chimeric antigen receptor (CAR) T-cell therapy, have led to significant improvements in survival, yet people with HMs still face significant risks of morbidity and mortality. Symptom burden, including physical and psychosocial symptoms, has been reported to be high in patients with HMs, with patients experiencing pain, dyspnea, nausea/vomiting, anorexia, mood disturbances, weight loss or weight gain, bleeding, and infections, to name a few.

There is a growing body of literature showing that early integration of palliative care for people with cancer can lead to an array of positive outcomes, including better symptom management, improved quality of life, reduced anxiety and depression, and even better survival. Family caregivers have also been found to have improved outcomes with earlier integration of palliative care. However, despite these known benefits, few palliative care intervention studies have included patients with HMs. In addition, palliative care referral rates for people with HMs have been reported to be low and often these referrals occur very late in the illness trajectory, meaning that patients and their loved ones may not have sufficient time to benefit from comprehensive palliative care. This presentation will provide an overview of the palliative care needs that patients with HMs may experience throughout the disease and treatment trajectories, and will review the state of the science on the integration of palliative care in patients with HMs.

### **I-5-C** **Enhancing delivery of palliative care on an acute care oncology unit through the use of simulation-based learning**

Amina Malik, Sarah Yip, Sarah Branton

North York General Hospital

The integration of palliative care for patients with serious illness in acute care settings supports symptom management and the overall quality of care provided. Of the people who receive palliative care, only half receive it in their last 30 days of life and most of them die in hospital (Health Quality Ontario, 2019). Therefore, it is imperative for all hospital staff to have a basic understanding of palliative care in order to feel comfortable, competent and confident to provide care for patients and families.

Nurses providing end-of-life care in hospital often receive very little formal training, resulting in discomfort addressing patients palliative care needs, specifically as care plans transition from life prolongation towards comfort-focused care. Simulation has been proven to be an effective teaching tool for developing nursing clinical skills and increasing confidence (Randall et al., 2018). Based on that, the palliative and oncology team decided to offer an eight-hour formal education day for nurses working in inpatient palliative care unit with the goal to assess and improve their knowledge, skill, and comfort, as well as preparing them to work as a team. Both didactic and simulation-based learning strategy using a high-fidelity mannequin were incorporated and was planned to be offered four times in the month of April with a goal to cover at least 75% of full-time and part-time nursing staff. Educational topics included goals of care, recognizing signs of death, supporting caregivers at end of life, palliative sedation, Medical Aid in Dying, symptom management, and engaging in self-care and reflective practice.

A pre- and post-test questionnaire was developed to assess their current knowledge and confidence, and to evaluate the impact of the education provided. As this program is still in implementation, results will be shared in the month of May.

### **I-6-A** **Recognizing the needs and challenges of the pediatric cancer survivor and the pivotal role nursing plays**

Connie Richardson

The Ottawa Hospital Cancer Centre

At the age of 18, pediatric cancer survivors treated at the children's hospital in Ottawa undergo a transition of care to the specialized Pediatric Oncology Group of Ontario (POGO) late effects clinic at The Ottawa Hospital. The POGO program is equipped with a multi-disciplinary team who monitor the late physical effects of cancer treatment, as well as supporting patients' social and emotional needs as they learn to navigate the maintenance of their health in adulthood. During annual visits, each patient receives specialized care from a pediatric oncologist, radiation oncologist, oncology nurse and social worker attending to individualized issues.

Many of these children spend a significant portion of their young lives focused on finishing treatment, perhaps not realizing health issues that may stem from these treatments will need to be monitored indefinitely. Providing wholistic health-care services for this patient population is vital. Nurses play a pivotal role in helping patients to cope with the physical sequelae, but also in identifying their psychosocial, emotional, practical, and informational needs.

This presentation will use the Supportive Care Framework to discuss the findings of a case study that highlights the challenges this unique population faces. It will seek to outline our team's approach to facilitate individualized care, communicate the healthcare needs of the patient, and fully use the skill set of the interdisciplinary team to ensure optimal outcomes.

Learning objectives:

1. Explore the nursing approach to care of pediatric cancer survivors in adulthood using the Supportive Care Framework.
2. Focus on strategies to assist young cancer survivors manage their fears and challenges.
3. Discuss future directions to improve care for this special patient population.

## **I-6-B** **Addressing suffering in children living with cancer and their families**

*Kimberley Widger*

*Lawrence S. Bloomberg Faculty of Nursing, University of Toronto*

Children living with cancer and their families experience suffering from even before diagnosis through to long-term survivorship or death from the disease. While some of this suffering is not able to be fixed or removed, families report their suffering is sometimes added to unnecessarily by the actions or inactions of health professionals. This trajectory of suffering requires nurses to provide primary palliative care throughout the illness to reduce unnecessary suffering and ensure the child and family are well-supported. Through this presentation, we will identify the similarities and difference between primary and specialty palliative care, explore use of the "Supportive Care Model" as a guide for providing primary palliative care, examine the central importance of connections as the key component to addressing suffering, and identify methods for establishing strong connections with families. The Supportive Care Model was first developed in the early 1990s to describe care provided to adults, and later assessed for its relevance to providing pediatric care. Components of the model include valuing, connecting, empowering, doing for, finding meaning, and preserving integrity. More recent research conducted with children living with cancer, their siblings, and their parents, as well as with bereaved parents, continues to highlight the relevance of the model in guiding practice in pediatric cancer care. In particular, the connecting component is highlighted within this body of research as critical to prevent unnecessary suffering and enhance coping throughout illness. We will examine successes and challenges in establishing strong connections with children and families to enable being with suffering that cannot be removed and addressing suffering that is unnecessary.

## **I-6-C** **Psychological distress in pediatric cancer: Measuring the issue in children and their families and intervening to improve quality of life**

*Lindsay Jibb*

*Lawrence S. Bloomberg Faculty of Nursing, University of Toronto & Hospital for Sick Children, Peter Gilgan Centre for Research and Learning*

Childhood cancer is a singularly stressful life event for the ~1,500 children and adolescents diagnosed with this disease each year in Canada, and for their families. Pediatric cancer therapy typically requires intensive treatment and repeated and sometimes prolonged periods of hospitalization. This treatment can last months to years, with substantial short- and long-term toxicities and the risk of premature death. These circumstances are often overwhelmingly distressing for those affected by childhood cancer and constitute substantial threats to their mental and physical health. Research conducted by our group has indicated that improved access to mental and psychosocial supports for children with cancer and their family caregivers experiencing traumatic stress is regarded by patients, survivors, families, and clinicians as a top Canadian pediatric cancer research and care priority. This presentation will review the state of the literature related to psychosocial distress in pediatric cancer, research conducted by our group to characterize the severity and frequency of traumatic stress symptoms in the children's primary family caregivers, and the results of our interventional study examining the feasibility of a manualized semi-structured psychotherapeutic intervention to alleviate traumatic stress and improve wellbeing in family caregivers. Together, this presentation will highlight the problem of distress in those affected by childhood cancer and underscore the urgent clinical need for psychosocial supports for this population.

## **I-6-D** **Working together to foster treatment innovation for pediatric cancer**

*Nadine Prévost, Christina Sit*

*Leukemia and Lymphoma Society of Canada*

Children experiencing cancer can face the biggest challenges. Although there is an 84% five-year survival rate, existing treatments leave long-term side effects: 80% of childhood cancer survivors develop chronic health issues from treatment.

There are multiple innovation barriers for pediatric cancer in Canada, including rarity of childhood cancer, lack of investment and difficulties in treatment access. Some pediatric cancer treatments have gaps of thousands of days between Health Canada approval and public reimbursement.

In this session, we will present two Leukemia and Lymphoma Society-led pediatric research initiatives: 1) PedAL Master Clinical Trial, matching patients to treatment based on their cancer's unique tumour biology; 2) AML Data Commons, a platform for consistency in global data reporting. We will

also present our working group activities advocating for system changes to accelerate pediatric research and drug access.

Nurses play a key role in helping to capture the real-life impact of treatments. Join us to learn more about our paradigm changing plan for treatment and care for pediatric cancers, and how nurses play a key part. Together we will power innovative research and advocate for newer, safer treatments that help children thrive.

Objectives:

- Discuss barriers to pediatric oncology treatment access in Canada
- Discuss the role of nurses in helping increase treatment access
- Learn about a new international trial for pediatric AML and how it can accelerate research in other pediatric blood cancers.

## II-1-A

### Chemo Smartbook: Strengthening systemic therapy scheduling at BC Cancer

Anika Patel

BC Cancer

**Background:** BC Cancer (i.e., the comprehensive cancer control agency for the province of British Columbia) delivers outpatient systemic therapy (ST) at its six regional cancer centres. Stabilizing, improving, and sustaining BC Cancer's capacity to deliver ST services is of vital importance given (1) the essential role that ST plays in the care of people living with cancer, and (2) a growing demand for ST services due to the rising incidence of cancer in the BC population.

**Intervention:** Chemo Smartbook (CSB2) is a homegrown enterprise scheduling optimization solution that uses a provincial data dictionary to calculate protocol-specific nursing and chair resource requirements as a means of scheduling ST treatment delivery. Implementation of CSB2 is underway and is projected to be complete at all six regional cancer centres by 2024. Sustainment hinges on all sites using the same data dictionary; yet, standardizing nurse and chair resource requirements across different facilities is challenging and highlights workflow and models of care differences that would otherwise remain hidden.

**Results:** As the implementation team focuses on each site in serial, new challenges to standardization arise including (1) models of care, (2) workflow, and (3) subjective differences in resource allocation at the protocol level. As we see more new, complex, and longer ST treatment protocols, the difficulties with standardization become more evident.

**Discussion:** The provincial activation of CSB2 at BC Cancer will enable the collection of invaluable metrics that will help us understand the health of our system, identify trends, and allow us to shift to a prospective capacity-building strategy. We expect CSB2 to advance the quintuple aim in cancer care by increasing capacity, decreasing variability in patient and clinician experience, promoting resource optimization, and building provincial-regional collaboration.

## II-1-B

### Real-world implementation barriers and facilitators of electronic patient-reported outcomes (PROs) in oncology in Quebec: A qualitative study

Sylvie Lambert<sup>1</sup>, Mona Maghalaes<sup>2</sup>, Manon deRaad<sup>2</sup>, Zeev Rosberger<sup>3</sup>, Tarek Hjal<sup>4</sup>, Krisen Jean Julien<sup>2</sup>, Adrian Langleben<sup>5</sup>, Fabienne Germeil<sup>5</sup>, Jossephine Lemy Dantica<sup>5</sup>, Christine Bouchard<sup>4</sup>, Marie Solange Bernatchez<sup>4</sup>

<sup>1</sup> École des sciences infirmières Ingram, Université McGill

<sup>2</sup> Centre de recherche de St. Mary, CIUSSS de l'Ouest-de-l'Île-de-Montréal

<sup>3</sup> Institut Lady Davis pour la recherche médicale

<sup>4</sup> Centre universitaire de santé McGill

<sup>5</sup> CIUSSS de l'Ouest-de-l'Île-de-Montréal

**Objective:** The systematic screening of patient-reported outcomes (PROs) has numerous benefits for patients and clinicians. Despite this, PRO programs remain scarce outside of clinical trials. Since 2017, in Quebec, electronic PRO programs are being implemented across several cancer centres (called e-IMPAQc). This study explored key barriers and facilitators from patients' and clinicians' perspectives to implement e-IMPAQc.

**Methods:** A qualitative study was undertaken with 30 patients and five clinicians who used e-IMPAQc. Semi-structured interviews were conducted over the phone, online, or in person to explore the determinant of e-IMPAQc's implementation. All interviews were audio-recorded, verbatim transcribed, and coded using thematic analysis.

**Results:** Lack of a universal patient portal integrated with the electronic medical record was an implementation barrier for both patients and clinicians. For clinicians, this meant logging in to another platform to view the PRO results, which was too time-consuming. Other patient barriers included: not always having enough time to complete the PROs prior to the appointment, health literacy, and lack of awareness of how to use e-IMPAQc. Facilitators for patients were the PRO measures themselves (they were easy to complete) and the perceived benefits of participating in e-IMPAQc. Other clinician barriers were PRO screening remained an individual clinician decision and a perception that PROs were "extra." Whereas facilitators were graphical summaries that were colour-coded, administrative support and high buy-in.

**Conclusion:** PRO programs are complex interventions that require extensive clinical resources and clinician and patient buy-in, and inevitably change care processes for all.

## II-1-C

### Introducing MySymptom Report: A comprehensive electronic patient-reported outcome questionnaire to support oncology practice

April Hildebrand<sup>1</sup>, Claire Link<sup>1</sup>, Andrea DeIure<sup>1</sup>, Linda Watson<sup>1,2</sup>

<sup>1</sup> Cancer Care Alberta

<sup>2</sup> University of Calgary Faculty of Nursing

Since 2012, Cancer Care Alberta has utilized a paper patient-reported outcome (PROs) measure to help care teams identify and respond to physical and psychosocial distress experienced by patients. The paper PRO measure consisted of the revised Edmonton Symptom Assessment System (ESAS-r) and Canadian Problem Checklist (CPC). The ESAS-r asks patients to rate the severity of nine common symptoms while the CPC captures additional concerns. In preparation for launch of a new provincial clinical information system, the paper PRO measure was redesigned. The new electronic PRO (ePRO) measure is called MySymptom Report (MSR) and consists of modified versions of the ESAS-r and CPC.

This presentation will describe the design principles used to develop the MSR. The measure was designed based on commonly checked items on the CPC, as well as feedback from engagement sessions with key stakeholders, including patient and family advisors. Three components of the new measure will be highlighted: 1) The ESAS-r Cancer, a modified version of the ESAS-r, which includes six new symptoms and expanded definitions for all 15 items; 2) Symptom-specific branching questions, triggered for patients when certain symptom ratings are selected, providing additional insight into a patient's symptom experience; 3) The modified CPC, called MyPersonal Needs (MPN). The MPN uses referral-specific domains designed to support oncology nurses in facilitating collaborative care through timely involvement of supportive care teams.

Using PROs to inform person-centred care optimizes nursing time, facilitating relevant conversations to ensure patients receive needed care in a meaningful way. Although designed in Alberta, the MSR is also relevant to other Canadian jurisdictions that may wish to use the full measure or specific components.

## II-1-D

### Enhancing immunotherapy safety: The use of electronic patient-reported outcomes for detection and prediction of immune-related adverse events

Saeed Moradian<sup>1</sup>, Mahdieh Dastjerdi<sup>1</sup>, Catriona Buick<sup>1</sup>, Charlotte T. Lee<sup>2</sup>, Doris Howell<sup>3</sup>

<sup>1</sup> York University

<sup>2</sup> Daphne Cockwell School of Nursing, Toronto Metropolitan University

<sup>3</sup> University Health Network

Immunotherapy using immune checkpoint inhibitors (ICIs) has revolutionized cancer treatment, but it is associated with immune-related adverse events (irAEs) that can be life-threatening if not promptly recognized and treated. Patient-reported outcomes (PROs) are valuable tools for

collecting patient-centred data and are frequently used in oncology trials. However, there are few studies on electronic PRO (ePRO) follow-up for blood cancer patients treated with ICIs, which may reflect a lack of support services for this population. Here, we present the development of a digital platform (V-Care) using ePROs for a new follow-up pathway for cancer patients receiving ICIs. The V-Care platform was developed using the CeHRes roadmap, and the application was categorized into two phases for user interface and user experience designs. The findings from our project can be used to investigate whether symptoms collected by the ePRO tools on cancer patients being treated with ICIs follow symptoms reported in clinical trials and if they are linked to specific symptoms that do occur. The V-Care platform has the potential to address significant challenges in providing oncology services and enable personalized intervention based on PRO data in real-time. The next step is to develop computable algorithms and establish the threshold alerting scores to align with the early detection of irAEs through the V-Care platform.

## II-2-A

### The leading role of nurses in providing patient-centred care for patients with ambulatory 5-Fluorouracil infusors

Tracey Huber<sup>1</sup>, Denise Bryant-Lukosius<sup>2</sup>, Nancy Carter<sup>2</sup>, Sharon Kaasalainen<sup>2</sup>

<sup>1</sup> Walker Family Cancer Centre

<sup>2</sup> McMaster University

Treatment for advanced gastrointestinal (GI) cancer often requires continuous infusion of 5-Fluorouracil (5-FU) over 46-hours via an ambulatory infusor, which may impact on patients' daily activities and quality of life (QoL). There is limited research on the impact of this technology on patient health or if current practices meet health needs.

Informed by Picker's model of patient-centred care (PCC), this study aimed to explore patient experiences in receiving 5-FU through an ambulatory infusor at home for GI cancers. A qualitative descriptive design was used. Participants were patients diagnosed with a GI cancer who had received 5-FU through an infusor within the last 12 months at a cancer centre in Southern Ontario. Semi-structured interviews were conducted by telephone, transcribed verbatim, and analyzed using content analysis methods.

Ten patients with four types of GI cancer participated. Their experience with infusors ranged from 8-54 treatment cycles. Three themes were identified from the data: 1) the psychosocial impact of having an infusor related to mental exhaustion, fear, the constant reminder of having cancer, and restrictions on daily life; 2) the intense work of patient self-management including coordinating appointments and managing problems with the infusor; and 3) the importance of supporting patients in self-management. How current practices did/did not align with Picker's principles for PCC are identified.

Results illustrate the pervasive and negative impact of the infusor on patients' daily activities and QoL, especially related



to mental health. Oncology nurses have a leading role to identify, respond to, and advocate for cancer services that better meet patient needs. Evidence-based nursing interventions to promote the delivery of patient-centred cancer care and improve patient experiences and health outcomes will be outlined, including ways to engage patients and their caregivers in the improvement process.

## II-2-B

### **Oncology nurses as partners in head and neck cancer treatment recovery: The development of a nurse-led gastrostomy tube removal clinic**

*Claire Kelly, Jennifer Deering, Melanie Woodside, Simonne Simon, Simranjit Kooner*

*University Health Network, Princess Margaret Cancer Centre*

The removal of a temporary balloon retention gastrostomy tube after treatment for head and neck cancer completes an important chapter in the patient's cancer journey. However, in the post-pandemic era, there are now significant wait times for gastrostomy removal appointments by interventional radiology services. Such delays negatively impact patients' quality of life and add unnecessary burden to healthcare resources.

In response to this delay in care, head and neck oncology nurses questioned the feasibility of nurses removing gastrostomy tubes to reduce wait times.

A multidisciplinary working group collaborated to create the quality improvement (QI) initiative of a nurse-led gastrostomy removal clinic. An environmental survey and literature review were performed and demonstrated that the removal of balloon retention gastrostomy tubes can safely be performed in a hospital clinic setting by trained nurses. As a result, a standard operating procedure (SOP) was developed. To support this SOP, nursing education and competency certification of specialized oncology nurses with the removal process was implemented. Following this, the nurse-led clinic was launched. Data collected will determine the clinic's impact on wait times, patient outcomes and satisfaction.

This oral presentation will share the development, implementation and lessons learned of this pilot nurse-led gastrostomy tube removal clinic.

## II-2-C

### **Living well with pancreatic cancer. Maintaining excellence in oncology nursing care for patients and their families living with pancreatic cancer**

*Carolyn Kei<sup>1</sup>, Orla Adams<sup>2</sup>*

<sup>1</sup> BC Cancer

<sup>2</sup> BCCA

In 2022, an estimated 6,900 Canadians were diagnosed with pancreatic cancer and approximately 5,700 died from the disease. Most people are diagnosed with advanced or metastatic pancreatic cancer. Currently, 50% of people survive beyond four months, while the overall five-year survival rate remains very low at 7-10%. Despite it being only the 11th most

commonly diagnosed malignancy in Canada, pancreatic cancer is now the third leading cause of cancer death in Canada. This high death rate reflects the known challenges of screening for and confirming the diagnosis, as well as the tolerability and treatment efficacy of pancreatic cancer.

In the past two decades, evidence-based combination chemotherapy treatments for pancreatic cancer have provided more hope for controlling peoples' cancer and offer longer progression-free survival, as well as improved symptom control and better quality of life. Thirteen to 20% of people have upfront surgery followed by adjuvant chemotherapy. A recent study reported the five-year survival rate of 43% with a median metastasis-free survival was 29 months post surgery followed by adjuvant FOLFIRINOX.

Furthermore, there is now evidence that the integration of early palliative care and supportive care enhances symptom control and quality of life for both the person with pancreatic cancer and their family, leading to better treatment outcomes.

This comprehensive workshop will utilize interactive progressive case-based learning and patient scenarios to describe the roles the oncology nurse will enact with patients and their families having surgically resectable or advanced pancreatic cancer. There will be an emphasis on the evolving role of surgical oncology options and clinical trials for patients with pancreatic cancer and highlight the importance of the treatment for pancreatic insufficiency and integrating early palliative care, pain and symptom management in concert with oncologic treatments.

1. Review of incidence/mortality of pancreatic cancer
2. Review signs/symptoms, diagnostic testing, symptom management and role for pain and symptom management/palliative
3. Review the treatment options for resectable, locally advanced and metastatic pancreatic cancer
4. Review role for clinical trials and translational research for pancreatic cancer.

## II-2-D

### **The impact of peer support on the psychosocial functioning and social support of young adults with gynecological cancer**

*Rey Ann Carter*

*York University*

Younger adults with gynecological cancer are at a higher risk of psychological deterioration, as they struggle with managing the effects of treatments and handling psychosocial issues unique to their age group. Thus, supporting this group of patients throughout their treatment is crucial through a multidisciplinary approach, such as peer support programs to meet their distinct psychosocial needs. This study aims to examine the impact of a nurse-led peer support group on the psychosocial functioning and social support of young adults with gynecological cancer. Using McMillan and Chavis's Sense of Community theory, the peer support group will be tailored according to the distinct needs of these patients, such

as providing a harmonious emotional connection and clarity within the group with the help of a nurse facilitator. The inclusion criteria will include those between the ages of 25-39 diagnosed with gynecological cancer and have dependents and intimate partners. Participants who do not have access to Internet, IT literacy, and cannot read and write in English will be excluded from the study. Patients currently in another peer support group will also be excluded. The study will employ a quant-qual research design. It will include a prospective survey design that will collect measures on participants' psychosocial functioning level and social support pre- and post-nurse-led peer support intervention, followed by in-depth qualitative interviews of participants to explore experiences and perceptions of the intervention in relation to psychosocial functioning and social support. This presentation will describe the study's peer support group intervention design process and discuss its potential impact on psychological functioning and social support for young patients with gynecological cancer.

### II-3-A

#### An overview of targeted systemic cancer therapy

Jodi Hyman

Cancer Care Manitoba

Over the past 20+ years, advances in the number of new systemic cancer therapies have exploded. Developments in chemotherapy, targeted therapy, and immunotherapy have been responsible for improving cancer related morbidity and mortality.

In the past, oncology nurses primarily cared for people receiving conventional chemotherapy with similar and predictable side effects. Now there are many different types of systemic therapies with a majority being targeted therapies. As the understanding of cancer cell mutations and specific tumour markers increase, so will the complexity of systemic treatments.

Oncology nurses are at the forefront of patient care and it is important to understand the types of targeted therapies available, their uses, side effect profiles and nursing interventions needed to care for patients.

This presentation will focus on foundational knowledge around targeted therapy. At the end of the presentation the participants will be able to:

- Understand the different types of targeted therapies and their uses
- Review mechanism of action for CheckPoint Inhibitors and how this is different from other targeted therapies
- Predict and manage side effects from targeted therapy.

### II-3-B

#### Closed-loop medication management - A QI initiative

Taslin Janmohamed-Velani

BC Cancer – Vancouver

**Background:** Closed-loop medication management is a patient safety issue, a nursing practice responsibility, and an accreditation standard. With the launch of CST Cerner, patient and medication barcode scanning have been put into place to support this practice. Audits indicated in December 2022, that scanning rates hovered around the 20% mark, indicating significant gaps in meeting practice standards.

**Methods:** A mixed-methods approach of epidemiology, interviewing of staff, and cohort observation was used to extract data and identify the issue. A partnership was formed between clinical nurse educators and clinical informatics to review the reports in detail, identify where the potential gaps were, and strategize solutions.

**Results:** Prior to the education and informatics partnership, front-line leadership were unaware of the gaps in meeting the practice standards. Rates of scanning were inconsistent, without a sense of what was simply operational (missing/broken scanning equipment), versus a true lack of awareness among staff on how to appropriately scan both the medication and the patient's armband.

As of the end of March, reports indicate that scanning rates have more than doubled in some areas, and increased by 25x in other areas, with the lower end of scanning rates coming in at 70%.

**Discussion:** While there is still room for improvement and regular efforts are still being made to ensure the rates of closed-loop medication management continue their steady increase, much progress has been made and the partnership continues to expand, with pharmacy colleagues being the latest addition. As staff develop comfort with identifying where their own gaps are, next steps include sustainment planning and moving the audits to an operational responsibility, where the practice and education team will continue to be engaged as needed.

The education, pharmacy and informatics team will then be able to turn its focus to the next priority.

## II-3-C

### Administration of systemic therapy for cancer on non-oncology inpatient units

Carolyn Fifield<sup>1</sup>, Christina Fraga<sup>2</sup>, Claudia Harding<sup>3</sup>, Julia Kaal<sup>4</sup>, Marilyn Landry<sup>1</sup>, Jennifer LeBlanc<sup>1</sup>, Erin Leith<sup>5</sup>, Al Logan<sup>6</sup>, Mary Kate MacDougall<sup>7</sup>, Laura V. Minard<sup>3</sup>, Josee Rioux<sup>1</sup>, Hilary Ripley<sup>1</sup>, Alex Tarasuk<sup>1</sup>, Joy Tarasuk<sup>1</sup>, Terra Thibault<sup>1</sup>, Ray Wright<sup>1</sup>

<sup>1</sup> Nova Scotia Health Cancer Care Program

<sup>2</sup> Nova Scotia Health, Division of Hematology

<sup>3</sup> Nova Scotia Health Pharmacy

<sup>4</sup> Nova Scotia Health Research and Innovation

<sup>5</sup> Nova Scotia Health Quality Improvement and Safety

<sup>6</sup> Nova Scotia Health Pharmacy

<sup>7</sup> Nova Scotia Health Interprofessional Practice and Learning

As cancer increasingly becomes a chronic disease managed by long-term parenteral systemic therapy treatments (pSTC), the frequency of patients requiring admission to non-oncology units while receiving pSTC drugs is expected to increase. Within Nova Scotia, safety concerns have occurred related to patients receiving pSTC drugs on inpatient units with inadequate access to knowledgeable pharmacy, nursing, and physician supports. This quality improvement initiative aimed to improve patient safety and efficiency of workflow related to administration of STC drugs in non-oncology areas.

As most events of administration of STC drugs in non-oncology inpatient units involved hematology patients, a multi-disciplinary team was assembled including nurses and pharmacists specialized in hematology, nurses and pharmacists from non-oncology units, hematologists, and administrative leadership to explore the challenges and propose change ideas. Change ideas were then tested using a Plan-Do-Study-Act (PDSA) approach with a combination of quantitative and qualitative measurement tools to measure impact. Workload measurement tools for nurses and pharmacists captured time spent coordinating care for patients admitted to non-oncology units and a qualitative survey for oncology and non-oncology staff was used to identify challenges.

Change ideas tested included:

- Addition of an oncology “tip sheet” to the inpatient chart to provide key information to non-oncology nursing staff
- Development of standardized communication pathways for hematology specialty staff to clearly articulate role accountabilities
- Involvement of the hematology clinic nurse to oversee care coordination including support for patient education and discharge planning.

Although PDSA cycles are ongoing, there have been benefits observed such as improved communication among members of the hematology team, earlier involvement of hematology clinic nurses, and clearer coordination of care with non-oncology staff.

## II-3-D

### Levelling up: Defining the levels of care for systemic therapy administration in Nova Scotia

Kara Jamieson, Jill Petrella, Meghan Bragg, Carolyn Fifield, Joy Tarasuk, Bruce Colwell, Deb Barnhill, Joanne Houlihan, Erin Wentzell

Nova Scotia Health Authority

The Nova Scotia Health (NSH) Levels of Care Policy outlines the infrastructure and staffing standards required for the safe delivery of parenteral systemic therapy for cancer (pSTC) at NSH facilities. Originally written by Cancer Care Nova Scotia in 2012, a revision was required to reflect the increased complexity of pSTC, the organizational changes within NS, as well as to incorporate new information about targeted therapy, immunotherapy, and medical response to infusion reactions.

It was also necessary to define the required process for classifying regimens at a particular level designation and the creation of a drug regimen index was the result; providing an easily accessible tool for staff to reference the level defined for any approved regimen in NS.

The revised policy defines intermediate, advanced and specialized levels of care, auditing requirements, contingency plan needs, and processes for requesting to prepare and administer a pSTC regimen higher than the facility's assigned level.

An assessment tool was distributed to 11 NSH facilities, where parenteral systemic therapy is currently administered to gather baseline information around the current infrastructure and staffing related to pSTC, and site visits were conducted to understand and resolve any gaps that may exist prior to the new policy going live in September 2023.

## II-4-A

### Exploring oncology patient self-management support in baccalaureate nursing curriculum: A case study approach

Carrie MacDonald-Liska<sup>1</sup>, Jennifer Mitton<sup>1</sup>, Cathy MacDonald<sup>1</sup>, Maureen Coady<sup>1</sup>, Doris Howell<sup>2</sup>

<sup>1</sup> St. Francis Xavier University

<sup>2</sup> Princess Margaret Cancer Research Institute

**Background:** As the largest cancer care workforce, nurses are well situated through daily interactions to provide effective oncology self-management support to improve health outcomes and quality of life for cancer survivors. Self-management support education for nurses is very limited and an urgent need for research in baccalaureate nursing education is required to ensure nursing students are prepared when entering the workforce to support patients with cancer in the self-management of cancer as a chronic disease.

**Purpose:** The aim of the proposed study is to gain an understanding of the extent, if any, that educational approaches of oncology self-management support interventions, including health coaching as an intervention, exist and the impact, if any, upon baccalaureate nursing curriculum, its educators, and students.

**Methodology:** A qualitative exploratory case study will be conducted at a baccalaureate nursing program. Purposeful sampling technique will recruit participants who will include one lecturing professor, one administrative faculty professor, two nurse educators, and five third- or fourth-year nursing students. Each participant will engage in one-on-one semi-structured interviews. Additional data sources will include course syllabi, textbook(s), and reflective journaling notes. Inductive and deductive thematic analysis will be used to analyze the data and identify themes.

**Discussion:** This study will fill an identified critical gap in the literature by exploring the extent and impact of educational curriculum on nurses' knowledge and application of cancer self-management support in nursing practice. Understanding the extent to which nursing students are prepared to assist patients self-manage the consequences of cancer is a prudent first step. This presentation will provide an overview of the research aim, theoretical framework, literature review, and methods, and early preliminary results will be shared.

## II-4-B

### Supportive care needs among adults affected by hematological cancers and their caregivers

Samantha J. Mayo

<sup>1</sup> Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

<sup>2</sup> Princess Margaret Cancer Centre, University Health Network

The experiences of adults affected by hematological cancers and their caregivers are characterized by unique physical and psychosocial supportive care needs that impact quality of life and may persist beyond the completion of cancer treatment. However, patients and caregivers often report that their supportive care needs are inadequately addressed. In the present context of rapid advances in treatment options and changing models of care, there is also an opportunity to design innovative clinical approaches that attend to patient and caregiver supportive care needs in a meaningful way. Guided by the Supportive Care Framework, this presentation will provide an overview of the current research evidence related to the supportive care needs in this population, with an emphasis on physical, psychosocial, and information-related outcomes among both patients and caregivers. The overview will draw from a review of recent literature, as well as findings from an ongoing program of research using quantitative and qualitative methods to understand the experience of with adults affected by hematological cancer, caregivers, and clinicians. Implications for the development of tailored nurse-led and interprofessional interventions will be proposed.

## II-4-C

### Patient education pamphlets and usual care are not enough; what do patient decision aids offer patients facing cancer decisions?

Dawn Stacey<sup>1,2</sup>, Joelle Doucet<sup>3</sup>, Alda Kiss<sup>3</sup>, Maureen Smith, Meg Carley<sup>2</sup>, Karina Dahl-Steffensen<sup>4</sup>, Bob Volk<sup>5</sup> for the Cochrane Patient Decision Aids Review Team\

<sup>1</sup> School of Nursing, University of Ottawa

<sup>2</sup> Centre for Implementation Research, Ottawa Hospital Research Institute

<sup>3</sup> The Ottawa Hospital

<sup>4</sup> Lillebaelth Hospital, Vejle, Denmark

<sup>5</sup> MD Anderson Cancer Center, Houston, Texas

**Background:** Patients with cancer face many healthcare decisions. Oncology nurses can support them in decision making, but usual care is often limited to verbal teaching and/or providing patient education pamphlets.

**Purpose:** To compare patient decision aids to usual care (typically patient education pamphlets) for patients who face decisions across the cancer care continuum, from preventing cancer to supportive care.

**Patients and Methods:** Two reviewers independently screened the 209 trials in the preliminary findings from the 2023 Cochrane review to identify eligible trials of patient decision aids across the cancer continuum. Outcomes were quality of the decision and decision-making process. A meta-analysis was conducted for similar outcome measures.

**Results:** Eighty-two randomized controlled trials evaluated patient decision aids for cancer care, including 42 on screening decisions (51%), 27 on treatments (33%), 6 on prevention (7%), 5 on genetic testing (6%), and 2 on supportive care (2%). Common decisions were about colorectal cancer screening (22%), prostate cancer screening (18%), breast cancer treatment (17%), and prostate cancer treatment (11%). Compared with usual care, patients who received a decision aid made higher quality decisions with 12.8% higher knowledge, 68% more accurate risk perception, and 163% better value-choice agreement. Compared with usual care, patients who received decision aids also had a better decision-making process with decreased decisional conflict (fewer felt uninformed and fewer felt unclear values), 43% reduced clinician-controlled decision making, and 36% fewer patients were indecisive about the chosen option.

**Conclusion:** Patient decision aids help patients participate in making quality cancer decisions that are informed and reflect what matters most to them. Oncology nurses can better support these patients by using patient decision aids (instead of education pamphlets), as well as identifying topics for new patient decision aids.

## II-4-D

### Personas and journey maps to illustrate patients' life stories and contextualize patient-reported outcome measures in cancer care

Jae-Yung Kwon<sup>1</sup>, Melissa Moynihan<sup>2</sup>, Francis Lau<sup>1</sup>, Angela C. Wolff<sup>3</sup>, Maria-Jose Torreon<sup>4</sup>, Geraldine Irlbacher<sup>1</sup>, Amanda L. Joseph<sup>1</sup>, Lorraine Wilson<sup>5</sup>, Hilary Horlock<sup>6</sup>, Lillian Hung<sup>2</sup>, Leah K Lambert<sup>5</sup>, Rick Sawatzky<sup>3</sup>

<sup>1</sup> University of Victoria

<sup>2</sup> University of British Columbia

<sup>3</sup> Trinity Western University

<sup>4</sup> BC SUPPORT Unit

<sup>5</sup> BC Cancer

<sup>6</sup> Provincial Health Services Agency

**Aims:** While patient-reported outcome measures (PROMs) can help clinicians better understand patients' health needs, one challenge has been to assist them in understanding how responses to PROMs relate to patient stories for identifying and addressing the healthcare needs of individual patients. Personas (i.e., hypothetical representations of patients) and journey maps (i.e., visualizations of patient healthcare encounters) can help illustrate patients' life stories, making them valuable tools for understanding the person when using PROMs. This project, focused on cancer-related experiences, aimed to develop personas and journey maps as knowledge translation strategies to support clinicians' use of PROMs for person-centred cancer care.

**Methods:** Eight older adults participated in online workshops to co-develop personas and six older adults participated in individual interviews to co-develop journey maps. Participants were asked to identify themes that focused on thinking/feeling, tasks/activities and influences/supports. Participants subsequently completed an emotional well-being PROM. Personas and journey maps were further refined based on key themes identified in the workshops and interviews.

**Results/Conclusion:** Four personas and six journey maps representing participant experiences were developed to help clinicians link PROM responses to patients' life stories and contextualize PROMs data. As a knowledge translation strategy, personas and journey maps can help to foster clinician awareness of how responses to PROMs can be used to initiate conversations to better relate and understand patients' unique life situations.

## II-5-A

### Medical assistance in dying in Canada: An update on the amended legislation

Reanne Booker

<sup>1</sup> Alberta Health Services

<sup>2</sup> School of Nursing, University of Victoria

Medical assistance in dying (MAiD) has been legal in Canada since June 2016. Since then, more than 31,000 Canadians have undergone provision of MAiD. The legislation pertaining to MAiD has undergone revision and, in 2021, Bill C-7, An Act to Amend the Criminal Code (Medical Assistance

in Dying) was passed in Parliament, allowing for immediate changes to be made to the MAiD legislation. Notable changes included amendments to the eligibility criteria with repealing of the criterion that death must be reasonably foreseeable and the inclusion of the ability to waive final consent. The former change has led to the creation of two tracks for MAiD in Canada: track one, where natural death is considered reasonably foreseeable, and track two, where natural death is not reasonably foreseeable. Bill C-7 explicitly outlines safeguards to be adhered to for tracks one and two and conditions that must be met in order for the waiver of final consent to be permitted.

This presentation will provide an overview of the current MAiD legislation, including review of the eligibility criteria, the safeguards in place, and a synopsis of the statistics pertaining to MAiD in Canada since legalization in 2016. Challenges and controversies will be presented with an opportunity for participants to engage, ask questions, and share their own experiences, to the extent that they are comfortable doing so. Additional options for managing suffering and distress in the context of serious illness, including cancer, will be presented.

## II-5-B

### Perspectives of family members of MAiD recipients: Considerations for oncology nurses

Tracy Powell<sup>1</sup>, Kelli Stajduhar<sup>2</sup>

<sup>1</sup> Mount Royal University, PhD candidate, University of Victoria

<sup>2</sup> Palliative Approaches to Care in Aging and Community Health, School of Nursing and Institute on Aging & Lifelong Health, University of Victoria

Family members of those with a life-limiting illness are an understudied and undersupported population, as a whole, particularly in the area of medical assistance in dying (MAiD), resulting in knowledge gaps. With the most common underlying health condition of those who choose MAiD being cancer-related, members of these families are more likely impacted.

Since MAiD was legalized in Canada, few published studies focus on family members' experiences, and of these studies, family members are seen to have roles and responsibilities in the MAiD process, are generally supportive of their loved one's choice, but also experience challenging times throughout the process. The impact of provincial and territorial MAiD policy, processes, and implementation on family members' experiences, however, has received minimal attention in the literature.

This presentation will highlight findings from a two-province study that begins to address the identified knowledge gap and provide contextual considerations at individual and policy levels. We will highlight supportive interventions, policy, and potential programming for family members who have had a significant other receive MAiD in the Canadian context. Through this presentation, oncology nurses and cancer care leaders will be better able to identify how family members can be supported when a loved one receives MAiD, and advocate for change within their settings and jurisdictions.

## II-5-C

### End-of-life care among adults with hematological malignancies: Implications for nursing practice

Argin Malakian, Jocelyn Brown

Princess Margaret Cancer Centre

Hematological malignancies (HM) are complex diseases of the blood and bone marrow characterized by complicated long-term treatment trajectories, unpredictable progressions, and high symptom burdens. Although treatment for some sub-types has improved, adult mortality rates remain high. End-of-life care can be challenging for this population given their unique needs, and often results in high healthcare utilization and frequent anti-cancer therapy in the last month of life, high incidents of hospital death, and low hospice and palliative care referrals.

Professional nursing is central to the delivery of end-of-life care to any individual with a serious or life-limiting illness in any setting. The goal of nursing in providing care at the end of life is to address the physical, psychological, social, spiritual, and practical issues that patients and families face, as well as their associated expectations, needs, hopes, and fears. This includes preparing for and managing end-of-life choices and the dying process, coping with loss and grief, addressing all active issues, preventing unnecessary suffering, and fostering opportunities for meaningful experiences.

The aim of this presentation is to explore the challenges associated in providing end-of-life care for adults with HM and the implications for nursing practice. It will also highlight the importance of specialized palliative care integration in this population, and nursing's role in this collaborative care model.

## II-6-A

### Nurse-parent relational complexity within pediatric oncology contexts: Navigating closeness, conflict, and online and offline communication

Katherine Webber, Nancy Moules

University of Calgary, Faculty of Nursing

**Background and Purpose:** As a result of the complex nature of childhood cancer, involving intense treatments and extended hospital stays, it is not uncommon for nurses and parents to develop meaningful and close relationships. However, this closeness may lead to dilemmas about how to navigate professional boundaries. Social media, a globally relevant communication innovation, has further complexified the distinction between personal and professional lives. Markedly lacking in the research are nurse and parent perspectives of relational complexity in pediatric oncology. The purpose of this research was to seek to understand nurses' and parents' perspectives about their relationships with one another, including the potential influence of social media on these relationships.

**Method:** Hermeneutics, with its rich philosophical foundation, was applied methodologically to this research using the internationally acclaimed approach detailed by Moules et al.

(2015). Using purposive sampling, data collection involved 12 topic-focused interviews with six parents and six nurses within a Canadian pediatric oncology context. Data analysis involved the hermeneutic tradition of interpretation, with careful reading and re-reading of the transcribed interviews.

**Results:** Preliminary data analysis includes the following interpretations: 1) "You're basically crawling into bed with them": Intimacy in nurse-parent relationships; 2) "Sergeants" and "difficult parents": Navigating conflict in nurse-parent relationships; 3) "Thinking twice": Social media considerations for nurses and parents; 4) Friendly, friend-like, friendship, or none of the above: Finding language to describe nurse-parent relational complexity.

**Implications:** Preliminary findings suggest that, in both online and offline contexts, nurses and parents would benefit considerably from supports to navigate conflict, closeness, and complexity in their relationships with one another.

## II-6-B

### Understanding the family dynamics of emerging adults diagnosed with blood cancer and their parents and siblings

Sandip Dhaliwal

University of Calgary, Faculty of Nursing

Emerging adults, ages 18 to 29, are often "in-between," neither adolescents nor fully adults, but at an age characterized by focus on self and exploration of love, relationships, work, and worldviews. A diagnosis of blood cancer during this transitional life stage can serve to create challenges and complicate emerging adults' relationships, including those with parents and siblings. However, parent-child and sibling relationships are better understood in childhood illness contexts, as family presence is expected during this time, but less attention has been given to familial relationships in emerging adulthood when an individual is expected to be increasingly independent. How a diagnosis of blood cancer might affect parent-child and sibling interactions, patterns of communication, roles, and boundaries in emerging adulthood is not yet well understood. Philosophical hermeneutics, developed by Hans-Georg Gadamer, is an interpretive research inquiry that provides an opportunity to understand complex human phenomena through interpretation. In this presentation, I will outline my proposed thesis work, a hermeneutic study that will aim to answer the question: How might we understand the family dynamics of emerging adults navigating blood cancer and their biological or adoptive parents and siblings? I will outline the clinical experience that guides my topic and contextualize my research through a discussion of the literature review I have conducted as I approach data collection. My hope is for this research to help healthcare professionals bridge an identified gap in knowledge and professional practice, as well as direct the development of healthcare guidelines for supporting emerging adults diagnosed with blood cancer and their family members with their relational challenges and concerns.

## II-6-C

### Developing an adolescent and young adult program within CancerCare Manitoba – Initial steps

Mackenzie Jansen

CancerCare Manitoba

**Background and Aims:** Nationally, approximately 7,600 Canadians ages 15 to 39 are diagnosed with cancer (CPAC, 2017). Adolescent and young adult (AYA) patients with cancer are a unique group and distinct from pediatric or older adult patients. Their needs span across many developmental milestones and a diagnosis of cancer can significantly impact their futures.

More than 300 AYAs are newly diagnosed in Manitoba annually. As part of their strategic plan, CancerCare Manitoba (CCMB) set to improve care of AYA patients through developing a multidisciplinary care program. Through a three-year grant funded by Cancer Care Foundations, CCMB is expanding the program to enhance clinical care of AYA patients.

Initial steps in developing the AYA Program was to perform an environmental scan (ES) of CCMB performed by the AYA Clinical Nurse Specialist. The objective of this ES was to learn about the patient experience along the cancer continuum and any barriers present.

**Methods:** The ES was implemented over a 10-week period where the CNS visited each disease site group, observed clinics, and generated discussion with providers.

**Results:** Through analysis of environmental and contextual factors, information will be gathered to guide the design and development of an effective AYA program.

**Conclusion:** The ES will be used to guide the development of an effective program. We hope to enhance current practices and strengths of the organization, create clinical pathways and guidelines, educate frontline staff, and further improve CCMBs care of AYA patients.

## II-6-D

### Addressing the complex needs of adolescents and young adults (AYAs) diagnosed with a hematological cancer

Alessia Lamanna, Aisha Winn, Graeme Oliver

Odette Cancer Centre, Sunnybrook Health Sciences Centre

**Introduction:** Adolescents and young adults (AYAs) diagnosed with a hematological cancer often face aggressive treatment interventions and have complex physical, developmental, and psychosocial care needs. This group, defined by the ages of 16-39, have not seen the same level of improvements in recent decades as older and younger cohorts. AYAs in hematological cancers are unique, as other areas of cancer care have Advanced Practice Nurses who specifically focus on this population. However, hematological AYA patients do not have Advanced Practice Nurses and little is known as to what supports they require. There is a need to understand and address

how best to provide supportive care to this complex population and tailor healthcare services to address this gap.

**Objectives:** To describe the current literature and future directions on the complex needs of AYAs with hematological cancers.

**Methods:** This presentation will discuss the major challenges facing AYAs diagnosed with a hematological cancer. The literature regarding our current understanding of the complex needs of AYAs will be discussed. Finally, an overview of care currently provided on a complex malignant hematology unit at an urban Toronto hospital will be discussed.

**Conclusion:** By understanding individual circumstances, barriers, access to supports and challenges contributing to the complex needs of AYAs diagnosed with a hematological malignancy, future research and groundwork can be targeted to identifying interventions for this special patient population.

## III-1-A

### Primary nursing model in practice: Halifax Cancer Care Program, Ambulatory Oncology

Colleen Colville, Lisa Bourne

Nova Scotia Cancer Centre

Patients receiving radiotherapy at the Nova Scotia Cancer Centre in Halifax are assessed weekly for toxicities associated with treatment. Traditionally, breast radiotherapy patients had these weekly review assessments (WRAs) exclusively performed by Registered Nurses (RNs) and Radiation Oncologists (ROs). To decrease the number of patient visits to the weekly review clinic and improve efficiency for breast cancer patients and staff, radiation therapists (RTTs) in our centre began performing the week 2 toxicity assessments. This study was performed to ensure assessment of skin reactions were similar between RTTs and RNs/ROs.

The study included a mandatory self-guided learning module containing a skin anatomy review, and radiation skin reaction principles. At the end of the module participants were required to assess and score nine different test cases with photos of skin reactions. An RO, specializing in breast cancer radiotherapy treatment, scored the test cases and these scores served as the gold standard.

This presentation explains the scope of the WRA study and describes materials and methods used. The outcomes of the study and initiative will be explored, including impact to review clinic numbers and flow, as well as patient experience. The positive effect this study had between RNs and RTTs is highlighted. An update on the longevity of the initiative will be provided, and potential for expansion discussed.

### III-1-B

#### Radiation oncology team-based care: A post-implementation overview of system, patient, and nursing outcomes at BC Cancer – Kelowna

Dana Dalglish, Letecia Hayes, Jessica Nadeau

PHSA BC Cancer

**Background:** British Columbia's (BC) 10-Year Cancer Action Plan describes team-based care (TBC) as a strategy to (1) provide wrap-around care for patients and their families, and (2) to ensure a strong oncology workforce. At BC Cancer - Kelowna (i.e., the regional cancer centre that serves BC's Southern Interior), we have implemented several teams in our radiation oncology department. We sought to characterize the post-implementation system-, patient-, and nursing-level outcomes from the perspective of three registered nurses (RNs) working in this new, complex capacity.

**Intervention:** TBC is a multi-disciplinary approach to cancer care, which, at BC Cancer - Kelowna's radiation oncology department, includes an RN, a radiation oncologist, clerical, and other allied disciplines. This enhanced collaboration allows us to (1) tailor care plans, (2) better anticipate patient care needs, and (3) provide greater continuity of care across the trajectory of diagnosis, treatment, survivorship, and end-of-life care.

**Outcomes:** The implementation of TBC has resulted in early system-level improvements, including fewer transitions in care between clinics and care providers. Early patient-level outcomes include (1) improved patient-team rapport; (2) more timely identification of changes in patients' health status; and (3) enhanced follow-up care. Nursing-level outcomes include (1) increased job satisfaction; and (2) advancements in scope of practice.

**Discussion:** In light of the expected system-, patient-, and nursing-level outcomes that we anticipate with TBC, we have identified two important priorities: first, the role of the TBC RN is fluid and flexible, and requires RNs to practice at the top of their legal scope; this emboldens the need for policies that support specialized TBC RNs to gain greater autonomy in their nursing practice. Second, as the number of TBC RNs increases at BC Cancer – Kelowna, the measurement and reporting of nursing-sensitive outcomes will be essential.

### III-1-C

#### Organizing and carrying out a massive transfer of oncology activities to a new building: The experience of CHU de Québec-UL

Audrey Paquet-Beaupré, Sonya Deraspe, Maria-Gabriela Ruiz-Mangas, Isabelle Germain

CHU de Québec-UL

Since 2014, the CHU de Québec-UL has been planning and carrying out the building of the largest clinical project in the province of Quebec, le Nouveau complexe hospitalier (NCH).

The Integrated Cancer Center of the CHU de Québec-UL (CIC) is the first clinical component, which opened its doors on May 17, 2023.

With an area of 32,230 m<sup>2</sup>, the CIC is the largest cancer centre in Quebec and one of the largest in Canada. It offers a wide range of specialized and superspecialized services and care to cancer patients including : 70 chemotherapy chairs, 12 linear accelerators and two suites of brachytherapy.

With the opening of the CIC , the opportunity was seized to transform the organization in which we care for oncologic patients. Following a holistic, interdisciplinary and human-centred approach, the CIC was designed to accommodate highly technological equipment and state-of-the-art clinical treatments while providing psychological support to patients at all stages of their care journey. Under the theme of air and light, the team of professionals was keen to develop a “healing environment” through the development of ultramodern, spacious, bright, green and highly functional facilities.

We present to you the ups and downs of this transformation, transition, as well as the lessons learned in this major project, in terms of human resources management, the transformation of work processes and the maintenance of clinical activities in times of great disturbances.

### III-1-D

#### How to prioritize safety in the context of a major developmental project

Sonya Deraspe, Audrey Paquet-Beaupré, Maria Gabriela Ruiz Mangas

CHU de Québec – Université Laval

Since 2014, the CHU de Québec-UL has been planning and carrying out the building of the largest clinical project in the province of Québec: le Nouveau Complexe hospitalier (NCH). At the end of the project, planned for 2030, the NCH will bring together all the activities of two major hospitals in the region. Two buildings will be linked together by footbridges. Given the scope and complexity of the project, these buildings are being delivered in two sequences.

First, the Integrated Cancer Center (CIC) that offers a wide range of specialized and superspecialised services to cancer patients including : 70 chemotherapy chairs, 10 linear accelerators, two suites of brachytherapy, and an oncologic pharmacy. This building was delivered in May 2022.

The second phase will be delivered in 2030 and is the critical care building comprising the emergency services, imaging, intensive care and hospital care units.

In this context of phasing, the CIC will, therefore, experience a transition of nearly eight years during which it will be totally isolated from the other clinical buildings. The challenge is great to set up adequate emergency procedures without having direct access to critical care teams and to ensure an equitable distribution of the clientele in the emergency, imaging and hospitalization of the other existing sites. Many strategies were developed to mitigate the impact for the clientele and ensure security. This is what we will share with you in this presentation.



### III-2-A

#### A maelstrom of feelings: Psychosocial wellbeing of female patients with hormone receptor-positive breast cancer and its nursing implications

Jue (Lois) Luo

BC Cancer-Vancouver Centre

Clinical experience and research indicate that female breast cancer patients on hormone therapy are at risk for a variety of psychosocial concerns, including depression, anxiety, sleep difficulty, and sexual dysfunction. This risk is more salient among younger and older age groups, those with previous psychiatric diagnoses, and those undergoing the first 18 months of treatment. Psychosocial wellbeing is linked to treatment adherence and survival of hormone receptor-positive breast cancer via complex bidirectional mechanisms. On one hand, patients with pre-existing distress may feel overwhelmed by the need to initiate and complete hormone therapy in its prescribed length; long-term therapy often elevates stress and somatization of symptoms for those who are already vulnerable. On the other hand, hormone agents induce physical side effects (e.g. hot flashes, arthralgia, vaginal dryness) that lead to emotional, functional, and relational impairment; those agents can also directly cause mood disturbances through pharmacological pathways. Moreover, the effects of hormone therapy contribute to cognitive changes such as altered body image, felt loss of femininity, and heightened perception of aging. With those in mind, this presentation will review relevant literature and research findings, interspersed with the presenter's observations and reflections from working in an outpatient oncology clinic. As long-term hormone therapy typically requires less frequent provider visits, nursing has a crucial role to play in fostering psychosocial wellbeing and enhancing treatment outcomes for patients. Some examples of nursing interventions include patient education, detecting and managing side effects early on, facilitating patient-provider communication, promoting healthy lifestyle choices, screening for psychiatric symptoms and high-risk individuals, and referral to professional and community supports.

### III-2-B

#### Preferences for psychoeducational interventions among caregivers of patients undergoing allogeneic stem cell transplant for hematological malignancy

Grace Kusi<sup>1,2,3</sup>, Charlotte T. Lee<sup>4</sup>, Viswabandya Auro<sup>2</sup>, Martine Puts<sup>1,2</sup>, Samantha J. Mayo<sup>1,2</sup>

<sup>1</sup> Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

<sup>2</sup> Princess Margaret Cancer Centre, University Health Network

<sup>3</sup> Kwame Nkrumah University of Science and Technology

<sup>4</sup> Toronto Metropolitan University

**Background:** Caregiving for patients who are undergoing allogeneic stem cell transplant (alloHCT) for hematological malignancies can be a stressful experience that can negatively impact caregivers' physical and psychosocial health. Psychoeducational interventions (PEI) have been shown

to improve caregiving outcomes in other caregiving contexts. Despite the potential benefits of these interventions for alloHCT caregivers, particularly at the time of the patient's discharge from hospital, it is unclear what preferences caregivers have for such interventions.

**Objectives:** The primary objective of this study is to explore alloHCT caregivers' preferences for the content and format of PEI delivered at the time of hospital discharge.

**Methods:** The proposed study will comprise a secondary qualitative analysis of data collected from a longitudinal qualitative study of alloHCT caregivers' experiences. The analysis will focus on transcripts of 17 interviews conducted with caregivers at the time of the patient's discharge from hospital for alloHCT. Thematic analysis will be both deductive and inductive, with some predetermined codes related to PEI content and format, but with the possibility of new codes to be generated as appropriate. Themes and sub-themes based on categories of codes will be determined to fulfill the study objective.

**Results:** Preliminary results will be presented, with each theme and its associated sub-themes supported with illustrative quotes from the participants. The implications of the findings for the design of PEI will be discussed, guided by the TIDieR framework.

**Conclusion:** Findings from this secondary qualitative analysis can inform the development and delivery of psychoeducational interventions for caregivers of patients undergoing alloHCT in the future.

### III-2-C

#### E-Learning modules for oncology nurses to better address psychosocial issues in young adults: A collaborative project with the LLSC

Karine Bilodeau<sup>1,2</sup>, Billy Vinette<sup>1,2</sup>, Pascale Rousseau<sup>3</sup>, Jolyane Pelletier<sup>3</sup>, Charlotte Gélinas-Gagné<sup>2</sup>, Nicolas Fernandez<sup>4</sup>

<sup>1</sup> Faculty of Nursing, University of Montreal

<sup>2</sup> Maisonneuve-Rosemont Hospital Research Center

<sup>3</sup> Leukemia & Lymphoma Society of Canada

<sup>4</sup> Centre de pédagogie appliquée aux sciences de la santé, University of Montreal

**Background:** Many young adults (YA) diagnosed with hematological cancer can experience psychosocial issues during cancer survivorship. Given their significant impacts, healthcare professionals must be aware of these issues. To train healthcare professionals in this regard, it is imperative to develop educational activities based on the lived experiences of YA. The purpose of this presentation is to share the pedagogical approach used in developing e-learning modules for oncology nurses to better address these psychosocial issues.

**Method:** A one-day co-design workshop was organized, in collaboration with the Leukemia and Lymphoma Society of Canada (LLSC). YA affected by a hematological cancer (n=8) took part in this activity. Discussions were audio recorded, transcribed then analyzed using a thematic approach.

Subsequently, three sessions were held, with a working group, to develop and refine the content included in the e-learning modules. These modules were based on co-design workshop themes, the Adult Learning Theory, and existing resources from the LLSC.

**Results:** Different e-learning module scenarios were created to support nurses learning on psychosocial issues experienced by YA diagnosed with hematological cancer during their survivorship. E-learning modules discussed different topics including: 1) How to maintain YAs' dignity during care, and 2) How to foster psychosocial support during YA cancer survivorship. Various educational materials were used such as podcasts, videos, website links, and written documents.

**Conclusion:** The use of a co-design approach is especially interesting in developing educational resources that are tailored to the psychosocial needs of YA diagnosed with hematological cancer. Ultimately, this project allowed a non-profit organization to have access to e-learning modules specially designed to facilitate the learning of healthcare professionals on psychosocial issues YA diagnosed with hematological cancer might face.

### III-3-A

#### What do cancer survivors believe caused their cancer? A secondary analysis using the Causes Subscale of the Illness Perceptions Questionnaire

Jacqueline Galica<sup>1</sup>, Stephanie Saunders<sup>2</sup>, Ziwei Pan<sup>1</sup>, Amina Silva<sup>1</sup>, Hok Kan Ling<sup>1</sup>

<sup>1</sup> Queen's University

<sup>2</sup> The Ottawa Hospital

**Objective:** Given that risk reduction and healthy lifestyles can prevent 4 in 10 cancers, it is important to understand what survivors believe caused their cancer, so as to inform risk-reduction interventions.

**Methods:** In this secondary analysis, we analyzed cancer survivor responses on the Causes Subscale of the Revised Illness Perception Questionnaire, which lists 18 possible causes of illness. We used descriptive statistics to determine cancer survivors agreement to the listed causes and conducted separate partial proportional odds models for the top three identified causes.

**Results:** Of the 1,001 participants, most identified as Caucasian ( $n = 764$ , 77%), female ( $n = 845$ , 85%), and were diagnosed with breast cancer ( $n = 656$ , 66%). The most commonly believed causes of cancer were: stress or worry ( $n = 498$ , 51%), pollution in the environment ( $n = 471$ , 48%), and chance or bad luck ( $n = 412$ , 42%). The significance of demographic and clinical variables varied across the models.

**Conclusions:** Study results illuminate cancer survivors' beliefs about varying causes of their cancer diagnosis and identify characteristics of survivors who are more likely to believe certain factors caused their cancer. Results can be used to plan risk-reduction interventions and highlight which cancer survivors (e.g., by cancer diagnosis) for whom such interventions would be most suitable.

### III-3-B

#### Developing an evidence- and experience-informed educational resource for gynecological cancer survivors and their caregivers

Jacqueline Galica<sup>1</sup>, Amina Silva<sup>1</sup>, Kathleen Robb<sup>2</sup>

<sup>1</sup> Queen's University

<sup>2</sup> Patient-Partner

**Objective:** Building upon the need for greater education identified by gynecological cancer survivors and their caregivers, the objective of this presentation is to describe our patient-clinician-researcher partnership to develop an evidence- and experiential-based educational resource.

**Methods:** We engaged in five-phases using multiple research methods: 1) assembling the essential expertise, 2) reviewing the literature, 3) drafting the resource, 4) testing the resource, and 5) disseminating the resource.

**Results:** Our diverse partnership provided expertise toward multiple research methods that produced results used in each successive phase. This combination – a diverse partnership and multiple research methods – resulted in a useful resource to fulfill a gap identified by knowledge users.

**Conclusion:** There is little-to-no guidance to develop educational resources to support cancer survivors and/or their caregivers. Our process of utilizing multiple methods to incorporate empirical and experiential evidence resulted in the development a relevant educational resource. Our process incorporated diverse team skillsets and utilized multiple research methods across a series of phases. These combined features fill a procedural gap for clinicians and researchers intending to develop educational resources that are empirically and experientially founded.

### III-3-C

#### The unmet survivorship needs of adolescent and young adult cancer survivors

Mackenzie Jansen

CancerCare Manitoba

**Background and Aims:** Nationally, approximately 7,600 Canadians ages 15 to 39 are diagnosed with cancer. Adolescent and young adult (AYA) patients with cancer are a unique group and distinct from pediatric or older adult patients. Their needs span across many developmental milestones and a diagnosis of cancer can significantly impact their futures.

**Methods:** A literature search of peer-reviewed articles was conducted via an online library. The databases used were CINAHL and PubMed. Articles were briefly screened through reading abstracts and 27 articles were excluded further if there was no mention of survivorship, AYA population, or unmet needs. 29 articles were thoroughly reviewed and read in full, 14 articles were removed, and 15 articles were included in the review.

**Results:** The literature obtained consisted of systematic reviews, qualitative, and quantitative studies. Common themes highlighted the unmet needs of AYA cancer survivors were: 1) provision of information, 2) psychosocial support, and 3) health service needs to improve transition into survivorship. Interventions suggested by the literature to meet needs suggest standardized survivorship care plans, Digital Health tools, and survivorship clinics.

**Conclusion:** The interventions reviewed have significant potential to improve survivorship care needs and efficiently improve outcomes. As the literature reflects, a multi-faceted approach to care to uniquely tailor care for AYA cancer survivors and their unique and complex needs.

### III-3-D

#### The strength within: One Black oncology nurse practitioner's survival story

*Corsita Teresa Garraway*

*D'Youville University; Centre for Addictions and Mental Health*

**Background:** A healthy Black oncology nurse practitioner (NP) in 2012, began to experience profound fatigue and SOBOE. Visiting the physician for test results, trepidation increased. Visits were weighted with the fear of diagnosis with cancer. Dismay would be felt when the test results did not yield a significant diagnosis. Subjected to additional testing and more fears. Prescribed medications did not improve symptoms. Friends and relatives offered recommendations about suitable exercise and "healthy food" options. After three years, she received a diagnosis. Although well connected, she felt alone and lonely.

**Implications:** This NP worked at a high level that afforded opportunities for influence and community. Being doubted by some "colleagues" who were unfamiliar with her worthiness to be taken seriously was sometimes devastating. Dismissive behaviours and micro aggressive comments were experienced from healthcare providers who lacked compassion when treating Black bodies. What if she did not own property or a vehicle? What if no loving concerned children? What if she did not have friends to check in daily? How many vulnerable Black persons are at risk of not receiving adequate care?

**Plan:** The Black oncology NP is aware that she must use her experiences to improve the care that Black patients with mental health issues receive at the end of life through a quality improvement project at the Centre for Addiction and Mental Health.

### III-4-A

#### Strengthening from within: Informing policy to optimize the clinical nurse specialist workforce in oncology

*Leah K. Lambert<sup>1,2</sup>, Sandra Lauck<sup>2</sup>, Denise Bryant-Lukosius<sup>3</sup>, Jagbir Kaur<sup>1</sup>, Scott Beck<sup>1</sup>, Jonquil Francis<sup>1</sup>, Charissa Chiu<sup>1</sup>, Andrea Knox<sup>1</sup>, Sally Thorne<sup>2</sup>*

<sup>1</sup> *Nursing and Allied Health Research and Knowledge Translation, BC Cancer*

<sup>2</sup> *School of Nursing, The University of British Columbia*

<sup>3</sup> *School of Nursing, McMaster University*

Nursing has been disproportionately affected by the escalating health human resources crisis and oncology is no exception. Innovative strategies are urgently needed to adequately plan for, recruit, retain, and protect the oncology nursing workforce in Canada. In response, BC has prioritized implementation of a novel Clinical Nurse Specialist (CNS) program to promote quality care, nursing recruitment and retention, and improved readiness to meet increasing demands on our cancer care system. However, there are no policies, programs, or initiatives in BC to support the effective implementation or optimization of CNS roles in cancer care. In this multi-method study we are using an iterative three-phased knowledge mobilization approach informed by an iKT framework and patient-oriented research methods. The purpose of phase 1 is to generate evidence to help address the limited knowledge available on the CNS role by identifying and examining relevant policies and strategies that can guide recruitment, training, optimization, evaluation, and retention of CNSs. In this presentation, we will discuss the results of Phase 1, including (1) formation of a multidisciplinary project steering committee (the project's shared leadership and decision-making body); (2) use of a comparative policy analysis lens to generate and synthesize evidence on the optimization, evaluation, and sustainment of CNS roles; and (3) draft CNS workforce policy options. Clear, actionable, and evidence-based CNS policy recommendations will be used to shape nursing workforce transformation in BC and may hold relevance for other national and international policy and health-system decision makers.

### III-4-B

#### Designing engagement strategies for genomics-informed oncology nursing: Comparative prospective cross-jurisdictional policy analysis [DESIGN: Policy]

Jacqueline Limoges<sup>1</sup>, Kate Leslie<sup>2</sup>, April Pike<sup>3</sup>, Patrick Chiu<sup>2</sup>, Rebecca Puddester<sup>3</sup>, Lindsay Carlsson<sup>4</sup>, Sarah Dewell<sup>5</sup>, Lorelei Newton<sup>6</sup>, Nicole Letourneau<sup>7</sup>, Andrea Gretchev<sup>8</sup>, Emma Tonkin<sup>9</sup>, Kathy Calzone<sup>10</sup>

<sup>1</sup> Athabasca University Alberta, Ontario Cancer Research Ethics Board

<sup>2</sup> Athabasca University

<sup>3</sup> Memorial University Newfoundland

<sup>4</sup> Princess Margaret Cancer Centre

<sup>5</sup> University of Northern BC

<sup>6</sup> University of Victoria BC

<sup>7</sup> University of Calgary AB

<sup>8</sup> Douglas College

<sup>9</sup> University of South Wales, UK

<sup>10</sup> National Cancer Institute, US

Given the impact of genomic discoveries on cancer prevention, diagnosis, screening, treatment, and end-of-life care, oncology nurses need to be able to safely and competently integrate genomics into clinical care. Usually, nurses rely on policy documents such as practice guidelines, competency frameworks, and position statements to delineate responsibilities for required knowledge and professional practice. These documents are critical to safe and equitable healthcare and establish public expectations and nurses' accountabilities. However, in Canada, no such documents for genomics-informed nursing care exist. To address this gap, the evidence from our CIHR-funded DESIGN: Policy research project will generate recommendations for nursing policy, role descriptions, and guidelines on integrating genomics and precision healthcare across the cancer care continuum. The first phase of this research is a comparative policy analysis using documents from the US and UK. Our presentation will provide an overview of the key policy features and drivers that have shaped genomics-informed nursing practice in those countries and how oncology nursing practice is being developed in Canada. The presentation will show how policies can address key challenges, guide initiatives and accelerate genomics-informed nursing in Canada. Strategies for using leading policies and guidelines aimed at enhancing genomic literacy, genomics-informed nursing practice, workforce training, and future research will be highlighted.

### III-4-C

#### The future of HPV testing in times of international transition

Alessia Lamanna<sup>1</sup>, Catriona Buick<sup>1,2</sup>

<sup>1</sup> Odette Cancer Centre, Sunnybrook Health Sciences Centre

<sup>2</sup> York University, Faculty of Health, School of Nursing

**Introduction:** The international community is focused on the integration of high-risk Human Papillomavirus (HrHPV) as the primary screening test in current cervical cancer screening programs. Within Canada, each province or territory is

responsible for the delivery of health care services, and it is anticipated that screening guidelines nationally and internationally will recommend primary HrHPV testing for cervical screening. Navigating best practice guidelines and recommendations for cervical screening guidelines can be overwhelming for primary care providers. Several barriers and challenges have been identified from countries that have already transitioned to primary HPV-DNA testing in screening programs.

**Objectives:** While there are many obvious clinical advantages to primary HPV testing, it is critical to explore the attitudes of women and knowledge of healthcare providers in the context of new HPV testing recommendations.

**Methods:** This presentation will discuss the evolution of HPV testing in the context of transitioning from pap testing to HrHPV testing. It will highlight and discuss international examples of implementing these change into existing cancer screening practices. Finally, an overview of existing evidence related to women's attitudes and healthcare providers knowledge surrounding HPV testing and self-testing will be discussed.

**Conclusion:** As the transition to new guidelines in cervical screening are implemented, the role of the oncology nurse in these processes will be critical to educating patients and healthcare providers in navigating evidence informed screening guidelines.

### III-4-D

#### Standardizing pregnancy testing and contraceptive counselling practices for patients of reproductive potential undergoing anticancer therapies

Luisa Luciani Castiglia, Joanne Power, Annie Leung, Selda Elmas

McGill University Health Centre

**Background:** There are gaps in the literature with regards to the definition of reproductive potential, what constitutes contraception education, and the need and timing for pregnancy testing in patients undergoing anticancer therapies. These patients should avoid pregnancy due to teratogenicity, and have unique contraception needs. In our centre, there was practice variability in the provision of contraception education and no systematic process for pregnancy testing.

**Objective:** The objective of this QI project was to develop a policy on pregnancy testing and integrate routine contraception education for patients of reproductive potential starting systemic or radiation therapy.

**Methods:** After conducting a literature review and benchmarking, a survey was developed and sent to clinicians to describe current practices, challenges, and needs. Using best available evidence and expert opinion, a clinical protocol was drafted by an interprofessional team, including a patient partner. This was piloted using a PDSA model.

**Results and Discussion:** Survey results demonstrated that although most respondents informed patients to avoid pregnancy, only 50% felt comfortable to provide contraception

education, and 20% discussed specific contraception options. Only 25% of oncologists ordered a pregnancy test before the start of treatment.

This project allowed us to: define patient of reproductive potential in a 2SLGBTQIA+ inclusive way; distinguish contraception education and counselling; develop an algorithm for pregnancy testing before starting treatment; describe inter-professional roles and responsibilities; and develop tools such as a patient information pamphlet and an informed consent document.

**Conclusion:** This project aims to implement best practices around pregnancy prevention for patients on anticancer therapies. It also highlights how essential patient engagement is with regards to informed choice and ongoing adherence to contraception throughout the treatment trajectory.

### III-5-A The RPM: A benevolent tool to support people living with cancer

*Sabrina Lapointe, Arnela Kovac, Sarah Darveau, Vincent Beauregard*

*Centre de coordination de la télésanté, CIUSSS de l'Estrie - CHUS*

Home sweet home. This expression represents the purpose of remote patient monitoring (RPM). It allows for remote monitoring of patients' health status and vital signs while they are in their own environment, whether they live in a rural area or in an urban location. For the patient, RPM promotes:

- Optimal management of their condition
- Empowerment through learning
- A personalized follow-up based on their needs and reality
- Easier access to care and services
- Easier contact with his network of caregivers
- A reduction in travel time and costs
- A feeling of safety and trust
- Maintenance or improvement of quality of life.

Although the RPM service-offer stems from a desire to improve the management of patients with chronic diseases, it was recently proposed to better serve cancer patients, more specifically for patients who are starting an oral anticancer agents (OAA). This treatment is taken independently by the patient at home rather than in a hospital, which poses challenges for the clinical team in terms of supervision and the management of the side effects. Thus, the RPM allows the team to recognize the undesirable side effects caused by the treatment against cancer and to address them at the right time, to treat them in the right way and, above all, to refer the patient to the right resource to promote well-being and adherence to treatment.

As part of this service-offer, patient's follow-up is carried out by a multidisciplinary team made up of pharmacists and clinical nurses and takes place over the entire period of their treatment or according to their improvement and needs. This is an innovative service for oncology clients and the patients who have tried it so far are very satisfied!

### III-5-B

#### Oncology nurses' experiences with virtual care in Canada: Preliminary findings

*Charlotte T. Lee<sup>1</sup>, Lorelei Newton<sup>2</sup>, Catriona Buick<sup>3</sup>, Jennifer Lounsbury<sup>4</sup>, Shari Moura<sup>5</sup>, Elizabeth Borycki<sup>2</sup>, Jason Wong<sup>6</sup>, Minkyong A. Kweon<sup>1</sup>, Katelyn Marcelo<sup>1</sup>, Margaret Fitch<sup>6</sup>*

<sup>1</sup> Toronto Metropolitan University

<sup>2</sup> University of Victoria

<sup>3</sup> York University

<sup>4</sup> Hamilton Health Sciences

<sup>5</sup> University Health Network

<sup>6</sup> University of Toronto

**Background:** The COVID-19 pandemic has resulted in an increase in virtual care, including for oncology patients. However, there is a lack of data on the practice of virtual care specifically for oncology nurses. A systematic, theory-informed approach is needed to optimize the quality of care and support nurses' day-to-day functioning in an interprofessional environment.

**Research Purpose:** This mixed-method, sequential explanatory study aims to explore the experiences of oncology nurses practicing virtual care in Canada. This presentation aims to discuss the preliminary findings of the Phase 1 survey.

**Methods:** Frontline nurses providing care to cancer outpatients were invited to complete a one-time survey assessing their experience of virtual nursing practice and virtually collaborating within an interprofessional team. A quantitative descriptive approach was utilized to analyze the data.

**Implications:** The preliminary survey findings provide important insights into the experiences of oncology nurses practicing virtual care. The findings suggest a need for further support and training for nurses to effectively utilize virtual care technology and communicate with patients. These findings can inform the development of interventions to support nurses in transitioning to the "new normal" beyond the pandemic. Future research will utilize a mixed-method approach to confirm and further explore the preliminary findings.

### III-5-C

#### APOLLO: personalized rehAbilitation PrOgram in aLLOgenic bone marrow transplantation

*Edith Pituskin, Puneeta Tandon, Irwindeep Sandhu, Margaret McNeely, Carla Prado, Gabor Gyenes, Mark Haykowsky, Richard Thompson*

*University of Alberta*

People who undergo allogeneic transplant for leukemia and lymphoma receive the highest possible chemotherapy doses that humans can receive and still survive. As a result, they have devastating side effects during and for years after the procedure. Damage to organs and muscles cause long-lasting physical weakness and the psychological experience is severe enough to be termed 'post traumatic stress disorder'. These

effects are worsened by the fact that most Canadians live several hours away from treatment and transplant centres, leaving them entirely on their own to manage debilitating side effects. We will perform a qualitative study to learn the experiences of people undergoing allogeneic transplant when they receive access to a supportive care computer 'app' and telephone support from nursing, exercise and nutrition experts. We aim to learn the most helpful type and timing of supportive care from those who have firsthand knowledge.

### III-5-D

#### **Surgical transitions remote patient monitoring (RPM) program**

Jennifer Lounsbury<sup>1</sup>, Kanae Nagatani<sup>1</sup>, Prathiba Harsha<sup>1</sup>, Micheal McGillion<sup>2</sup>, Kelly-Lynn Nancekivell<sup>3</sup>, Carley Ouellette<sup>3</sup>, Leonard Potts<sup>3</sup>, Janny Proba<sup>3</sup>, Karen Robinson<sup>3</sup>

<sup>1</sup> Hamilton Health Sciences

<sup>2</sup> Heart and Stroke Foundation/Michael G. DeGroot Endowed Chair in Cardiovascular Nursing Research Scientist, Population Health Research Institute, International Visiting Professor of Digital Health, Coventry University, United Kingdom School of Nursing, Faculty of Health Sciences McMaster University

<sup>3</sup> Juravinski Hospital and Cancer Centre, Hamilton Health Sciences

Patient empowerment through optimizing technological advances is an important aspect of clinical care for oncology nurses. In 2022, the provincial Ministry of Health supported funding opportunities for regional health teams to support surgical patients through remote patient monitoring programs, as part of the pandemic response to ease the increasing surgical backlog and prevent surgical cancellations. An acute care healthcare system committed to the strategic priority of implementing a Surgical Transitions Remote Patient Monitoring (RPM) program to support adult surgical oncology patients. In partnership with their healthcare team, patients are able to establish mutually negotiated plans of care and information sharing within a secure digital platform. Improved access to highly skilled surgical oncology and virtual nurses is established with clearly defined remote symptom monitoring clinical pathways based on previous research with cardiovascular surgical patient populations.

This presentation will discuss the partnership between a surgical oncology unit and a virtual care nursing team. The ultimate goal of this innovative virtual care model is to facilitate hospital to home transitions for surgical oncology patients with the integration of a virtual care nursing and medical team during the 14-day post-discharge time period. Evaluation measures of this initiative will be discussed including; improved patient engagement and self-care management in discharge planning, early discharge and reduced length of stay and reduced emergency room visits and readmission rates post discharge.

### III-6-A

#### **Measuring the impact of new systemic therapy treatments**

Carolyn Fifield<sup>1</sup>, Bruce Colwell<sup>2</sup>, Helmut Hollenhorst<sup>3</sup>, Joanne Houlihan<sup>3</sup>, Marilyn Landry<sup>3</sup>, Kelly Leadbeater<sup>3</sup>, Jill Petrella<sup>3</sup>, Joy Tarasuk<sup>3</sup>, Erin Wentzell<sup>3</sup>, Ian Wilson<sup>4</sup>

<sup>1</sup> Nova Scotia Health Cancer Care Program

<sup>2</sup> Nova Scotia Health Division of Medical Oncology

<sup>3</sup> Nova Scotia Health Cancer Care Program

<sup>4</sup> Nova Scotia Health Project Management

New cancer therapies have historically been introduced without assessment or understanding of the operational impact to the healthcare system. Provincial governments have been invested in understanding the cost of the drug, but have lacked an understanding of the impact on resources not addressed through drug funding, as additional therapies and previously untreated patient populations are cared for within cancer care. As more patients are treated, there has not been a corresponding increase in staffing resources to support clinics (oncology, nursing, pharmacy) or in the numbers of treatment chairs used to provide specialized infusions. This can lead to wait lists for cancer services. In addition, impacts to the healthcare system outside of cancer care such as increased requirements for molecular testing, lab and diagnostic imaging services have not been accounted for in resource planning.

The Nova Scotia Cancer Care Program has built a tracking database to estimate the anticipated operational net impact for all new treatments and the accumulated impact to resources over time. Working with a multi-disciplinary group of representatives within and outside of Cancer Care, including medical ethics, pharmacy, pathology, and diagnostic imaging, we have developed a clearer understanding of the demand on resources. Quantifiable measures of cumulative resource impact also support improved advocacy for increased resources to support changes in standard of care.

In addition to gaining an understanding of system impact with the introduction of new therapies, reviewing drug submissions proactively has provided an opportunity to streamline our approach to patient and staff education, and Standard Order set development required for the safe administration of systemic therapy for cancer. Future directions of this work will include measuring frequency of toxicities that require subspecialty consultation to address broader resource impacts on the healthcare system.

### III-6-B

#### Fostering strength within: Establishing a provincial oncology educator community of practice

*Kara Jamieson, Nicole Duerksen, Carolyn Fifield, Andrea Healey, Kate Heighton, Jeannie Kennedy, Sarah Lace, Mary-Kate MacDougall, Julia MacLeod, Melissa Paruch, Navanna Pelletier, Paula Watkins*

*Nova Scotia Health*

Nova Scotia (NS) has historically had a limited number of oncology nursing roles to support clinical practice across the province. Within the past several years, a considerable investment by the Nova Scotia Health (NSH) Cancer Care Program has been made into these critical practice support roles. As the team supporting education and practice provincially expanded, there was a desire to have dedicated time to connect; thus, an Oncology Educator Community of Practice was formed. This group is comprised of all Oncology Clinical Nurse Educators (CNEs), Professional Practice Leader, Nurse Educator Faculty and the Manager of Oncology Clinical Programs.

Terms of Reference were created along with defined standing agenda items. The forum has served as means to standardize practice related to new policy, new equipment, discuss challenges and opportunities. This group has established a remarkable provincial network of support, particularly as several new oncology CNEs are being integrated into the zones.

The group meets virtually, biweekly for one hour. Based on the rich quality of conversations and content covered, that has since increased to 90 minutes. The NSH Interprofessional Practice and Learning portfolio also recognizes the value and importance and financially supports the group coming together in person, three times a year. Meeting in person allows the group to continue to grow their supportive relationships, as well as have focused, uninterrupted time to work on provincial initiatives promoting collaborative practice across NS.

### III-6-C

#### Between the lines: How a book club impacted oncology nursing practice and staff wellbeing

*Tanya MacDonald, Alisa MacBride Smith, Emily Gilpin*

*Grand River Hospital*

As we entered the COVID recovery phase in 2022, the idea of an oncology book club was presented as a way to re-invigorate the nursing team and build relationships that had been impacted by COVID protocols (social gatherings, new staff, etc.). The idea of a book club grew from staff on the inpatient unit as a way to socialize with team members, support professional growth, and improve morale.

The purpose of the book club initiative was to increase inpatient oncology staff members understanding of different perspectives of people involved in a cancer journey, provide inspiration, identify areas for further personal learning, share knowledge, and foster connections between team members in an unconventional manner. Similar themes were found in the research article: Self-care perspective taking and empathy in a student faculty book club in the United States.

Our presentation will focus on the processes that we followed to develop the book club, the review and evaluation of each session, and the education that occurred as a result of staff-identified needs. We will discuss the topics that resonated with staff, the impact to their nursing practice, and how staff wellbeing was supported through team building and sharing of personal experiences as a way to draw strength from one another.

### III-6-D

#### An undergraduate nursing student pursuing cancer care; Diagnosis, nursing school, advocacy

*Taaha Ijaz*

*Ontario Tech University*

My passion for cancer care nursing began after being diagnosed with cancer in grade 12. Through nursing school, placements/externships, and political advocacy experiences, I have gained a deeper understanding of the field. Despite the COVID-19 pandemic's challenges, I adapted to the changing landscape of healthcare and embraced new opportunities for growth.

In the presentation, I will discuss the transition from nursing student to newly graduated nurse in cancer care, which presents many opportunities for growth and development. I will offer insights on how to support and encourage nursing students interested in pursuing a career in cancer care nursing. The presentation aims to inspire and support the next generation of nurses in this important and rewarding field.

In conclusion, I look forward to the opportunity to present at the Canadian Association of Nurses in Oncology Annual Conference, connect with attendees who share my passion, and offer valuable advice and resources. Through sharing my experiences, I hope to contribute to a better understanding of the challenges and opportunities facing nursing students interested in cancer care nursing.

### IV-1-A

#### The power in empowerment: Development of a local peer support program

*Lisa Lun, Michelle Ladouceur, Danielle Cameron McIndoo, Shaniza Sakoor, Liloutie Datt, Anita Datt*

*Humber River Hospital*

In the past two years, on-site peer support has been identified as a gap through observations from patients in the Cancer Care Clinic of a community hospital. Newly diagnosed patients are speaking with other patients who have similar experiences and seeking information and support. Peer support commonly occurs informally in the patient waiting room and treatment area. Acknowledging that many successful peer support program services already exist in other hospital and community settings, patients from the Cancer Care Patient & Family Advisory Council took the initiative to work together with the hospital's cancer care team to develop a local peer-to-peer support program that is innovative and provides safe,

compassionate care to our diverse community. This presentation will provide an overview of how this local peer-to-peer support program was developed, including the use of a home-grown digital platform for peer interaction, communication, and resource-sharing. Development of collaborative processes, and learnings from clinicians and peer volunteers will also be highlighted.

#### IV-1-B

### Strength within: A nurse-led pilot of remote patient monitoring for immunotherapy patients

Nicole Hudson, Stephanie Townsend

PHSA-BC Cancer

Immunotherapy drugs have a different mechanism of action than cytotoxic chemotherapy and, therefore, have different side effects and toxicities. Immunotherapies enable the body's immune system to better recognize and attack cancer cells, meaning the toxicities can be autoimmune in nature (immune-related adverse events or irAEs). irAEs require timely assessment and complex management with corticosteroid treatment. We are also seeing increased use of immunotherapy, driving a need to develop efficiency in nursing assessments and irAE management. Last year, a pilot project ran at BC Cancer Kelowna that trialed the use of remote patient monitoring (RPM) for immunotherapy patients. RPM utilizes scheduled online questionnaires and Bluetooth-enabled vital sign equipment to allow health and symptom monitoring from home. This project modelled primary care nursing and the use of RPM to assist in monitoring this complex patient population. This unique initiative was proudly nurse-led. By presenting at CANO, we hope to highlight the strength within oncology nursing to make positive changes to patient care. In our presentation we will share our process for creating our questionnaires and monitoring schedule, our monitoring plan for patients on treatment and those experiencing irAEs, and the outcomes of our pilot. By sharing our project, we hope to inspire fellow nurses to participate in care improvement projects, and to highlight how primary care nursing plays a critical role in patient advocacy for this patient population.

#### IV-1-C

### Utilizing a community outreach program to improve cancer health literacy

Gabriella Wong Ken

Health Collective

As cancer rates rise, the importance of equitable access to cancer screening, prevention, and treatment has become increasingly pertinent. Gaps in health literacy and access to care have led to inequitable rates of diagnosis and mortality among marginalized populations. Community outreach programs targeted to underserved groups are one way to address these gaps.

Health Collective is a low-cost multidisciplinary event that brings together health professionals such as nurses,

dietitians, and acupuncturists, as well as community resources and health information for underserved individuals. Nurses belonging to marginalized groups and with experience working with the focus populations provide information on cancer screening programs, symptoms, risks, and prevention.

Participants are asked to complete a survey on their knowledge level and barriers to accessing information on cancer and screenings. Results from the first survey showed the majority of participants were aware of screening programs, but never accessed them despite being eligible. The main reasons for this were not having a primary care provider to discuss with and poor past health experiences. By utilizing nurse-led community outreach, participants were able to discuss their questions and concerns one on one, receive assistance with understanding terminology and their personal risks, book self-referral screening appointments and review prevention strategies and symptoms.

Future iterations of Health Collective include partnerships with other public health organizations and services to bring mobile cancer screening and prevention programs such as HPV vaccinations to marginalized communities.

#### IV-1-D

### Acute outpatient management of immune effector cell therapy: The pivotal role of oncology nurses

Laura Olmi, Samantha Scime

Princess Margaret Cancer Centre

**Background:** The emergence of immune effector cell (IEC) therapy has changed the treatment landscape in oncology. While this exciting therapy provides evolving treatment potential across a variety of malignant and non-malignant disorders, it presents with unique adverse events during and after administration.

At Princess Margaret Cancer Centre, patients who receive standard of care and investigational IEC products are transitioned to an ambulatory care setting for management during their acute post-infusion period. Specialized oncology nursing care and patient education is essential to ensuring timely escalation, intervention and overall patient safety.

**Program Overview:** In this phase within the treatment trajectory, specialized oncology nurses, in collaboration with nurse practitioners, enact a hybrid model of care performing daily patient monitoring including in-person and telephone visits. In addition, patients and their caregivers require tailored nursing education and support for home monitoring, as essential members of the care team. Once patients are no longer in the acute phase, they are transitioned to a reduced-monitoring model within the clinic setting.

**Discussion:** With increased outpatient therapy options on the horizon, this model of continued monitoring and support can be tailored to meet the particular needs of heightened surveillance related to adverse event risk level. In this presentation, the point-of-care nursing role will be highlighted, including patient monitoring, education and escalation of care protocols. Program learnings and next steps will also be shared.



## IV-2-A

### Oncology clinical trials nursing: Helping to fortify the strength within

Marcie Flynn-Post, Chana Korenblum

The Princess Margaret Cancer Centre

Not only did the COVID-19 pandemic exacerbate already high levels of job stress in oncology nursing, but it also exposed a lack of institutionally driven approaches to support mental health and prevent burnout among healthcare workers. Specific challenges faced by a group of 85 clinical trials nurses at a large cancer centre in Toronto included legitimate fears of job loss when trial accruals were initially held, in addition to distress related to high mortality risk in their immunocompromised patients, rapid spread in healthcare settings with tenuous PPE supplies, redeployment, and expanding obligations outside work. In response, a variety of supports were offered to the nurses to fortify their strength from within, so they could uphold their renowned high quality of care. Managers offered frequent opportunities for clear, direct communication, and a newly developed hospital program called CREATE (Compassion, REsilience And TEam-building) facilitated by a team member from the Psychosocial Department. CREATE is a proactive, evidence-based intervention embedded into clinical workflows, which incorporates peer support to enhance team cohesion, facilitate emotional validation, normalize traumatic reactions, and problem-solve collaboratively. As initial acute stressors have shifted to more chronic pressures, job demands remain high and nurses continue to report psychosocial needs. In our presentation, we examine results of staff feedback and review literature supporting ongoing use of effective tools to help promote nurses' wellbeing and ensure the future of the field.

## IV-2-B

### VIRTUAl clinical trials navigation to improve Outcomes for Princess Margaret advanced SOLid tumour patients (VIRTUOSO)

Lindsay Carlsson, Rachel Taylor, Luana Flores Pereira

Princess Margaret Cancer Centre

**Background:** Clinical trials advance scientific research, support patient access to new treatments, and provide cost savings to the healthcare system. Despite this, less than six percent of adult cancer patients in Ontario participate in therapeutic clinical trials. Barriers to trial participation include strict eligibility criteria and protocol complexity, travel from remote and rural communities to urban cancer centers, and a lack of knowledge of available clinical trials. In the era of precision medicine, there is an increasing number of biomarker-driven drug trials, which introduce additional barriers due to limited patient access to genomic profiling.

**Project overview:** The VIRTUOSO project created a novel clinical trials nurse navigator (NN)-led virtual care pathway for advanced cancer patients receiving treatment at community

hospitals in Ontario to improve access to clinical trials offered at Princess Margaret Cancer Centre (PM). The project has three objectives: (I) to create a clinical trials digital platform to support community oncologists and their patients awareness of clinical trials; (II) develop a novel collaborative care model (CCM) to effectively address the complex clinical and psychosocial needs of trial patients; and (III) to evaluate the impact of an early referral virtual pathway on trial participation, access to genomic profiling, and patient reported outcomes.

**Results:** Preliminary findings from the pilot project evaluating the clinical impact of this virtual pathway will be available at the time of the conference.

**Significance:** The VIRTUOSO project is the first clinical trials NN-led program in Canada that provides personalized support to community oncologists and patients to improve access to molecular profiling and trials. The development of an integrated trial-matching digital platform and dedicated virtual care pathway will enhance clinical research activities across PM, which can be extrapolated to other clinical areas.

## IV-2-C

### The Nursing Role in the DOvEEgene Study: An opportunity for future innovations to improve timely access to care for women with symptoms of gynecologic cancers

Lucy, Gilbert<sup>1</sup>, Joelle Malek<sup>2</sup>

<sup>1</sup> Department of Obstetrics & Gynecology, Department of Oncology, McGill University; Gynecologic Cancer Service, McGill University Health Centre

<sup>2</sup> Research Institute – McGill University Health Centre

Together, endometrial and ovarian cancers affect about 10,000 Canadian women and cause 3,000 deaths each year; deaths are caused by high-grade subtypes, which are diagnosed in advanced stages. The death rate for endometrial cancer is rising relentlessly in all age groups. The DOvEEgene test, a genomic pap test to identify somatic mutations (early events in carcinogenesis), has the potential to detect these cancers in earlier stages and is being tested in a Phase 3 trial. Many participants have abnormal peri/postmenopausal bleeding, but had not been investigated because they were unaware it was abnormal or had difficulty accessing care. Nurses play a pivotal role in this innovative project. They obtain a health history and symptom screening using a questionnaire, educate and counsel participants, collect blood and saliva samples, and follow up on test results using an algorithm. Analysis of preliminary data from the study suggests that expanding the concept to introduce an open-access, "early detection" clinic for all gynecologic cancers would be beneficial. These clinics could be led by Nurse Practitioners, who could play a proactive role in educating women on abnormal symptoms and provide efficient access to screening for symptomatic women who may not have primary care providers or gynecologists. This could reduce delays in the diagnosis of these cancers and help alleviate strain on the primary care system.

## IV-2-D

### The role of a clinical nurse specialist in the development of an oncology nursing research centre

L. Cooper<sup>1,2</sup>, A. Julius<sup>1</sup>, S.J. Mayo<sup>1,2</sup>

<sup>1</sup>Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

<sup>2</sup>Princess Margaret Cancer Centre, University Health Network

Clinical Nurse Specialists (CNS) have the expertise to support nurse-led research and scholarship. This abstract describes the development of a novel CNS role and their contributions to developing an oncology nursing research centre in a cancer centre. In the establishment of the oncology nursing research centre, it was determined that a CNS role was essential. Based on the Canadian Nurses Association Advanced Practice Nursing Framework, the CNS role was developed with responsibilities reflective of the competencies: leadership, evaluation and research, clinical care, and the advancement of nursing practice.

The CNS role was implemented with the establishment of the centre in the fall of 2022. Leadership activities have included planning of centre programming and developing strategic partnerships with oncology nursing research centres and stakeholders. Evaluation and research activities have included leading a needs assessment to identify targeted interventions to support oncology nurses in their scholarly activities. Clinical care activities have included consulting on quality improvement projects that enhanced the implementation of evidence-based practice and knowledge translation. Activities to advance oncology nursing practice have included developing educational workshops and mentoring nurses engaging in research and scholarship.

Going forward, the CNS will play an essential role in expanding the centre programming to meet the needs of oncology nurses with the overarching goal of improving clinical care in the oncology setting. Scholarly collaborations will also be pursued to publish and disseminate our lessons learned.

## IV-3-A

### Oncology nurses' readiness to provide person-centred care informed by genomics: A mixed-methods study

Rebecca Puddester<sup>1</sup>, Joy Maddigan<sup>1</sup>, April Pike<sup>1</sup>, Holly Etchegary<sup>2</sup>, Angela Hyde<sup>2,3</sup>, Lesa Dawson<sup>2,4</sup>, Kathleen Stevens<sup>1</sup>

<sup>1</sup>Memorial University of Newfoundland Faculty of Nursing

<sup>2</sup>Memorial University of Newfoundland Faculty of Medicine

<sup>3</sup>Cancer Care Program, Eastern Health

<sup>4</sup>University of British Columbia, Faculty of Medicine

Knowledge of genomic cancer variants informs patients' eligibility for life-saving risk-reduction strategies. However, many carriers remain under identified. In several jurisdictions, genetic testing is mainstreamed through oncology clinics, decreasing wait times for genetic testing. There are plans to deliver a cancer genetics service through the Newfoundland and Labrador Cancer Care Program (NL-CCP). In preparation

for this novel service, it is important to assess oncology nurses' readiness to provide information and support about genomic implications of cancer risk and management that is responsive to the needs of these individuals and families.

**Research question:** Are NL oncology nurses ready to deliver person-centred genomics-informed care?

**Objectives:** 1: Assess NL oncology nurses' competency with genomics. 2: Determine the needs/preferences of individuals with cancer-predisposing variants, as they navigate their genomic healthcare.

**Methods:** 1. The Genomic Nursing Concept Inventory (GNCI©) will be distributed to (n=80) nurses in the NL-CCP. Key genomic learning targets will be identified through descriptive statistics. Multivariate statistics will be used to identify predictors associated with performance on the GNCI©. 2. Patient-oriented qualitative interviews (co-developed with patient partners) will be conducted with 25 carriers of cancer-predisposing genetic variants in NL and analyzed using an interpretive descriptive approach. Qualitative and quantitative findings will be synthesized to inform education to be delivered to nurses in the NL-CCP on person-centred genomic care. Findings will inform nurse-led strategies for cancer survivorship and prevention.

## IV-3-B

### Supporting the transition: Examining a nurse practitioner-led intervention for gynecological cancer survivors

Alexandra Lawrynuik<sup>1</sup>, Jacqueline Galica<sup>1</sup>, Jan Giroux<sup>2</sup>

<sup>1</sup>Queen's Cancer Research Institute

<sup>2</sup>Kingston Health Sciences Centre

After treatment, gynecological cancer (GC) survivors experience increased distress and unmet needs. A one-arm feasibility design was used to assess the feasibility, acceptability, and potential effectiveness of a 45-minute nurse practitioner (NP)-led intervention in addressing unmet needs in GC survivors entering the surveillance phase. Quantitative data (a demographic form and Cancer Survivors' Unmet Needs assessment tool) was gathered pre-intervention and 3-, 6-, and 12 months post-intervention; qualitative data were obtained through one-on-one interviews before and 6 months after the intervention. Data were analyzed using descriptive analysis. Twenty-seven women participated, who were, on average, 63 years of age (range 38-78, SD± 10.63 years). Participants had been diagnosed with ovarian (n=15), uterine (n=9), vaginal (n=1), or cervical cancer (n=1) an average of 10-27 months previously. Survivors reported 0-22 unmet needs at the end of treatment, primarily related to existential survivorship, informational needs, comprehensive care, quality of life, and relationships. Pre-intervention qualitative findings revealed that many survivors were unsure of what to anticipate during the post-treatment phase. Post-intervention qualitative results revealed that survivors appreciated the person-centred approach, length,

and amount of detail included in the intervention, as well as suggestions for improving support from cancer care providers. These findings demonstrate NPs are uniquely situated to provide a personalized intervention to address the post-treatment needs of gynecological cancer survivors and illuminate implications for other cancer care providers providing supportive care to this population.

### IV-3-C

#### Understanding how to better support oncology nurses in conducting advanced care planning in BC's Cancer Care System

Heather M Kilgour<sup>1,2</sup>, A Fuchsia Howard<sup>2</sup>, Michael McKenzie<sup>1,2</sup>, Sally Thorne<sup>2</sup>, Leah K Lambert<sup>1,2</sup>

<sup>1</sup> BC Cancer

<sup>2</sup> University of British Columbia

**Background:** Advanced care planning (ACP) is a process that supports patients in understanding and sharing their personal values and preferences for care. Benefits of ACP include improved quality of life at end of life and goal-concordant care. Oncology nurses are well-positioned to conduct ACP, yet, across British Columbia's (BC) regional cancer centres, ACP has not been integrated into standard nursing practice. Therefore, the study purpose was to understand how to better support oncology nurses in conducting ACP across BC.

**Methods:** Using a qualitative interpretive descriptive approach, we conducted and inductively analyzed data from individual, semi-structured telephone or Zoom interviews with 19 oncology nurses across BC.

**Results:** The accounts of oncology nurses suggest there is no standard practice for ACP across clinical settings, or an education/learning pathway to support nurses in adequately preparing to engage in ACP conversations. Nurses described several structural barriers that limit their involvement in ACP, including a lack of time, space, and privacy to hold ACP conversations; and service delivery models that constrain nurses from establishing longitudinal relationships with patients and do not support multidisciplinary colleagues working together to support ACP.

**Conclusion:** Several structural factors appear to either facilitate or limit oncology nurses from engaging in ACP discussions with their patients and colleagues. A clear and cohesive organizational approach to ACP is needed to support oncology nurses in engaging in meaningful ACP discussions, including service delivery models that encourage ACP, organizational support, educational training, and opportunities for interdisciplinary collaboration. Findings presentations will target oncology nurses and may inform the revision of workflow processes to support nurses in ACP.

### IV-4-A

#### The genetic evolution of AML: Implications for nursing practice

Hassan Zahreddine

Hamilton Health Sciences

Acute myeloid leukemia (AML) is a heterogeneous type of leukemia that develops due to the clonal expansion of myeloid progenitor precursors in the bone marrow. Genetic mutations play an important role in the development and progression of AML. Understanding the genetic basis of AML is pivotal to identifying patients at high risk for relapse and identifying tailored treatments aimed at long-term remission and cure. Because of their holistic approach to care, nurses are challenged with the rapidly evolving genetic knowledge in cancer. According to the Canadian Nurses Association, there's nearly an absence of genetics and genomic content in the Canadian nursing curriculum. Nursing literature posits that nurses are underprepared to integrate genetics and genomic foundation into practice. When caring for a patient with AML, nurses are expected to support patients with information on genetic mutations, and their implications on care trajectory. Genetic mutations provide the basis for treating some patients with allogeneic stem cell transplant, and nurses have a key role in supporting patients from diagnosis to post transplant. Moreover, nurses are patient advocates, and are the gatekeepers for ensuring that patients have informed consent on treatments that targets genetic mutations. Nurses are unable to meet these demands without understanding the genetic underpinnings of AML. The author will provide an overview of the genetic basis of AML, and implications on nursing practice. The main objective is to create an awareness on the unmet nursing need of genetic knowledge in AML, and provide resources on genetics and genomics for nurses.

### IV-4-B

#### Exploring the need for Human Leukocyte Antigen (HLA) matched platelets in patients diagnosed with a hematological cancer

Alessia Lamanna, Aisha Winn

Odette Cancer Centre, Sunnybrook Health Sciences Centre

**Introduction:** In Canada, an estimated 21,000 people will have been diagnosed with a hematological cancer in 2019. Hematological malignancies require intensive and long-term treatment such as constant platelet transfusions, which brings a significant burden on patients. Research indicates 20% of this population who receive multiple transfusions will develop platelet transfusion refractoriness (PTR). PTR is common in hematology and oncology patients, and is an important barrier in treating thrombocytopenia and hemorrhage. Many of these patients that develop PTR will require specially matched human leukocyte antigen (HLA) platelets.

**Objectives:** This presentation will describe the clinical advances to HLA-matched platelets use in hematological cancers

with platelet refractory. Furthermore, it will highlight the barriers health care providers may face such as accessibility and constant patient need for HLA matched platelets.

**Methods:** This presentation will discuss the importance and process of delivering HLA-matched platelets to patients diagnosed with hematological malignancies. The literature regarding our current understanding and barriers associated with the need for HLA-matched platelets will be discussed. Finally, a case study will be presented from a complex malignant hematology (CMH) unit at a Toronto hospital.

**Conclusion:** In light of current research and clinical observations made on a CMH unit, gaps in knowledge and barriers have been identified in association with the utilization of HLA-matched platelets. The role of the oncology nurse will be critical to the education of patients and health care providers in navigating best practice guidelines.

#### IV-4-C Strategic collaboration between cancer patient organizations and Canadian Oncology Nurses: Learning from myeloma patient groups worldwide

*Martine Elias<sup>1</sup>, Beth Faiman<sup>2</sup>*

<sup>1</sup> Myeloma Canada

<sup>2</sup> Cleveland Clinic Taussig Cancer Institute

This presentation will focus on the importance of strategic collaboration between patient organizations and Canadian oncology nurses to improve the quality of care for cancer patients. Using examples from myeloma patient groups worldwide, a nurse leader will highlight successful collaborations (i.e., nurse education, patient education, awareness and advocacy efforts) with patient organizations that have positively impacted their practice and led to improved care. By sharing these experiences and synergistic benefits, we aim to inspire and maximize interactions with the Canadian oncology nurse community to create opportunities for collaborative efforts in the Canadian context. Join us for a session that will showcase the power of collaboration and build on its potential to advance cancer care.

#### IV-4-D An overview of myeloproliferative neoplasms, symptom assessment and the shared-care model at Princess Margaret Cancer Centre

*Verna Cheung, Hassan Sibai, Aniket Bankar, Marta Davidson, Vikas Gupta, Dawn Maze*

*Princess Margaret Cancer Centre*

**Background:** Myeloproliferative neoplasms (MPNs) are a group of rare clonal disorders of hematopoietic progenitor cells associated with morbidity from disease-related symptoms, thrombotic events, and risk of transformation to acute myeloid leukemia. The rarity and complexity of care for these patients led to the establishment of the MPN program at Princess Margaret (PM) Cancer Centre. The program is a

provincial and national referral centre. We use a shared-care model whereby our team partners with community hematologists to ensure patients continue receive care close to home, and allow for care to extend beyond PM.

**Aim:** The purpose of this workshop is to provide an overview of MPNs and, specifically, the three common subtypes (i.e., polycythemia vera, essential thrombocythemia and primary myelofibrosis), and highlight the value of symptom assessment tools (i.e., ESAS-r and MPN-10 symptom) to oncology nurses.

**Method:** The workshop will, first, provide an overview of MPNs from diagnosis to treatments. Second, by reviewing case studies, we will demonstrate how the MPN-10 symptom assessment tool assists in treatment decisions and symptom management. In addition, we will discuss the MPN shared-care model, its value, and share feedback received. Last, through the workshop, we will emphasize the oncology nursing role within this patient population and model of care. We anticipate, following the workshop, attendees will better understand how the shared-care model can be utilized in other chronic complex malignant disease patient groups.

#### IV-5-A Connect and exchange for system transformation – A workshop for oncology practice leaders

*Joy Tarasuk, Kara Jamieson, Julia Kaal, Carolyn Fifield, Pamela Robichaud, Julia MacLeod, Carla MacDonald, Natasha McMaster, Margaret Ann Morrison, Helmut Hollenhorst*

*Nova Scotia Health Cancer Care Program*

The Nova Scotia Health Cancer Care Program is in a significant time of system change, from new models of care to respond to a rapidly changing oncology landscape, to rapid implementation of a provincial oncology information system. Oncology nurse practice leaders have an influential role in the introduction, integration, and sustainability of practice changes at the point of care. Ensuring practice leaders have the knowledge of and are involved in the initiatives is pivotal for knowledge dissemination and overall project success.

The purpose of the Connect and Exchange for System Transformation Workshop, which took place in Halifax, NS, in Spring 2023, was to bring practice leaders together from across the province to create a shared purpose and understanding for excellence in cancer care practices. Led by oncology nurse practice leaders, presenters and attendees included senior program leaders; provincial, operational and clinical trials managers and directors; professional practice leaders; clinical nurse and radiation therapy educators; clinical/unit resource nurses; charge nurses; physician leaders; research; and industry partners.

The day allowed for practice leaders to network with other practice leaders from across the province, learn about priority initiatives, understand what the different initiatives mean for leaders and their teams, and get involved with system transformation. Assessment of the value and impact of this approach to practice leadership engagement involved multiple

approaches: pre and post “temperature checks” using an interactive digital platform, opportunities to provide feedback on flipcharts, and a post-workshop evaluation using Select Survey. A CIHR Health System Impact Fellow joined the Cancer Care Program in Fall of 2021 and is supporting this work from an implementation and evaluation science approach. Results will be shared to inform future engagement strategy planning.

#### IV-5-B

##### How to start that conversation?: A simulation about sexual health among breast cancer survivors

Amina Silva<sup>1</sup>, Jacqueline Galica<sup>1</sup>, Kevin Woo<sup>1</sup>, Laura Killam<sup>1</sup>, Jovina Concepcion Bachynski<sup>1</sup>, Reanne Booker<sup>2</sup>, Janet Giroux<sup>1,4</sup>, Debora Stark<sup>3</sup>, Marian Luctkar-Flude<sup>1</sup>

<sup>1</sup> School of Nursing, Queen’s University

<sup>2</sup> Palliative and End-of-Life Care Services, Alberta Health Services

<sup>3</sup> Kingston Health Sciences Centre, Kingston General Hospital Site and the Cancer Centre of Southeastern Ontario

<sup>4</sup> Department of Obstetrics and Gynecology, Queen’s University

Navigating among healthcare settings and providers during the transition from active cancer treatment to surveillance period is often fraught with challenges from both patient and healthcare professionals’ perspectives. Despite cancer survivorship involving a variety of issues, there is evidence highlighting that the psychosocial issue that most commonly affects female cancer survivors, and is poorly addressed by healthcare providers, is sexual problems. Additionally, virtual simulation (VS) is an innovative and engaging knowledge translation strategy that can improve healthcare providers’ knowledge and skills. However, there is no evidence published related to the use of simulation to improve cancer survivorship care.

In this presentation, we describe our experience of developing a VS to educate primary healthcare professionals about sexual health disturbances among breast cancer survivors, including steps followed for developing the simulation content, the filming and assembling process, the feasibility and efficacy testing, challenges and strengths. Based on literature in other contexts, this VS may help increase health professionals’ knowledge and skills needed to assist breast cancer survivors with sexual health concerns. Our VS experience can be used to guide other researchers planning to develop similar interventions in the future.

#### IV-5-C

##### Targeting nurses’ needs and leveraging strengths to accelerate genomics-informed practices: Results from the GGNPS-CA Survey

Lindsay Carlsson, Jacqueline Limoges, April Pike, Nicole Letourneau, Ann Meyers, Rebecca Puddester

**Background:** Advances in genomics directly impact clinical practice and patient needs across the cancer continuum. Given the recognized urgency for oncology nurses to develop genomic literacy and integrate genomics in practice, the Canadian adaptation of the Genetics and Genomics Nursing

Practice Survey (GGNPS-CA) was administered to nurses by the Canadian Nursing and Genomics Initiative team. This survey benchmarked nurses’ knowledge, confidence, attitudes, confidence, adoption and workplace supports on genomics.

**Methods:** Canadian nurses were recruited for this national, cross-sectional, descriptive study. Consenting participants completed a demographic questionnaire and the GGNPS-CA. Participants were given their knowledge scores from the GGNPS-CA and invited to complete two online learning modules on genomics.

**Results:** 1,013 nurses completed the GGNPS-CA. Most (54%) had completed an undergraduate degree and the majority (72.3 %) worked in direct clinical practice. Few participants were exposed to genetics in their academic training (32.3%) or through continuing education (9.2%). Participants self-ranked their knowledge as poor (73%), and generated a mean knowledge score of 8.59/12 on the knowledge questions. Nurses indicated that access to additional education was important, the majority answered that they see the advantage of genomics to patient and, 19% of nurses stated that patients had asked them about genomics within the last three months. Nurses reported low confidence to integrate genomics into their practice and indicated they were not using genomic data, such as a family history, when making clinical decisions or referrals to genetic services.

**Significance:** This study identified strengths and priority areas for genomics education. The findings can be used by clinical educators and nurse leaders to inform policy and educational initiatives that will support nurses to develop genomics-informed practices.

#### IV-6-A

##### Intégration d’un dépistage systématique de la fragilité onco-gériatrique par l’infirmière; les retombées d’un projet pilote

Marie-Ève Bélanger, Maria Gabriela Ruiz Mangas

CHU de Québec – Université Laval

Avec le vieillissement général de la population et l’évolution constante des traitements, les personnes chez qui on diagnostique un nouveau cancer et celles qui y survivent sont de plus en plus âgées. La prise en charge de la clientèle âgée atteinte de cancer nécessite une approche individualisée. Ainsi, une évaluation gériatrique est recommandée en période pré-traitement oncologique. Au CHU de Québec – Université Laval, en partenariat avec le CIUSSS de la Capitale-Nationale, nous avons intégré un dépistage systématique de la fragilité onco-gériatrique chez la clientèle âgée atteinte d’un myélome multiple. Ce dépistage est réalisé par l’infirmière, suivant la rencontre médicale. Lors de la présentation, nous aborderons les besoins qui ont sous-tendu le projet, le rôle et l’expérience de l’infirmière, l’outil de dépistage développé ainsi que les résultats qui en ont découlé, entre autres sur le plan de traitements et les soins au patient.

## IV-6-B

### Évaluation et gestion de la détresse par les infirmières en oncologie : une revue de la portée

Jean-François Desbiens, Farida Hamidou, Gabrielle Griffith

Université Laval

Vivre avec un cancer constitue une expérience difficile qui peut entraîner de la détresse, risquant ainsi d'interférer avec la capacité des personnes atteintes à affronter la maladie, les symptômes et les traitements, en plus d'affecter leur qualité de vie. Le dépistage de la détresse constitue une stratégie d'identification rapide des personnes souffrant psychologiquement, dans des milieux cliniques souvent surchargés. Les infirmières qui effectuent le dépistage de la détresse peuvent contribuer aux soins psychosociaux qui réduisent la détresse et les émotions souffrantes. Cependant, parmi les barrières à l'implantation du dépistage, des infirmières ont mentionné que cette pratique rendait les personnes atteintes de cancer trop émotives et quelles se sentaient alors inconfortables comme cliniciennes. Des études ont aussi montré que les infirmières tendaient à fréquemment référer les personnes qui éprouvent de la détresse à d'autres professionnels de la santé, sans que l'on sache spécifiquement quelles interventions sont offertes et dispensées par ces dernières. La présente étude a pour objectif de documenter la prise en charge par les infirmières en oncologie des personnes atteintes de cancer qui présentent de la détresse. Plus spécifiquement, cette revue de la portée vise à déterminer quelle est l'étendue de nos connaissances au sein de la littérature scientifique, notamment en ce qui concerne les interventions mises en place, leur contexte, leur objectif et leur effet, ainsi que les barrières et les éléments facilitants. Les résultats préliminaires permettent déjà de documenter comment les infirmières en oncologie interviennent pour soulager la détresse et les émotions souffrantes chez les personnes atteintes de cancer, mais aussi les connaissances qu'il nous manque encore quant à la gestion de la détresse par ces dernières. Il sera possible, grâce à cette étude, de cibler comment mieux soutenir les infirmières dans cette pratique.

## IV-6-C

### Normes et compétences en radiooncologie : étude temps-mouvement de la pratique infirmière

Sonia Joannette, Bianca Prémont, Eve Turcotte-Audy

Centre intégré de santé et de services sociaux de la Montérégie-Centre

Les normes de pratique en radiooncologie définies par l'Association canadienne des infirmières en oncologie décrivent le rôle infirmier attendu (ACIO-CANO, 2019). L'application de ces normes vise à offrir des soins de qualité et une expérience positive en santé aux personnes touchées par le cancer. L'étude temps-mouvement a étudié dans l'action la pratique des infirmières en radiooncologie au Centre intégré de santé et de services sociaux de la Montérégie-Centre. La collecte de données s'est faite par des observations de type shadowing. Les activités et les soins directs ou indirects ont été calculés

pour une journée de travail auprès de 6 infirmières. Un journal de bord a permis d'annoter : impressions, notes méthodologiques et commentaires recueillis afin de bonifier l'analyse. Un atelier en pratique réflexive sur les résultats a fait émerger des recommandations pour l'harmonisation et le déploiement optimal du champ de pratique des infirmières. Durant cette présentation, le temps moyen consacré aux activités les plus fréquemment accomplies selon les normes de pratique sera décrit. Les compétences requises et les activités professionnelles de l'équipe des soins infirmiers en radiooncologie seront discutées. Sous le thème Puiser la force en soi, ce moment d'échange contribuera à mettre en lumière la mobilisation au quotidien de chacune des infirmières auprès de la clientèle en radiooncologie, des équipes interprofessionnelles et des partenaires.

## V-1-A

### Oncology nursing at BC Cancer: A thoughtful trajectory of education, experiences, and emergence

Michelle LaFreniere, Jeevan Dosanjh, Crystele Montpetit

BC Cancer Agency

Professional practice nursing (PPN) models support the creation of a culture of excellence, which is based upon a common set of values and performance expectations that influence practice. This culture of excellence persisted as the last few years of the pandemic meant drawing on our strength within and supporting clinical care of oncology patients during a period of frequent change in practice, staffing challenges, and overlying stress and anxiety. Time has now allowed us to shift towards the future, take inventory, and enhance our resources to rebuild and strengthen.

Cancer care continues to evolve with continuing advances in research and treatment options for patients. Professional nursing development is essential to best possible patient care. This presentation will outline our approach at BC Cancer Professional Practice Nursing to refine and streamline education while considering the unique needs of the novice to expert nurse pathway. This pathway begins at the foundational level, expands to oncology specialization, and to professional development and leadership. Educational resource updates, skills and competency mentorship are all components to support nurses whether they are students, new graduates, new nurses to oncology, or experienced oncology nurses in optimized roles.

The recruitment and retention of nurses in oncology is dependent upon a thoughtful, intuitive and relevant evidence-based educational approach.

## V-1-B

### Onboarding an internationally educated nurse on a transplant and cellular therapy inpatient unit

Phillip Nguyen<sup>1,2</sup>, Olga Pivovarova<sup>1</sup>

<sup>1</sup> The Ottawa Hospital

<sup>2</sup> University of Ottawa

There is a shortage of nurses across Canada. In an attempt to address the nursing shortage crisis, many provincial governments are turning to internationally educated nurses (IENs), both those currently in Canada and to their international recruitment. Transplantation and cellular therapy is a highly complex field. Oncology nurses who look after transplant patients provide pre- and post-transplant care to patients whose bone marrow has been damaged. This presentation will provide: a sample learning pathway for inpatient units for new learners and will discuss the experience of both the mentor and learner, as well as supportive resources to onboard future internationally educated nurses.

## V-1-C

### Designing a specialized oncology nursing transition to practice pathway: A Nova Scotia experience

Kara Jamieson, Kate Heighton, Carolyn Fifield, Paula Watkins, Pamela Robichaud, Karen Swan, Andrea MacDonald, Melissa Paruch, Joy Tarasuk, Carla MacDonald

Nova Scotia Health

Specialty practice requires a formalized program to support Nurses in their transition to practice (TTP) competently and confidently. The Nova Scotia Health Cancer Care Program (NSH CCP) recognized that nurses entering specialty oncology practice often have minimal/no experience in acute care settings prior to arriving in oncology. Orientation practices differed throughout the province, leading to a lack of standardization in the staff onboarding experience.

The NSH CCP and Interprofessional Practice and Learning partnered to create an orientation and TTP plan for all new staff entering oncology practice areas. Four specialty pathways were identified: community, in-patient, ambulatory systemic therapy, ambulatory clinic. The development of the four pathways aims to provide practice areas the required structure, education, and tools to successfully transition nurses into cancer care as well as serve as a means of recruitment and retention.

A working group was formed to define the Community Oncology Nursing Specialty TTP pathway including the design of the Cancer Systemic Therapy Certification Course, which was required to support safe and competent administration of systemic therapy for cancer in the rural/community sites. Additional resources were created to assess practice progression and support clinical leadership teams, as they integrated the pathway into their clinical practice areas. Similar project plans are in place to define the remaining pathways.

Initial evaluation data demonstrate that oncology nurses feel more supported and better prepared to care for the complex needs of persons living with cancer in rural/community areas.

## V-2-A

### Informing the role, onboarding, and transition to practice of nurse practitioners in community oncology: A pilot project in Nova Scotia

K. Julia Kaal<sup>1,2,3</sup>, Kara Jamieson<sup>1</sup>, Duana d'Entremont<sup>1</sup>, Pam Robichaud<sup>1</sup>, Jennifer Murdoch<sup>3</sup>, Joy Tarasuk<sup>1</sup>, Margaret Ann Morrison<sup>1</sup>, Sudeep Shivakumar<sup>1</sup>, Helmut Hollenhorst<sup>1</sup>

<sup>1</sup> Cancer Care Program, Nova Scotia Health

<sup>2</sup> Dalhousie University

<sup>3</sup> Nova Scotia Health, Research, Discovery & Innovation

Advanced practice nurses play an important part in cancer care. Despite their involvement in cancer care teams for several decades, there is lack of clarity about their role, scope of practice, and how to best integrate the role into existing care teams. The aim of this pilot project is to explore the onboarding and transition to practice experience of nurse practitioners (NPs) in oncology within two tertiary cancer care centres to inform the implementation of a new NP role in a rural community oncology setting.

Key informant interviews with current NPs at two tertiary cancer centres in Nova Scotia (NS) were conducted. The semi-structured interview guide contained three focus areas: onboarding and transition to practice; scope of practice and team/clinical environment. Analyses were guided by the theoretical domains framework. A follow-up focus group was held to communicate and validate findings.

A total of eight NPs participated in interviews; out of those eight, four participated in the follow-up focus group. Participants had been registered nurses between 6 to 26+ years prior to entering the NP role. At the time of the interviews, participants had been in the NP role between 5-16 years. Pertinent factors related to the onboarding and transition to practice experience fell into the domains of skills, environmental context and resources and social/professional role and identity.

Findings informed the design of the onboarding and transition to practice plan for a new NP role in community oncology. The evaluation of the implementation of this new role is ongoing and will inform how the NP role will be implemented in seven additional community oncology settings across Nova Scotia.

## V-2-A

### Addressing gaps in transitions for lymphoma/chronic lymphocytic leukemia (CLL) follow-up patients with an NP-led model

Jessica Holmes, Laura Patton, Karyn McKeever, Tara Baetz, Leslie Young, Renée Hartzell

Kingston Health Sciences Centre

Patients with lymphoma and chronic lymphocytic lymphoma (CLL) are typically followed for many years after completion of treatment in outpatient cancer clinics. Follow-up care consists of monitoring for recurrence or progression of disease, as well as managing long-term toxicity from treatment. A nurse practitioner (NP)-led clinic was developed at

Kingston Health Sciences Centre (KHSC) in 2018 to redistribute patient volumes from treatment clinics and to focus on follow-up care for this population. The clinic is a well-utilized resource, demonstrated by high referral and active patient volumes. The presentation will describe the clinic model and how it aligns with CCO's 2018 Expert Recommendation Report on Clinical Nurse Specialist and Nurse Practitioner Roles in the Delivery of Adult Cancer Services in Ontario, including how NP-led clinics can provide alternate care during transition phases, as well as complex diagnostic work-ups. Furthermore, the presentation will highlight quality improvement (QI) work done in 2021 in partnership with multiple stakeholders, including medical oncologists, hematologists, primary care providers, lymphoma survivors/patient advisors and patient education specialists. This QI work addressed identified gaps in lymphoma/CLL follow-up care to enhance patient education, with a focus on psychosocial care and health promotion, and to streamline the process for transition back to primary care. Our goal overall is to improve access to comprehensive lymphoma/CLL follow-up care and enhance coordination between teams for a safe and patient-centred transition from specialist to primary care.

## V-2-C

### Developing a nurse practitioner-led outpatient CART follow-up program at Princess Margaret Cancer Centre

Susan Jomha, Zubaida Mohamed, Christina Zeglinski, Sita Bhella, Christine Chen

Princess Margaret Hospital

**Introduction:** Chimeric Antigen Receptor T-cell (CART) therapy is a novel potentially curative cellular therapy for patients with aggressive lymphoma/leukemia who otherwise have dismal survival. In Canada, there are limited centres with resources and expertise to provide CART therapy. At Princess Margaret, CART patients undergo inpatient care immediately following cell infusion (minimum seven days), then are transitioned to a nurse practitioner (NP)-led outpatient day unit for follow-up. This presentation will describe the development of this program from vision to inception and the critical role of the NP as lead.

**Methods and Results:** The outpatient CART follow-up program was envisioned, developed and implemented by an interdisciplinary team including hematologists, nurse coordinators, educators, and NPs. NPs guide the care and assessment of patients in an outpatient day unit open 7 days/week, with resources to provide comprehensive services, including parenteral medications, blood products, procedures, and specialty consultations. Standardized policies include home vitals monitoring, caregiver neurotoxicity screening, escalation/direct admission protocols, daily phone reviews, and many others aimed at preventing emergency department visits and streamlining the care of these complex and needy patients. The NP functions at full scope and incorporates the College of Nurses of Ontario professional core competencies such as health promotion, assessment, diagnosis and therapeutics.

**Conclusion:** This novel NP-led CART follow-up program improves the complex patient's quality of care and satisfaction, by enhancing care integration, decreasing emergency department use, and streamlining care.

## V-2-D

### Optimizing the nurse practitioner role to meet patient and health service needs in complex malignant hematology: A qualitative descriptive study

Margaret Forbes<sup>1,2</sup>, Nancy Carter<sup>2</sup>, Kerry Balonjan<sup>2</sup>, Kristi MacKenzie<sup>1</sup>, Tom Kouroukis<sup>1,3</sup>, Jennifer Lounsbury<sup>1,2</sup>, Dr. Denise Bryant-Lukosius<sup>1,2</sup>

<sup>1</sup> Juravinski Hospital & Cancer Centre

<sup>2</sup> McMaster University School of Nursing

<sup>3</sup> McMaster University Department of Oncology

Evidence-based care and treatment of people with complex malignant hematology (CMH – defined as acute leukemia and cellular therapies) diseases is constantly evolving, leading to better health outcomes. Demands for CMH care has increased nationally and worldwide, but human resources to meet these needs are lacking. At the Juravinski Hospital & Cancer Centre (JHCC), nurse practitioners (NP) have been part of the CMH model of care for more than 20 years. There has been no formal review of the NP role in CMH at the JHCC, nor recommendations for recruitment, retention, or optimization of the role to meet future patient and health service needs. There is also little published data on the use of NP roles in CMH.

Our study aimed to understand stakeholder perceptions of NP role structures, processes, and outcomes, and the extent to which the role is meeting current and anticipated patient and health services needs in the CMH program at the JHCC.

A qualitative descriptive study design and purposive sampling was used to recruit participants (n=30) from key stakeholder groups: patients, nurses, allied health, physicians, and directors. The PEPPA-Plus framework guided development of a semi-structured interview guide used for focus groups and individual interviews. Content analysis methods were used to analyze the transcribed data.

Preliminary findings show consistent stakeholder perceptions that NPs are essential providers of comprehensive, holistic, and patient-centred CMH care. Ways that organizational structures can be strengthened to improve the model of care and NP role implementation were identified. Perceived NP role outcomes are related to early detection and management of treatment side effects and patient symptoms, psychosocial support, and care coordination. Study results are important for informing organizational policies and strategies for the recruitment, retention, and optimization of NPs in CMH at the JHCC and other practice settings nationally and internationally.



### V-3-A

#### Effectiveness of cancer patient navigation on diagnostic resolution and treatment initiation in patients with primary lung cancer in Manitoba

Elizabeth Agnew Kazina

College of Nursing, University of Manitoba

Cancer patient navigation was first introduced in the province of Manitoba in 2011 as part of the provinces IN SIXTY cancer patient journey initiative, which sought to move patient from first suspicion to cancer treatment in 60 days or less. While the scope of cancer patient navigation has expanded beyond the IN SIXTY framework, ensuring patients receive timely oncology care continues to be a top priority for nurse navigators in Manitoba. However, no formalized evaluation has taken place to determine the degree to which nurse navigators support the original mandate of facilitating timely oncology care for Manitobans. This presentation will outline the protocol of a retrospective cohort study to examine the potential role of cancer patient navigation in facilitating the care continuum of patients living with primary lung cancer from first suspicion of cancer to final diagnosis, and to first anti-cancer treatment. A brief review of the nurse navigation literature and rationale for the proposed research study will be provided, including discussion of how care transitions make the diagnostic phase of the cancer continuum particularly challenging for individuals. This will be followed by a description of the proposed research methods, including plans for data collection and statistical analysis. The presentation will conclude with a discussion on how the research findings will contribute to our understanding of cancer patient navigation as a potential facilitator to care transitions throughout the diagnostic and early treatment phases of the cancer continuum.

### V-3-B

#### Cancer patient navigation – A Canadian perspective to enhance oncology nursing excellence

Sarah Champ<sup>1</sup>, Catherine Dixon<sup>2</sup>, Heather Brander<sup>3</sup>, Elizabeth Agnew Kazina<sup>4</sup>

<sup>1</sup> Alberta Health Services

<sup>2</sup> Northwest Territories Health and Social Services Authority

<sup>3</sup> Nova Scotia Health

<sup>4</sup> CancerCare Manitoba

Facing and receiving a cancer diagnosis can be a stressful and overwhelming time for patients, which is compounded by the fragmented and complex nature of the Canadian healthcare system. As the number of people living with or beyond cancer continues to grow, it is unrealistic to expect that any one provider can meet a patient's myriad of needs, or that all cancer patients will have a standard set of care needs. Cancer Patient Navigation (CPN) programs can ensure timely and equitable access to quality cancer care services, improve person-centred care, and address the challenges people living with cancer face. While the model of care for Cancer Patient Navigation may vary, the core intention and outcomes are the same: to facilitate and enhance timely delivery of high-quality, person-centred oncology care. This model can be used on a global level to fully enhance patient care.

Currently, the majority of provinces and territories across Canada have implemented CPN programs. While there are a variety of models seen within the different programs, the core of navigation remains the same. The emerging trend of CPN programs across Canada and the evolving role of the oncology nurse in navigation highlighted the need for a CANO Oncology Navigation Special Interest Group (SIG). The navigation SIG explores navigation within Canada and creates a network of navigators nationally who learn from each other and share the challenges and successes of each program.

This presentation by members of the navigation SIG will use case studies to explore the various models of cancer patient navigation within Canada and outline the strengths and challenges of each.

### V-3-C

#### Patient reported outcomes (PROs) in cancer care: Leadership and nursing strengths

Renata Benc<sup>1</sup>, Karine Lepage<sup>1</sup>, Gabrielle Chartier<sup>1</sup>, Nathalie El-Haddad<sup>1</sup>, Nathalie Leon<sup>1</sup>, Lucie Tremblay<sup>1</sup>, Catherine Bigras<sup>1</sup>, George Loutichin<sup>2</sup>, Carmen G Loiselle<sup>1,3</sup>

<sup>1</sup> Jewish General Hospital of CIUSSS West Central Montreal

<sup>2</sup> Rosy Cancer Network

<sup>3</sup> Ingram School of Nursing, McGill University

The routine use of PROs in cancer care has been found to contribute to enhanced symptom control, health-related quality-of-life, patient-clinician communication, and patient/family engagement.

Our oncology team developed and piloted an electronic version of what we call the "Wellness Questionnaire" (WQ), which includes standardized PROs measures (i.e., ESAS-R, Canadian Problem checklist and the Distress thermometer), with secondary assessments (BPI, CFS, PHQ-8, GAD 7) when indicated.

Throughout implementation and beyond, nursing's strengths of assessing, teaching, providing support and coordinating care (e.g., key cancer information provider, active listening skills, concern validation, normalizing and addressing fears, focusing on patients' resources) were mobilized while identifying barriers and facilitators to further integration into routine practice. Documentation and communication across nursing care teams throughout the cancer trajectory contributed to continuity in care.

All patients received tailored education material. Patients with scores indicating high symptoms or concerns, were contacted by the symptom management hotline nurse for rapid intervention and, if needed, coordinated visits to the urgent care clinic, and/or advanced access to cancer specialists. Then, there were follow-ups with nursing teams while undergoing treatment modalities.

Overall, 85% of the time, patients ( $n = 247$ ) accepted the proposed nursing interventions, with 12% ( $n = 30$ ) requiring referrals to psychosocial or supportive care services.

This project supports nursing strengths in addressing, in a timely manner, the complex needs of patients and families affected by cancer.

## V-3-D

### Early palliative care across Canada: A scoping review

Stephanie Lelond<sup>1,2</sup>, Vanessa Slobogian<sup>3</sup>

<sup>1</sup> CancerCare Manitoba

<sup>2</sup> University of Manitoba

<sup>3</sup> Alberta Health Services

**Objective:** The objective of this presentation is to share the results of a scoping review aimed at systematically identifying and mapping the scope of available evidence on early palliative care (EPC) models and patient populations in Canada.

**Introduction:** As increasing evidence for the benefits of EPC in oncology emerge, various methods of delivering this care to diverse patient populations have also emerged. A lack of consensus on the definition of EPC, differing resource availability, inconsistent evidence in cancer types, and a lack of stakeholder buy-in have all contributed to inconsistent delivery of EPC across Canada. Further exploration is required to provide clarity around the definitions, patient populations, and models being used in EPC in oncology in Canada.

**Inclusion Criteria:** This review will include all Canadian studies reporting EPC in oncology for advanced/incurable cancers. Studies including children will be excluded.

**Methods:** This scoping review will use the methodology described by the Joanna Briggs Institute. In collaboration with a librarian scientist, a comprehensive search will identify and retrieve reports published in English from 1990 to present. Databases searched will include MEDLINE, CINAHL, EMBASE, Scopus, Cochrane Library, and PsycINFO. Data will be extracted by two independent reviewers, synthesized, and reported in a summary table and in a narrative format describing the breadth of EPC in oncology models and patient populations, while clarifying the concept of EPC being used in Canada.

**Results:** Results from this scoping review are expected to be available by fall 2023.

**Conclusions:** This scoping review will provide a better understanding of the concept and delivery of EPC established in Canada to help inform the development of future EPC programs and identify further research needs.

## V-4-A

### Insights into the relationship between patient-initiated telephone calls and women treated for gynecological cancer: A retrospective study

Catriona Buick<sup>1,2</sup>, Angela Leahey<sup>1</sup>, Virginia Waring<sup>1</sup>, Alessia Lamanna<sup>1</sup>, Meagan Kennedy<sup>1</sup>, Saeed Moradian<sup>2</sup>, Akinkunle Oye-Somefun<sup>1,2,3</sup>, Danielle Vicus<sup>1</sup>, Lilian Gien<sup>1</sup>

<sup>1</sup> Odette Cancer Centre, Sunnybrook Health Sciences Centre

<sup>2</sup> York University, Faculty of Health, School of Nursing

<sup>3</sup> Rotman Research Institute-Baycrest Centre for Geriatric Care

**Introduction:** In Canada, 9,950 new cases of reproductive cancers are diagnosed annually with 90% of those cancers found in the uterus, ovary, and cervix. While pathways will differ for each gynecological malignancy, a woman may undergo

multiple treatment modalities (radiation, surgery, chemo), which has a significant impact on their quality of life, symptom burden, and psychosocial distress. The Odette Cancer Centre (OCC) Live Voice Answer Gynecology Nursing Support Lines receives approximately 7,820 calls annually. Little is understood about the prevalence and predictors of these self-initiated patient calls.

**Objective:** The aim of this study is to provide insights into the relationship between patient-initiated telephone calls and those treated for a gynecological malignancy.

**Methods:** The study will use a retrospective design to identify factors that predict patient-initiated telephone calls to the Gynecology Oncology Nursing Support Line in those with a gynecological malignancy between the period of October 2021 and December 2021.

**Conclusion:** In light of current research, there are gaps in understanding the utilization of telephone support lines by the gynecological oncology population within a larger regional cancer centre. By identifying the prevalence and predictors of these calls, future research will focus on tailored interventions to address the associated symptoms. This study will lay the groundwork to identifying how to best meet the needs of those with a gynecological malignancy.

## V-4-B

### A new integrated cancer centre: An opportunity for an evolution of our nursing cancer care organization

Marie-Ève Bélanger, Maria Gabriela Ruiz Mangas

CHU de Québec – Université Laval

In 2022, the CHU de Québec – Université Laval opened his new Integrated Cancer Centre. In addition to a new physical environment, the merging of different care teams and the reorganization of our oncologic external consultation services gave us an opportunity to review our nursing cancer care organization. To do so, long before we move in, a thorough analysis, powered by consultations with clinicians and patients, was realized. The steps and the results of this analysis will be presented and discussed. Specifically, a description of the needs and problems that emerged will be first presented. Then, the solutions implemented and the vision we have acquired for a long-term purpose will be exposed. Finally, we will present the results of the evolution of our nursing cancer care organization, since its deployment.

## V-4-C

### The implementation of a clinical resource nurse in the ambulatory care setting: A pilot

Ashley MacDougall

Nova Scotia Health Authority

The resource nurse role is a position that is being implemented throughout inpatient units to support nurses in their practice and enhance patient care. Although this position commonly exists in the inpatient setting, there is minimal evidence

of this role existing in the ambulatory care setting. Due to shortages within the nursing profession, an outpatient hematology clinic in Halifax, Nova Scotia, recognized the impact of this human resource crisis. Historically, this unit experienced minimal turnover and primarily consisted of senior nurses. Since the COVID pandemic, this unit has experienced an influx of new oncology nurses, including new graduate nurses. This shift in demographics has resulted in an ongoing need for nurses to become certified in systemic and cell transplant therapy.

A Clinical Resource Nurse (CRN) position was implemented as a pilot project aiming to support new and current nurses on the unit, as well as address a gap in leadership. Within this unit, the charge nurse role has shifted to primarily focus on administrative duties, resulting in minimal opportunity to support nurses in patient care. The CRN role was developed through collaboration with staff, the clinical nurse educator and the charge nurse. The role has been invaluable in addressing staff learning needs and improving care delivery. This presentation will outline the process in which the new role was developed and its positive impact in the care setting.

#### V-4-D

##### A new integrated cancer centre: An opportunity for an evolution of our nursing cancer care organization

Erika Brown<sup>1</sup>, Lorelei Newton<sup>2</sup>, Renata Benc<sup>3</sup>, Catriona Buick<sup>4</sup>, Reanne Booker<sup>5</sup>, Amber Killam<sup>6</sup>, Mark Given<sup>7</sup>, Charles Kirkby<sup>8</sup>, Samantha Lloyd<sup>9</sup>, Shaun Loewen<sup>10</sup>, Teri Stuckless<sup>11</sup>, Laura Zychla<sup>6</sup>

<sup>1</sup> CARO/COMP/CAMRT/CANO Joint Advisory Group

<sup>2</sup> University of Victoria

<sup>3</sup> CIUSSS du Centre-Ouest-de l'île-de Montréal

<sup>4</sup> Odette Cancer Centre, Sunnybrook Health Sciences Centre

<sup>5</sup> Foothills Medical Centre

<sup>6</sup> The Ottawa Hospital

<sup>7</sup> Canadian Association of Medical Radiation Technologists

<sup>8</sup> Jack Ady Cancer Centre

<sup>9</sup> BC Cancer

<sup>10</sup> Tom Baker Cancer Centre

<sup>11</sup> Eastern Health

Of the two-in-five Canadians who develop cancer during their lifetime(1), an estimated 50% will require radiation treatment along their cancer care trajectory(2). Health human resource pressures, exacerbated by the COVID-19 pandemic are impacting cancer service wait times and healthcare provider retention and well-being. Thus, there is an urgent need to understand how the radiation oncology workforce will meet current and projected demands.

The Canadian Association of Nurses in Oncology/ Association canadienne des infirmières en oncologie (CANO/ ACIO) has partnered with the Canadian Association of Radiation Oncology (CARO), the Canadian Organization of Medical Physicists (COMP) and the Canadian Association of Medical Radiation Technologists (CAMRT) to collect workforce demographics, workload, and scope of practice trends in radiotherapy programs. Such data have the potential to provide insights on the health and capacity of the radiation oncology

workforce, as well as support predictive workforce modelling. We will report on the status of radiation oncology nursing nationally and the challenges of collecting data for this group. The study's findings will also advance our understanding of workload and interprofessional collaboration to support and advance radiation oncology nursing as a subspecialty.

1. Canadian Cancer Statistics Advisory in collaboration with Canadian Cancer Society, Public Health Agency of Canada. *Canadian Cancer Statistics: A 2022 special report on cancer prevalence*. <http://cancer.ca/Canadian-Cancer-Statistics-2022-E>
2. Delaney, G.P., Barton, M.B. (2015). Evidence-based estimates of the demand for radiotherapy. *Clinical Oncology*, 27(2), 70-6.

#### V-5-A

##### The strength of oncology nursing: Building a nurse-led program that facilitates in-home care for allogeneic stem cell transplant recipients

Samantha Scime, Zoe Evans, Katie McNamara, Laura Olmi, Susan Clarke

Princess Margaret Cancer Centre

**Background:** At the Princess Margaret Cancer Centre, approximately 180 patients undergo allogeneic blood and marrow transplant (BMT) annually. Historically, patients undergoing BMT have been cared for in hospital with strict isolation protocols over the course of several weeks. However, lengthy hospital admissions can have a significant impact on patient sleep, nutrition, exercise and mental health. In an effort to improve the patient experience and transplant-related outcomes, the Allo@Home team initiated an integrated care model that enables eligible patients to receive a portion of their transplant care in their home or a home-like setting close to the cancer centre.

**Program Overview:** Patients enrolled in the Allo@Home program, are admitted to the inpatient unit to receive their conditioning therapy and stem cell transplant. These patients are then transitioned to the ALLO@Home program with round-the-clock virtual monitoring by BMT RNs and daily in-person support from the BMT nurse practitioner team. Patients can temporarily be transferred back to the inpatient unit if they require higher levels of care, but can continue in the Allo@Home program until they engraft and are able to fully return to the community, with twice-weekly follow-up.

**Discussion:** Conceptualized during the height of the pandemic, the initiation of this program highlights the strength within oncology nursing. This presentation will provide an overview of the Allo@Home program and its development, as well as describe the collaborative approach to patient care. Roles and responsibilities of the BMT nurse and nurse practitioner will be highlighted and learnings to date, including feedback from relevant stakeholders, will be shared.

## V-5-B

### Developing a Home Parenteral Nutrition Program for Oncology Patients in a Community Hospital: The Expectation vs the Reality

Lisa Coles<sup>1</sup>, Pam Szabo-Kode<sup>1</sup>

<sup>1</sup> Niagara Health – Walker Family Cancer Centre, St. Catharines, ON

Maintaining nutrition is essential for patients with cancer but can prove to be challenging due to a number of varying factors. As the complexity of our patients continues to grow with advances in treatment and the expansion of our local oncology program at the Walker Family Cancer Centre, the need for patients to be on long term parenteral nutrition (PN) had also grown. PN is indicated when a patient is unable to meet their nutritional needs using the gastrointestinal tract, such as in the instance of a malignant bowel obstruction.

The need for PN can have a great impact on a patient's quality of life, hospital admission burden, and cost to the health care system. Home PN is an option that can be offered to help lessen some of these demands, but it requires a designated multidisciplinary team to support the patient and family beyond the care offered by their primary oncology team. Within our Hamilton Niagara Haldimand Brant (HNHB) health region, a home PN program exists that is limited to only 25 spaces to serve all patients, beyond oncology, who require home PN support. Hospital bed pressures and extended indefinite periods of admissions prompted us to think outside of the box, to find a way to efficiently use our resources and allow these patients to return home with PN, while avoiding a lengthy unknown waiting period. The need for this service led to the development of an oncology home PN program to support our patients. This involved bringing together multiple partners including local home care services, the inpatient team, an oncology internist, medical oncologists, and the parent home PN program in Hamilton. In our first 5 years of operation so far there have been many lessons learned, obstacles to overcome, and successes to share. But most importantly we realize that despite how small our home PN program may be, there continues to be a great need for this service that positively contributes to the quality of life for the patients we serve.

## V-5-C

### Optimization of workup pathways to improve access to cancer care programs and patients' experiences in rural and underserved communities

Aimee Brenna<sup>1</sup>, Candice Wilkie<sup>1</sup>, Enam Alsrayheen<sup>2</sup>, Jane Pham<sup>2</sup>, Mandy Nicholson<sup>1</sup>, Sue Chisholm<sup>3</sup>, Valerie Nugent<sup>1</sup>, Amanda Caissie<sup>3,4</sup>, Abdulmajeed Dayyat<sup>1,4</sup>

<sup>1</sup> Oncology Department, Nova Scotia Health Authority, Cape Breton Regional Hospital

<sup>2</sup> Research Innovation and Discovery Department, Nova Scotia Health Authority, Cape Breton Regional Hospital

<sup>3</sup> Radiation Oncology Department, Nova Scotia Health Authority, QEII Dickson Building

<sup>4</sup> Dalhousie University

**Purpose:** New healthcare models are needed in our Canadian healthcare system to improve access to care and patient experiences. Rural areas experience high incidence of cancer, late presentation of disease and high mortality rate. Delays in cancer care can negatively impact patient outcomes. Evidence-based nurse-led healthcare models have been implemented as structured delivery models. This project aims to evaluate the implementation of the Timely Access Patient Support (TAPS) clinic in a radiation oncology department in a mid-size cancer care center that serves rural Nova Scotia. It is hypothesized through expediting diagnostic work-up and connection with support services with role optimization of a nurse practitioner (NP), there will be a reduction in time to treatment and improved patient-reported outcomes (PROs).

**Methods:** The TAPS clinic involves a one-time visit within three to five days of referral to the radiation oncology department, with an NP and registered nurse, who provide assessment to ensure diagnostic work-up is complete and identify need for support services using validated assessment tools prior to radiation oncologist (RO) consultation.

**Results:** To date, 103 eligible patients have been assessed in the TAPS clinic, prompting more than 200 orders: 57 investigations, 107 referrals (top 3: social worker 43%, dietitian 30.8%, and cancer patient navigator 15%), and 40 interventions. Of patients seen in TAPS clinic, 80% were ready to treat (RTT) at RO consult compared with 44% for pre-implementation of TAPS. The mean wait time from referral to TAPS consult was five days compared to 15 days for pre-TAPS patients to be seen in RO consult. Post-TAPS patients reported less fatigue and better overall well-being during CT simulation compared to pre-TAPS patients.

**Conclusion:** This nurse-led model of care facilitated accelerated workup of malignancies, positively impacting RTT times. This study aims to improve not only PROs but also locoregional control and survival outcomes.

## V-5-D

### Oncotype by nurse, a new process to identify high-risk patients and to expedite treatment in early-stage breast cancer

Christine Bayne

Niagara Health – Walker Family Cancer Centre

#### Reducing the time to initiate breast cancer treatment by implementing Oncotype DX by nurse

The Oncotype DX test is a unique diagnostic test that helps identify which patients with early-stage invasive breast cancer, that are ER+ and HER2-, are more likely to benefit from adding chemotherapy to their hormonal treatment and to also assess the likelihood that their breast cancer may return. This information is useful to assist oncologists in making treatment decisions for their patients, and having the results available prior to a new patient consult is essential in reducing the time to initiate breast cancer treatment. We developed a process at Walker Family Cancer Centre to ensure that these results are available for a patient's initial consultation by having the new patient referrals department notify the clinic nurse if a new breast patient qualifies for Oncotype DX testing. From there, the clinic nurse calls the patient for consent and sends off the required documentation for the Oncotype DX test to be completed. Results typically take two weeks and would be made available for the oncologist to review before their initial consult with a patient. In developing this process, we have reduced the waiting period to initiate breast cancer treatment. We have also saved time through having this information available on hand for our physicians at the patient's first consultation and by avoiding the need for a follow appointment for the Oncotype results.

## V-6-A

### Bridging the knowledge gap: Development of an e-learning course on geriatric oncology

Susie Monginot<sup>1</sup>, Arielle Berger<sup>4</sup>, Linda Cerullo<sup>1</sup>, Elizabeth Faour<sup>1</sup>, Selynne Guo<sup>2</sup>, Andrew Holowynch<sup>3</sup>, Rana Jin<sup>1</sup>, Alana Miller<sup>4</sup>, Richard Norman<sup>4</sup>, Tina Papadakos<sup>3</sup>, Schroder Sattar<sup>5</sup>, Shabbir Alibhai<sup>2</sup>

<sup>1</sup> Princess Margaret Cancer Centre, University Health Network

<sup>2</sup> Department of Medicine, University of Toronto & UHN

<sup>3</sup> Cancer Education, Princess Margaret Cancer Centre

<sup>4</sup> Department of Medicine, University of Toronto, UHN/Mt. Sinai Hospital

<sup>5</sup> College of Nursing, University of Saskatchewan

**Introduction/Background:** More than 60% of cancers affect people aged 65 and older. Age-related disparities in cancer and cancer-care outcomes suggest oncology practitioners have a lack of knowledge about age-related concerns. As the population continues to age, addressing this knowledge gap will become even more important. Therefore, our multidisciplinary team is developing a set of freely available e-learning modules to enable nurses and oncology providers to learn about the unique needs of older adults and ways in which we can support them.

**Methods:** An environmental scan was conducted on relevant existing courses prior to development of the course outline. An expert team comprised of specialized oncology nurses, geriatricians, geriatric oncology fellows, a dietitian, pharmacists, and cancer education specialists are developing nine different modules based on the domains of the Comprehensive Geriatric Assessment, the gold standard tool used in this population. The initial "Introduction to Geriatric Oncology Module" is complete and has undergone user testing in the form of qualitative interviews. Eight interviews were conducted with physicians (4) and nurse practitioners (4) to collect perceptions around the benefits of the course, as well as areas for improvement and usability. Upon the launch of the remaining modules, user access data will be captured and surveys will be conducted to learn about usability and demographics of learners.

**Results:** Interviews indicated high level of usability and interest in the development of the course content. All users found the content highly relevant and would recommend the course to other oncology practitioners. The rest of the course is planned to be completed by the end of 2023. Updated findings will be presented at the time of the conference.

**Conclusions:** Our course aims to promote the strength of knowledge nurses and oncologists need to provide the highest level of care to older adults with cancer.

## V-6-B

### Co-designing a tailored self-management app with older adults with cancer and multimorbidities

Kristen Haase<sup>1</sup>, Sang-Wha Sien<sup>2</sup>, Francis Kobekyaa<sup>1</sup>, Margaret Tompson<sup>3</sup>, Penelope Hedges<sup>3</sup>, Martine Puts<sup>5</sup>, Leanne Currie<sup>1</sup>, Ireena Baro<sup>2</sup>

<sup>1</sup> School of Nursing, University of British Columbia

<sup>2</sup> Department of Computer Science, University of British Columbia

<sup>3</sup> Patient partner, School of Nursing, University of British Columbia

<sup>4</sup> Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

**Introduction:** In Canada, two in every five older adults aged  $\geq 70$  years is diagnosed with cancer with 70% living with other illnesses. Cancer self-management interventions tailored to the needs/abilities of older adults can optimize symptom management. However, few interventions target older adults with cancer/multimorbidities that provide digital self-management supports. Many apps for older adults have not been co-designed with older adults to increase usability and uptake. The purpose of this study was to co-design a self-management app to support older adults living with cancer/multimorbidities.

**Methods:** We used a design thinking approach, and older adults (median age-71) with lived experience to design a medium-fidelity prototype. Older adults with cancer/caregivers were recruited through community organizations/support groups to participate in co-design/evaluation of the app. Data has been iteratively integrated into the design process and analyzed descriptively and thematically.

**Results:** 20 older adults with cancer/caregivers participated in the design of the low-fidelity prototype and iteratively evaluated the medium-fidelity prototype. Participants with varying levels of technical know-how collectively emphasized the importance of tracking functions to make sense of information across physical and psychosocial symptoms linked to their health goals; clear visualizations; and organization of notes/reminders to communicate with care providers.

**Conclusions:** This App supports the complex healthcare needs of older adults with cancer creating a 'home base' for symptom management. Findings from this study will position the researchers to conduct feasibility testing and real-world implementation.

## V-6-C

### Nurse-led assessment using patient-reported outcomes among older adults with cancer

Erika Martinez<sup>1</sup>, Renata Benc<sup>1</sup>, Gabrielle Chartier<sup>1</sup>, George Loutochin<sup>1,2</sup>, Nathalie El Haddad<sup>1</sup>, Karine Lepage<sup>1</sup>, Carmen Loiselle<sup>1</sup>

<sup>1</sup> Centre Intégré Universitaire de Santé et de Services Sociaux (CIUSSS) du Centre-Ouest-de l'Île-de Montréal

<sup>2</sup> Rossy Cancer Network, McGill University

Older adults with cancer (i.e., 70 years and above) can be more vulnerable, as they navigate their cancer experience. This is, in part, due to unique age-related needs that may not be routinely assessed in standard cancer care. In our centre, we developed a series of standardized patient-reported outcome (PROs) that we call the Wellness Questionnaire (WQ), to capture cancer-related symptoms and distress. The WQ includes the ESAS-r, Canadian Problem Checklist, Distress Thermometer, Self-Reported G8 and QLQ-ELD14. In addition, secondary PROs including the BPI, CFS, PHQ-8 and GAD-7 were triggered if required.

Newly diagnosed cancer patients (N = 13) completed the WQ via Qualtrics – a secure web-based platform. A nurse navigator reviewed patients' reports and if needed they could be referred to relevant services based on further clarification of the nature of these symptoms. Secondary PROMs were triggered for pain, fatigue, anxiety and depression at a rate of 15%, 46%, 31% and 23% respectively. Nursing interventions included active listening and psychosocial support (82%), provision of informational materials and self-care strategies (64%), as well as referring to community resources (55%). Informational tip sheets were automatically sent to patients who reported particular symptoms.

Overall, these intervention processes were meant to address pressing age- and cancer-related concerns. If needed, vulnerable participants were also referred to the geriatric oncology department, to address needs/concerns and develop an individualized plan of care.

## V-6-D

### Implementing geriatric assessment and management for older Canadians with cancer: Adherence to and satisfaction with the intervention, results of the 5C Trial

Martine Puts<sup>1</sup>, Jihad Abou Ali Waked<sup>1</sup>, Fay Strohschein<sup>2</sup>, Henriette Breunis<sup>3</sup>, Naser Alqurini<sup>4</sup>, Arielle Berger<sup>5</sup>, Lindy Romanovsky<sup>5</sup>, Johanne Monette<sup>6</sup>, Rajin Mehta<sup>7</sup>, Anson Li<sup>8</sup>, Doreen Wan-Chow-Wah<sup>6</sup>, Rama Koneru<sup>9</sup>, Ewa Szumacher<sup>10</sup>, Caroline Mariano<sup>11</sup>, Tina Hsu<sup>12</sup>, Sarah Brennenstuhl<sup>1</sup>, Eitan Amir<sup>13,14</sup>, Monika K. Krzyzanowska<sup>13</sup>, Christine Elser<sup>13,14</sup>, Raymond Jang<sup>13</sup>, Anca Prisca<sup>13</sup>, Eric Pitters<sup>\*</sup>, Urban Emmenegger<sup>15</sup>, Ines B. Menjak<sup>15</sup>, Simon Bergman<sup>16</sup>, Manon Lemonde<sup>17</sup>, Francois Beland<sup>18</sup>, Shabbir M.H. Alibhai<sup>19</sup>

\* Older adult team member

<sup>1</sup> Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

<sup>2</sup> Faculty of Nursing, University of Calgary

<sup>3</sup> Department of Medicine, Princess Margaret Cancer Centre, University Health Network

<sup>4</sup> Division of Geriatrics, Department of Medicine, Amiri Hospital, Ministry of Health, Kuwait City

<sup>5</sup> Department of Geriatric Medicine, University Health Network

<sup>6</sup> Division of Geriatric Medicine, Department of Medicine, McGill University

<sup>7</sup> Division of Geriatric Medicine, Sunnybrook Health Sciences Centre

<sup>8</sup> Department of Geriatric Medicine, Royal Columbian Hospital, New Westminster

<sup>9</sup> Department of Medical Oncology, R.S. McLaughlin Durham Regional Cancer Centre, Lakeridge Health

<sup>10</sup> Department of Radiation Oncology, Odette Cancer Centre, Sunnybrook Health Sciences Centre

<sup>11</sup> Department of Medical Oncology, BC Cancer Center

<sup>12</sup> Division of Medical Oncology, the Ottawa Hospital

<sup>13</sup> Department of Medical Oncology and Hematology, Princess Margaret Cancer Centre, University Health Network

<sup>14</sup> Department of Medical Oncology, Mount Sinai Hospital, Sinai Health System

<sup>15</sup> Division of Medical Oncology & Hematology, Sunnybrook Health Sciences Centre

<sup>16</sup> Department of Surgery, Jewish General Hospital

<sup>17</sup> Faculty of Health Sciences, Ontario Tech University

<sup>18</sup> Public Health School, University of Montreal

<sup>19</sup> Department of Medicine and Institute of Health Policy, Management, and Evaluation, University Health Network and University of Toronto

**Introduction:** Geriatric assessment and management (GAM) is recommended by professional organizations and several recently completed randomized controlled trials (RCTs) demonstrated benefits of GAM on multiple health outcomes. However, little is known about the implementation of GAM for older adults with cancer and how well recommendations are implemented by participants. Understanding these issues is vital to designing GAM trials and clinical programs. Therefore, the goal of this study is to examine the adherence of older adults to and satisfaction of oncologists and intervention team members with the recommended interventions.

**Materials and Methods:** A two-group parallel RCT of GAM for older adults aged 70+ referred for chemotherapy/immunotherapy or targeted therapy was conducted in 8 hospitals across Canada (the 5C study). The intervention teams documented the implementation of management recommendations, and medical records were reviewed to assess which recommendations were implemented. Semi-structured interviews were conducted with intervention and oncology team members to assess implementation of the study and interventions.

**Results:** 350 participants were enrolled; 173 were randomized to the intervention (i.e., GAM) arm and 177 to the control group. The average age was 75.7 y (SD 4.8), 40.6% were

female. Median number of recommendations was seven. Mean adherence to recommendations based on the GA was 69%, but it varied by type of recommendation, ranging from 98% for laboratory tests to 28% for psychiatry/psychosocial oncology referrals. Oncologists and intervention team members were satisfied about the study implementation and intervention delivery.

**Discussion:** About two-thirds of all recommendations were implemented by older adults; adherence to laboratory investigations and imaging were generally very high, but were much lower for psychosocial support such as referrals to psychosocial oncology. Further collaborative work with older adults is needed.

# CANO/ACIO Annual Conference Poster Abstracts

**P-01**

## **The triggered referral program for acute leukemia inpatients**

*Kestral Danzmann*

*University Health Network – Princess Margaret Hospital*

Early involvement of specialized palliative care (PC) teams in acute leukemia patient care increases quality of life by helping mitigate symptom burden, social challenges, and psychological distress. Unfortunately, the early integration of PC alongside routine leukemia care is not standard practice; referral timing is often variable. This presentation describes a Triggered Referral Program (TRP), an evidence-based pathway aimed at increasing acute leukemia patients' quality of life by standardizing the PC referral process on inpatient hematology units. Standardized care pathways have successfully reduced PC referral variability and increased early integration among solid-tumour and congestive heart-failure patient populations. Thus, the TRP was conceptualized from Princess Margaret Hospital's (PMH) practice needs, as well as programs with similar goals implemented in solid-tumour malignancy and congestive heart failure populations. The TRP involves the development of a standardized referral pathway, as well as clinician education. The clinical pathway involves assigning patients a numerical score of referral need based on five domains: symptom burden, functional status, comorbidities, presence of advanced disease, and psychosocial need and would be integrated into the electronic medical record for access by clinical staff. Clinical education would support the interdisciplinary team in understanding the importance of early PC referral, their role in the process of increasing referral, and training on how to use the triggered referral pathway in their daily care. The TRP would offer standardization of the PC referral process with the hopes of increasing acute leukemia patient quality of life. Information gained from this program would have the potential to help inform the implementation and evaluation of other standardized referral pathways, impacting patient outcomes across Ontario.

**P-02**

## **Enhancing the patient's understanding of their oral anti-cancer therapy: A multidisciplinary approach to improving oral medication counselling**

*Lisa Coles, Emily Kaczmariski*

*Niagara Health – Walker Family Cancer Centre*

A review of telephone calls made after hours by patients showed a significant number of calls were related to medication concerns. At the Walker Family Cancer Centre in Niagara, a large proportion of these phone calls came from patients with hematological malignancies who either took their medication incorrectly, were confused about their medication dosing schedule, or who needed clarification about their prescription. This

prompted a multidisciplinary effort to identify gaps in patient education, and enhance strategies to improve and standardize the way in which patients receive their medication teaching. A teaching tool was developed for nurses and pharmacists to use when counselling patients on a new oral anti-cancer medication. The purpose of this tool is to standardize all new medication teaching and ensure that essential topics such as medication dose and schedule, side-effect management, safe handling and other safety precautions are discussed. Elements of the MOATT (MASCC Oral Agent Teaching Tool) were considered and incorporated in the development of this tool which will be built directly into the electronic medical record to serve as documentation in the patient chart. Future efforts will be to review the effectiveness of this teaching tool by measuring patients' reported level of understanding related to their medication by use of a patient experience survey. The success of this project will allow for consideration of the utility of this teaching tool across all disease sites.

**P-03**

## **How can nurses support health promotion following breast cancer in primary healthcare? Scoping review protocol**

*Pegah Torabi<sup>1,2</sup>, Maud Christine Chouinard<sup>1,2</sup>, Karine Bilodeau<sup>1,2,3</sup>*

<sup>1</sup> *Faculty of Nursing, University of Montreal*

<sup>2</sup> *Centre intégré universitaire de santé et de services sociaux du Nord-de-l'Île-de-Montréal Research Center*

<sup>3</sup> *Maisonnette-Rosemont Hospital Research Centre*

The survival rate for patients suffering from breast cancer increased due to more effective treatments and frequent screening. The period after active treatment is considered a "teachable moment," in which a patient is most conducive to engaging in health-promoting behaviours. During the post-treatment transition, the survivors have unique needs that can be met by primary care nurses, through their skills and knowledge in comorbidity management, health education, and health promotion. However, knowledge of nursing interventions that promote health after cancer treatments is limited.

The poster will present a scoping review protocol describing health promotion nursing interventions for female breast cancer survivors in primary care.

This project is based on JBI's updated methodological framework. The following databases will be searched: Embase, PsycINFO, PubMed, CINAHL, and Web of Science. The search keywords will include the terms "health promotion," "nursing," and "breast tumours," as well as "primary care" or survivors terms. The results will describe the main characteristics (e.g., objective, modes of delivery, schedule, and duration of the intervention) and components of the nursing interventions (e.g., approaches applied, and main determinants of health included in the interventions) that support health promotion for female breast cancer survivors in primary care.



This review will identify health promotion knowledge gaps in nursing practice and new areas for future research to improve primary care nursing for cancer survivors.

## P-04

### The Ontario Peritoneal Surface Malignancy Program

*Sophia Aksenchuk*

*Peritoneal Surface Malignancy Program, Mount Sinai Hospital, Toronto, ON*

The Ontario Peritoneal Surface Malignancy program was established in 2011 and serves adults (18 years of age and older) with a diagnosis of peritoneal cancer (malignant peritoneal mesothelioma, appendiceal, small bowel, and colorectal cancers). The program includes surgical oncologists, residents, a fellow physician, and a nurse clinical coordinator. The program is one of nine in Canada, and the only one in Ontario, to offer Hyperthermic Intraperitoneal Chemotherapy (HIPEC) with cytoreductive surgery. A quality improvement project was completed by a nurse coordinator to assess a baseline for program management and to review program performance from inception to date. Anonymized data of patients treated from 2011 to 2022 was manually collected at this provincial surgical program located in Toronto, Ontario. Data summaries are presented in two groups, (1) new referrals and triage data (July 2021 to now); and (2) general program data summary since 2011. This poster presentation will display trends, successes, and challenges of a unique surgical program. This knowledge will support the development of yearly quality improvement initiatives and help to identify future research projects.

## P-05

### Team-based care: A pre- and post-implementation journey map at BC Cancer – Vancouver

*Joyce W. Tse<sup>1</sup>, Amira Lalani<sup>1</sup>, Heather Kilgour<sup>2</sup>, Scott M. Beck<sup>2</sup>, Taslin Janmohamed-Velani<sup>1</sup>*

<sup>1</sup> BC Cancer – Vancouver

<sup>2</sup> Nursing and Allied Health Research and Knowledge Translation, BC Cancer

**Background:** BC Cancer (i.e., the comprehensive cancer care organization in the province of British Columbia) has recently introduced a team-based model of care (TBC). TBC is a collaborative, multidisciplinary approach to cancer care, which is meant to improve the efficiency, quality, and personalization of care for patients and their families. At BC Cancer – Vancouver, the province's largest tertiary cancer care centre, the implementation of TBC required a careful examination of the registered nurse (RN) role across our ambulatory clinics.

**Methods:** As two RNs working in two distinct tumor-based multidisciplinary teams (i.e., head/neck & lung, and gastrointestinal cancers), we sought to identify key changes to the RN role before and after the implementation of TBC at BC Cancer – Vancouver. To this end, we used journey mapping as an analytic framework.

**Results:** Prior to the implementation of TBC at BC Cancer – Vancouver, we found that RNs were inconsistently assigned to different clinics and tumour groups. This resulted in (1) challenges in multidisciplinary collaboration; (2) inconsistency of the RN role; and (3) poor continuity of care for patients and families. Post-TBC implementation, we found that the formation of consistent, tumour-based multidisciplinary teams has led to improvements in the RN role, including (1) increased trust and communication across disciplines; (2) improved rapport between the multidisciplinary team, patients, and families; (3) improved efficiency secondary to team-specific workflows; and (4) an improved sense of role clarity.

**Discussion:** Through journey mapping the RN role pre- and post-implementation of TBC at BC Cancer – Vancouver, we have early indications that TBC has produced improved communication between team members, and more efficient, consistent care for patients and families. Further research into the impacts of the RN role on patient and staff experience is needed.

## P-06

### Stem cell HVAC renovation project

*Phillip Nguyen*

*The Ottawa Hospital, University of Ottawa*

Stem cell transplants is starting to become a widely used modality in malignant and non-malignant diseases. Patients undergoing stem cell transplants are at high risk for being immunocompromised. The Stem Cell HVAC Renovation project at The Ottawa Hospital was designed and planned in order to improve the ventilation in the transplant and cellular therapy unit as a way to reduce the risk of infection and mortality. The improved ventilation includes HEPA filtration, increased air changes, and positive pressurization. This presentation will identify key barriers to implementation, compliancy amongst and strategies to support staff and patient's alike.

## P-08

### Exploring the experiences and influencing factors of oncology advanced practice nurses' engagement in research and scholarship in a cancer centre

*L. Cooper<sup>1,2</sup>, A. Julius<sup>1</sup>, L. Carlsson<sup>2</sup>, S.J. Mayo<sup>1,2</sup>*

<sup>1</sup> Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

<sup>2</sup> Princess Margaret Cancer Centre, University Health Network

In cancer care research, nurses make important contributions that enhance patient outcomes. Organizations have a role in supporting nurses' engagement in research and scholarship, but effective initiatives depend on appropriate tailoring to the staff's needs. We describe a novel quality improvement project that will capture the engagement of oncology APNs in research and scholarship and describe the influencing factors that impact their engagement.

This project will employ a sequential mixed methods design. Oncology APNs from a cancer centre will be invited to participate in a questionnaire in which they will endorse their

involvement in research and scholarship activities. The questionnaire will capture environmental and individual characteristics related to their involvement, as guided by the framework Gilberts Behavioural Engineering Model. A subgroup of participants will be invited to engage in interviews designed to elaborate on the findings from the quantitative survey. Quantitative and qualitative data will be analyzed separately and integrated using a joint display.

This project will commence in May 2023. Preliminary results will be available by the conference.

This project will identify the types of research and scholarship that oncology APNs are involved in, as well as provide insight into the environmental and individual characteristics that influence their engagement in these activities. These results will guide targeted interventions that can optimize their contribution to research and scholarship for oncology APNs in an academic cancer centre.

## P-10

### Predisposing, precipitating, perpetuating, and protective factors related to distress in parents of children with cancer: A systematic review

Mackenzie Murawsky<sup>1</sup>, Lindsay Jibb<sup>2</sup>, Dawn Stacey<sup>3</sup>, Gail Macartney<sup>4</sup>, Christina Di Carlo<sup>3</sup>, Lindsey Sikora<sup>3</sup>, Lauren Mulrooney<sup>5</sup>, Maria Gladkikh<sup>6</sup>, Victoria Sanderson<sup>7</sup>, Isabella Zaffino<sup>2</sup>, Kyobin Hwang<sup>6</sup>, Sasha Mazarello<sup>8</sup>

<sup>1</sup> Calgary, Alberta

<sup>2</sup> University of Toronto

<sup>3</sup> University of Ottawa

<sup>4</sup> University of Prince Edward Island

<sup>5</sup> Vancouver, BC

<sup>6</sup> McMaster University

<sup>7</sup> London, Ontario

<sup>8</sup> Ottawa, Ontario

**Background:** Pediatric cancer challenges the entire family system. This systematic review aimed to identify factors related to psychological distress in parents of pediatric cancer patients on active treatment.

**Methods:** Search strategies were entered into six academic databases. Randomized, nonrandomized, quantitative descriptive and mixed-method studies, examining factors related to psychological distress in parents of children with cancer on active treatment were included. Identified factors were coded as per the 4Ps of case formulation.

**Results:** Of the 14,454 articles assessed for eligibility, 79 studies were included in the review. Parental factors identified: 28 predisposing factors; 15 precipitating factors; 41 perpetuating factors; and 16 protective factors. A text-based, narrative synthesis and tabular summaries are presented.

**Discussion:** Findings can support the: (1) recognition of distress exhibited in parents; and (2) the timing of interventions specific to the chronological manifestations of distress in this population.

**Other:** International Prospective Register for Systematic Reviews (PROSPERO) registration number CRD42018109802. No sources of funding to declare.

## P-11

### Use of patient-reported outcomes (PRO)-based nurse-initiated interventions in gynecologic cancer patients receiving systemic therapy – A pilot study

Jann R Stewart<sup>1</sup>, Sue Gill<sup>1</sup>, Penelope Hedges<sup>2</sup>, Anna V Tinker<sup>3</sup>, Ursula Lee<sup>1</sup>, Savitri S Carlson<sup>4</sup>, Jenny J Ko<sup>1</sup>

<sup>1</sup> BC Cancer – Abbotsford

<sup>2</sup> Patient & Family Engagement, BC Cancer

<sup>3</sup> BC Cancer – Vancouver

<sup>4</sup> San Diego State University

**Background:** Evidence suggests that an intervention based on PRO may improve overall survival of advanced cancer patients. We evaluated the effectiveness of nurse-led interventions linked to routine use of Gynecology Clinical Initiative (GCI)-PRO questionnaire in cancer clinics.

**Methods:** This was quality improvement research using the Replicating Effective Programs framework for healthcare interventions. During two pilot periods (2019 and 2021), we collected data on patients in clinic undergoing systemic therapy for gynecologic cancer. Patients answered GCI-PRO questions prior to appointment. The pre-intervention group (PRE) received usual care, while in the post-intervention group (POST) questionnaire answers triggered nurse-led management of symptoms. Quantitative data summarized the number of interventions PRE and POST, while qualitative data were generated by interviewing nurses.

**Results:** During the first period (July-Aug 2019), we included 80 patients in PRE and 28 in POST. 36 (45%) in PRE and 14 (50%) in POST identified worsening or severe symptoms. 6 (17%) in PRE and 7 (50%) in POST received nurse-initiated management. During the second period (Oct-Nov 2021), we included 30 patients in PRE and 12 in POST. In PRE, 3 (10%) had in-person nurse-led management during clinic visit, while 6 (20%) phoned after clinic appointment seeking support. In POST, 9 (75%) had in-person nurse-led management during clinic visit, while 2 (17%) phoned after clinic appointment seeking support. Post-pilot interviews with clinic nurses revealed that the interventions resulted in increased in-person time with patients, more streamlined workflow, and improved identification of patients at risk for adverse outcomes.

**Conclusions:** Our data showed an increase in nurse-led interventions in clinic with the PRO-guided multidisciplinary management of patients with advanced gynecologic cancers. Nurses expressed satisfaction with potential strengths of the interventions guided by the GCI-PRO.

## P-12

### Evaluating the impact of the clinical nurse specialist role on patient care and in the myeloproliferative neoplasm program

Verna Cheung<sup>1,2</sup>, Jaime Claudio<sup>1</sup>, Greg Lindberg<sup>1</sup>, Taylor Nye<sup>1</sup>, Andrea Arruda<sup>1</sup>, Vikas Gupta<sup>1,2</sup>, Dawn Maze<sup>1,2</sup>

<sup>1</sup> Princess Margaret Cancer Centre

<sup>2</sup> University of Toronto

**Background:** Myeloproliferative neoplasms (MPNs) are a group of rare clonal disorders of hematopoietic progenitor cells associated with morbidity from disease-related symptoms, thrombotic events, and risk of transformation to acute myeloid leukemia. The rarity and complexity of care led to the establishment of the MPN program at Princess Margaret (PM) Cancer Centre. The program is a provincial and national referral centre, utilizing a shared-care model and partnering with local hematologist (shared-care partners) is necessary to ensure patients continue receive care close to home. The clinical nurse specialist (CNS) role was implemented to not only support the shared-care model, but also involved in triaging new patient referrals, providing consultation and follow-up. This presentation will provide initial findings of CNS role impact within the program.

**Method:** CNS role impact was evaluated holistically with quantitative and qualitative measures. Quantitative measures involved examining triage data including timeliness of triage and number of referrals accepted versus redirected. Qualitative measures involved obtaining PM team's and shared-care partners' feedback, regarding working with the CNS in the MPN program.

**Results:** Survey response from shared-care partners and PM team were positive. Triage data highlighted timeliness of triage with having CNS involve, and redirecting of inappropriate referral revealed a potential cost savings, with a conservative estimate of \$211,484.25.

**Next Steps:** The next steps for evaluating role impact will involve obtaining patient feedback of having a CNS involved in their care.

## P-13

### Managing the care of uninsured cancer patients during COVID-19 pandemic in Humber River Hospital (HRH) Cancer Clinic

Francis Cacao, Joan Myers-Harrison, Lisa Lun, Rachelle Soogree

Humber River Hospital

On March 11, 2020, the World Health Organization declared a global COVID-19 pandemic. The Ontario government followed suit, declared a state of emergency, and enacted The Emergency Management and Civil Protection Act to protect the health and safety of all Ontarians.

The Ministry of Health (MOH) issued two memorandums: First, hospitals must provide medically necessary services to

those people who do not have health insurance coverage under Ontario Health Insurance Plan or another insurance health plan from other provinces. Second, instructions outlined tracking and paying physicians and hospitals for these services. However, a lack of a clear definition of medically necessary services left hospitals with different interpretations of eligible services. Clinicians also needed clarity on how patients will receive integrated cancer care services during the pandemic.

In collaboration with stakeholders, the hospital's Cancer Program developed a pathway to align with the MOH's directives. Enhancements were made to the hospital's Multidisciplinary Treatment Planning Process for Uninsured (Non-OHIP) Patients, outlining processes and workflows to provide guidance on delivering medically necessary care to uninsured patients in the cancer clinic.

A total of 25 patients were accepted from August 2020 to February 2023. Each patient case was tracked, and drug costs were submitted to the MOH for reimbursement. The learnings and outcomes of stakeholders' collaboration in developing and implementing a multidisciplinary pathway will be shared and discussed.

## P-15

### Difficult conversations in malignant hematology: Modifying the SPIKES framework to support early integration of advanced care planning

Jenna French

Juravinski Hospital and Cancer Centre

Nurse practitioners in malignant hematology are often tasked with disclosing unfavourable information to their patients and families, particularly surrounding diagnosis, relapse, and deteriorating patient condition. Given the medical complexity and life-threatening nature of malignant hematological diagnoses, current recommendations support early integration of advanced care planning to ensure treatment remains patient-centred. When not integrated early, abrupt clinical decline can lead to missed opportunities to meet holistic needs, align care with patient and family values, and support legacy planning. The SPIKES framework is a commonly used protocol to structure the conversation when providing a patient with cancer, and their family, with bad news. This protocol does not incorporate advanced care planning into the proposed steps, leading treatment discussions to occur without exploring the patient values, wishes, or preferences. This research looks to review current advanced care planning frameworks applicable to malignant hematology patients, to integrate within the SPIKES framework. Modifying the SPIKES framework will support early integration of advanced care planning within difficult conversations in malignant hematology to improve patient-centred care.

This research is currently in progress, literature search completed. To be completed for the CANO conference in October.

## P-16

### Development of a nurse-led, high-risk melanoma surveillance clinic

Marilyn MacInnes, Michelle Blue, Karmen Schmidt, Shelley Sass, Megan Armstrong

Cross Cancer Institute, Edmonton, Alberta

High-risk melanoma patients require close surveillance for a number of years after adjuvant treatment. Traditionally, in Cancer Care Alberta, these appointments have been in a physician-led clinic. These clinics are operating over capacity and there is a need for change within the current state of the clinic model.

We propose that a nurse practitioner (NP)/registered nurse (RN) clinic model would be well within respective scopes and could provide the patient with quality, competent care throughout their treatment trajectory. This model is used while patients are on active treatment at the Cross Cancer Institute, a tertiary cancer centre in Edmonton, and could be applied to the surveillance setting.

Within this model, the RN will screen for recurrent disease, provide patient education on prevention, and support patients on their path to survivorship. The NP will perform advanced assessments including physical examination and interpretation of diagnostics, looking for recurrence of disease and any evidence of new disease. We will be seeking out additional educational opportunities to ensure select nurses are specially trained. Utilizing a pool of tumour-specific nurses will also ensure patients have regular visits within the same care team, ensuring continuity of care and improving patient experience.

Established surveillance guidelines will provide the framework for frequency of appointments. These have been approved by the multidisciplinary cutaneous tumour group. A roadmap outlining follow-up visits along with a diagnostic schedule will be provided to the patient, so they can be active participants in their care throughout their cancer journey. The overall purpose of this project is to enhance patient outcomes, encourage survivorship support, and provide continuity of care. As nurses, we are committed to improving patient experience and believe that innovative solutions, such as nurse-led surveillance clinics, are an integral part of how we can achieve this goal.

## P-18

### The patient access clinic for those experiencing symptoms (PACES): Symptom support for patients with uncontrolled symptoms related to cancer treatment

Hannah L. Stracey, Angelina E. Raghubir

Grand River Regional Cancer Centre

Grand River Regional Cancer Centre (GRRCC) provides treatment and support services to individuals living with cancer in the Waterloo-Wellington and surrounding region. As part of GRRCC's initiative to provide individuals with

high-quality and accessible support during their cancer journey, in 2017, the Patient Access Clinic for those Experiencing Symptoms (PACES) was created. This is a referral-based, ambulatory care clinic that is nurse practitioner (NP)-led. This is a highly autonomous, yet collaborative clinic where NPs provide same-day assessments, diagnosis, and interventions for individuals who present with unmanaged and, often times, complex symptoms or toxicities related to their cancer treatment (e.g. chemotherapy, radiation, and/or immunotherapy). The PACES clinic provides patients with rapid and direct access to a highly-specialized and integrated team consisting of one NP with support from registered nurses (RNs). Patients have access to this clinic Monday to Friday between 9 am to 5 pm and are referred by their oncologist. A Referral Decision-Making Tree has been established to help guide referring practitioners on the eligibility criteria for patient referrals. To date the PACES Clinic has seen more than 1,700 patients with 544 visits occurring in the 2021–2022 year. In addition to assessing and managing symptoms, the PACES clinic aims to divert visits to the emergency department, avoid hospital admissions, and provide individualized support to patients and their families throughout their treatment trajectory.

## P-19

### To page, or not to page: Optimizing the management of oncology drug reactions in a large outpatient chemotherapy unit

Raman Sandhu

BC Cancer

**Introduction:** Preliminary data from our Drug Reaction Pager (DRP) Residents showed that many calls for the drug paclitaxel could have been classified as grade 1 reactions according to our BC Cancer Protocol. According to this protocol, Grade 1 reactions do not require infusion interruption or intervention and can be managed by the Registered Nurse (RN) with assessment and monitoring independently. We wanted to assess if RNs were over managing drug reactions and wanted to evaluate if RNs would see the benefit of managing infusion-related drug reactions by using a pager system with a callback number for the DRP Resident.

**Methods:** To provide timely and efficient patient care, we piloted a change to the DRP paging process. The goal for nursing was to initiate a plan or interventions to manage patients for the best possible outcomes on the phone before the resident arrived on the unit. We hoped this would minimize the escalation of symptoms due to timely intervention for our patients and decrease the number of calls the residents had noted as high in their initial data collection. The change required involving key partners: operations, providers, and staff on the unit. Our pilot team introduced the changes to the staff which included documents to support the change, protocol reviews, introducing the project and work at unit-level huddles. This was followed up by four weeks of data collection to evaluate the response and findings.

**Results and Discussion:** Drug reactions were noted to come in waves with various oncology and biotherapy drugs. In looking at the preliminary data; there was consensus in the grading of reactions between the provider and the nurse that aligned. Majority of reactions required intervention, and the provider needed to attend. Nurses and Residents found that communication between the teams increased using this DRP process. This work is ongoing with full data analysis and evaluation in May with plans to implement as part of the permanent workflow.

## **P-20** **Enhancing patient safety: Implementing best practice guidelines for specific blood product administration**

*Amina Malik, Katrina Ayotte*

*North York General Hospital*

Blood transfusion is one of the critical procedures that may result in unexpected and harmful outcomes for patients. It is crucial for the healthcare providers involved in its administration to have knowledge and understanding about the principles of safe blood transfusion practices.

Based on the best practice guidelines of the Ontario Regional Blood Coordinating Network (ORBCON), hospital policy and guidelines to administer blood products were developed and implemented. However, it was observed that nurses were not aware and not consistently following best practice guidelines to administer 25% albumin and various IVIG products.

To address this critical observation, current order sets were reviewed and compared with the policy guidelines, which showed some inconsistency in ordering minimum and maximum rates of albumin 25%, as well as different brands of IVIG. The need was identified to work on current order set and policy guidelines to address discrepancies and create a clear document that is simple and comprehensive to be followed by the healthcare providers involved in prescribing and administering the products. Relevant stakeholders, which included transfusion medicine, nursing and clinical informatics, worked together to review the current order sets and policy guidelines to make them consistent with the best practice guidelines and were sent for approval. The next step was educating all the healthcare providers working in the organization in inpatient and outpatient settings.

For this, the professional practice team was involved to educate nurse educators to be the champions of their own areas, to further educate their own team of nurses. Moreover, use of mobile rowing carts was planned to educate nurses with scenario-based learning and playing games. Work is in progress with a revised policy guideline to be implemented and GO-LIVE on May 30. Project closure is expected in June and, therefore, results will be available in July.

## **P-21**

### **Clearing the haze: Heightening nursing understanding of the side effects of cannabis use and mitigating negative outcomes**

*Samuel Jennings*

*Hamilton Health Sciences*

There is growing literature supporting medical marijuana as a treatment for different unsavory patient experiences like pain, nausea, and vomiting. These are all prominent patient experiences in the oncology setting and it is imperative nurses are familiar with marijuana terminology and any expected or adverse effects of marijuana use. There are several different routes of administration: smoking, vaporizing, ingesting, and applying topically. Each of these routes has its own risks and benefits. There are “natural” and synthetic cannabis products, as well as products with varying levels of active ingredients like CBD or the psychoactive THC. There are expected, and often desired, psychoactive effects like euphoria and somnolence. However, there is the risk for dizziness, hallucinations, dry mouth, and/or confusion with any use of marijuana, and the risk of cannabinoid hyperemesis syndrome. Nurses are positioned to intervene directly in any safety risk situations in the inpatient setting, and are able to offer health teaching about safe use of marijuana in an outpatient setting.

## **P-22**

### **Navigating peritoneal malignancies: A patient guide to Ontario's Peritoneal Surface Malignancy Program**

*Sophia Aksenchuk*

*Mount Sinai Hospital*

Ontario Peritoneal Surface Malignancy Program was established in 2011 and serves adults (18 years of age and older) with a diagnosis of peritoneal cancer (malignant peritoneal mesothelioma, appendiceal, small bowel, and colorectal cancers). The program includes surgical oncologists, residents, a fellow physician, and a nurse clinical coordinator. The program is one of nine in Canada, and the only one in Ontario, to offer hyperthermic intraperitoneal chemotherapy (HIPEC) with cytoreductive surgery.

A quality improvement project was completed by a nurse coordinator to provide patients with a care pathway that assists in learning about and navigating our program. An infographic and patient guide were developed. This poster presentation will display the rationale, development, and outcomes of the guide. This knowledge will support the development of patient education resources and care pathways.

## P-23

### **Bridging the gap: Using a specialized nursing role to mentor new surgical oncology nursing hires**

*Barb Laughland, Kelly Nancekivell, Len Potts, Janny Proba, Ryanna Sparks*

*Hamilton Health Sciences*

This facility provides surgical oncology care for patients in various stages. The role of the resource nurse was implemented to offload the pressure for preceptors during the initial stages of orientation. This role augments the role of the educator, as it provides timely, at-the-elbow support for new hires. The resource nurse provides problem solving support, mentorship and surgical oncology skill development. Many novice nurses experience a crisis transition shock phase within four to six months after orientation ends, which leads to poor retention. Professional socialization is also required to help develop organizational commitment.

Traditionally new hires are paired with a preceptor, starting with a single patient assignment and build to a full complement. This left little time for professional socialization and surgical oncology skill development. Of the current nursing workforce, 68% has less than three years' experience, while 40% had less than one year of experience. To bridge this gap, the resource nurse uses a novel approach to orienting new hires. The new hires now engage in a two-phased orientation where they spend a week with the resource nurse gradually immersing into the clinical unit. This initial phase involves learners in cohort groups where bonds are formed through sharing of professional and personal experience and scaffolding of clinical skills. These new learners develop professional identity because professional socialization and engagement occurs through purposeful activities.

It is imperative to provide a supportive learning environment for developing nurses for empowerment. Dedicated time to learn team members/roles, environment and workflow eases feelings of overwhelm, and allows for social and professional engagement. This allows new hires to take responsibility for their learning while also feeling comfortable to ask for and receive mentorship support. Developing an environment that is supportive to new hires helps increase retention.

## P-25

### **An innovative collaboration: An artist and a nurse. Using art as a medium for palliative and end-of-life care**

*Jocelyn Brown*

*Princess Margaret Cancer Centre*

Jocelyn Brown, a Clinical Nurse Specialist (CNS) in Palliative Care, and Ramune Luminaire, an artist, collaborated to create a Book, "Love & Loss", and Art Exhibit. They were paired together by Taboo Health which is a collective of healthcare policy makers, strategists, designers, artists, and healthcare storytellers. The purpose of Taboo Health, specifically their program Collaborate for Change, is to bring the

healthcare, and social good sector with the social good sector with the creative industry. The CNS and artist developed an art project that was used to promote change with the public perception of palliative and end of life care. Jocelyn has worked as a CNS for 14 years and has used journaling to help enhance her self-awareness and provide space for self-expression. Luminaire created 14 pieces of artwork- pastel, paintings, linocuts, drawings, mono prints and photo transfers as a response to Brown's personal journal writing reflections about her nursing work, the art pieces include illustrative and purely intuitive works. The book and art exhibit have become a unique way to discuss the use of writing and art as a tool for healthcare providers to enhance self-expression, reflection and self-awareness and therefore increase resiliency. It has provided a unique medium to provide palliative and end of life care education to the public from a nursing perspective and this will be the focus of the presentation or poster.

## P-26

### **Specialized oncology nurses: Optimizing their role in sexual health assessment**

*Theresa Zapach*

*BC Cancer*

Despite the significant changes that a diagnosis of cancer and its treatment have on sexual health and quality of life, it is frequently unaddressed with clients. Specialized oncology nurses are well positioned to incorporate this into their role. However, they lack the specialized education and competencies to provide evidence-based and culturally safe sexual health assessment and interventions. A literature review was conducted to inform and make recommendations to oncology nurses, educators and leaders of the need for specialized sexual health education and competencies to improve the outcome of clients undergoing cancer treatment. The identified barriers to integrating sexual health assessment into practice are; the need for specialized education in sexual health and rehabilitation, cultural safety awareness to address the needs of clients with diverse cultural backgrounds including sexual and gender minority client populations, and a lack of allocated clinical time to address sexual health needs. The Permission Limited Information Specific Suggestions Intensive Therapy (PLISSIT) model and best practice guidelines are outlined to assist oncology nurses to provide competent sexual health care. In addition, application of the Knowledge to Action Process demonstrates how oncology nurses, in collaboration with their leaders, may successfully translate their sexual health knowledge into practice.

## P-27

### More than just chemo teaching: Providing education to patients newly starting systemic therapy

Carolyn Fifield<sup>1</sup>, Heather Brander<sup>1</sup>, Alice Fortune<sup>1</sup>, Amanda Harbers<sup>1</sup>, Jeannie Kennedy<sup>1</sup>, Sarah Lace<sup>1</sup>, Susan Loveless<sup>1</sup>, Mary Kate MacDougall<sup>1</sup>, Rhonda McNeil<sup>1</sup>, Kim Poirier<sup>1</sup>, Josee Rioux<sup>1</sup>, Rachel Sarty<sup>1</sup>, Philip Shaheen<sup>2</sup>, Vanessa Valentini<sup>1</sup>, Paula Watkins<sup>1</sup>

<sup>1</sup> Nova Scotia Health Cancer Care Program

<sup>2</sup> Nova Scotia Health Pharmacist

As systemic therapy treatment options become more complex and patient volumes increase, educating and empowering patients to recognize and manage side effects has become a key pillar in safe care. The Nova Scotia Health Cancer Care Program (NS Health CCP) has updated its approach to education for patients newly starting systemic therapy that is:

1. Provincially standardized to provide consistent messaging to patients across multiple treatment sites and disciplines,
2. Reflective of the variation in treatment options including resources designed for all patients starting any type of systemic therapy plus specific resources focusing on chemotherapy, immunotherapy, and oral anti-cancer agents,

3. Adaptable to multiple learning styles with options for self-guided online information, such as video education sessions, as well as written resources,
4. Accessible by any member of the healthcare team during group or one-on-one teaching sessions with patients.

A robust review process during development incorporated feedback from key clinical representatives providing a multi-disciplinary and provincial lens on content. Members of the NS Health CCP Patient and Family Advisory council were highly engaged in the development process, which led to significant improvements in resource content and structure, as the lived experience of past patients highlighted the key priorities for education of new patients. An evaluation framework, collecting data from both patients and healthcare providers was also applied to measure changes in patient access to standardized education resources and in perceptions of preparedness prior to starting systemic therapy treatment.



Canadian Association of Nurses in Oncology  
Association canadienne des infirmières en oncologie

## **CANO NATIONAL OFFICE BUREAU NATIONAL DE L'ACIO**

Canadian Association of Nurses in Oncology, Association canadienne des infirmières en oncologie,  
750 West Pender St., Suite 301, Vancouver, BC V6C 2T7  
Telephone: (604) 874-4322, Fax: (604) 874-4378, E-mail: cano@malachite-mgmt.com

## **BOARD OF DIRECTORS CONSEIL D'ADMINISTRATION**

**President:** Lorelei Newton, lorelei@uvic.ca

**Vice-President:** Catriona Buick, cbuick@yorku.ca

**Treasurer:** Simonne Simon, simonne.simon@uhn.ca

**CONJ Editor-in-Chief:** Margaret Fitch, marg.i.fitch@gmail.com

**Director-at-Large, Research:** Manon Lemonde, Manon.Lemonde@ontariotechu.ca

**Director-at-Large, Professional Practice:** Kara Jameison, Kara.jamieson@nshealth.ca

**Director-at-Large, External Relations:** Andrea Knox, AKnox@bccancer.bc.ca

**Director-at-Large, Education:** Sarah Champ, sarah.champ@albertahealthservices.ca

**Director-at-Large, Membership:** Jodi Hyman, jhyman3@cancercare.mb.ca

**Director-at-Large, Communications:** Joy Tarasuk, joy.tarasuk@nshealth.ca

**New Membership:** Gayatre Maharaj, gmaharaj@bayshore.ca

**New External Relations:** Jodi Hyman, jhyman3@cancercare.mb.ca

**New DAL – Advocacy & Equity:** Stephanie Lelond, slelond2@cancercare.mb.ca