Cancer Nurses College
NEW ZEALAND NURSES ORGANISATION

COMMUNICATING & NETWORKING FOR HAEMATOLOGY & ONCOLOGY NURSES ACROSS NEW ZEALAND

AUGUST 2018

cancernet

Editors' note

Welcome to the winter edition of Cancernet.

July has been an eventful month for all of us as members of NZNO with the industrial action already undertaken and this follows us into August. I hope you have all experienced strong, positive support during this time. Industrial action is never easy for any nurse to face. I hope for a resolution that recognises our worth, so we can continue to provide excellent care in a sustainable environment - one that cares for us while we care for others.

This edition highlights recent endeavours of some of our cancer nurse colleagues nationally. We have a research report article from Sue Morel on PICC-related skin reactions and chemotherapy which she undertook as part of her post-graduate study. Sue has completed her Master of Health Science after submitting this piece of work – congratulations Sue.

We welcome Kate Whytock as the newest CNC Committee member and she has provided her profile, so you can get to know her a little better.

Jo Tuaine provides us feedback on her attendance at the CNSA conference this year and Natasha Chisholm fills us in on a radiobiology course she attended. Congratulations to Natasha who has also just become an RN prescriber.

We are aiming to provide you with updates from the three cancer clinical advisory working groups who support the work of the Ministry of Health by providing a clinical cancer perspective. This edition features a report from the Haematology Working Group kindly written by Anita Wootton one of the current nursing representatives. These reports help provide a national cancer lens to work going on in cancer care at other levels that many of us would not otherwise know about.

There is a brief snippet on what the CNC committee are up to leading into the ISNCC conference in September. We are also considering running a study day/s in Wellington in 2019, in conjunction with the BGM - details TBC.

The ISNCC 2018 conference is not far away... September 23-26! We hope as many of you as possible have found the opportunity to attend.

We would love to hear from you on cancer nurse's achievements, which often happen quietly, or on the proposed study day/s or issues you may want us to look at in Cancernet in the future, please email us: cancernursesnz@gmail.com

Your Cancernet Editors
Sarah Ellery and Kirstin Unahi

RESEARCH REPORT

PICCs, skin and chemotherapy - **friends or foes?**

Cancer treatment often requires the presence of a stable intravenous access device that can be used for the delivery of chemotherapy or targeted therapies as well as providing a means to administer supportive cancer therapy such as antibiotics, blood products and TPN.

Central venous access devices (CVADs) are required for infusional chemotherapy and are identified as a cost-effective way of delivering chemotherapy to individuals in hospital or to those able to receive treatment from ambulatory cancer services.

Peripherally Inserted Central Catheters (PICCs) have become a reliable type of long-term venous access for oncology patients. Reducing the risk or incidence of known PICC complications reduces patient and family anxiety and means treatment can be delivered without delay. Any complication related to the PICC such as thrombosis, infection or migration could lead to increased institutional costs and interruption to or even premature cessation of treatment which may adversely affect a patient's outcome.

As a Master of Nursing (MN) student looking to complete a research report as my final requirement I approached the senior nursing team of the Canterbury Regional Cancer & Haematology Service (CRCHS) and asked if they could identify a clinical question I could examine.

The CRCHS have a prospective CVAD audit and were interested to see if I could formulate a question that explored the possible relationships between PICC site skin reactions and chemotherapy regimens.

The question reached - ***What effect do cytotoxic drugs have on PICC site skin reactions in the adult oncology patients receiving chemotherapy within the CRCHS?***

Why ask the question?

Anecdotal belief from oncology practitioners indicated patients receiving certain cytotoxic therapies appear more likely to develop a PICC skin reaction.

The aims were to identify:

- Is there evidence within the CRCHS CVAD audit that

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RESEARCH REPORT

PICCs, skin and chemotherapy - **friends or foes?**

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can demonstrate this belief?
- Does the wider literature support such thinking?
- If so are there recommendations to reduce risk and improve outcomes?

The literature review looked at identifying complications of PICCs to see if the skin reaction rates were like those the CRCHs encountered.

There was clear identification of the main complications of PWO, thrombus, migration and infection but little if any data about skin reactions. For example, the literature contained some qualitative research in which patients described how they felt about their PICCs (Alpenberg et al, 2015).

There were descriptions from patients of irritation, itchiness and increased frequency of dressing changes. I wanted to know why skin reaction appeared not to be an identified complication.

My belief is that rates of PICC-site skin reactions are lost in the recording of CVAD-related infections but unfortunately no research was located which identified the source of the CVAD infection as having come from a pre-existing skin complication.

The next part of the literature review explored the relationship between chemotherapy and the skin. I described the function of the skin and the intrinsic and extrinsic factors which influence the loss of skin integrity. The review identified the cytotoxic drugs with known skin toxicities and the likely influencing variables involved in PICC skin reactions such as dressing or cleansing allergies and procedural variations.

Method:

The research investigated Christchurch Oncology Service audit data on PICC complications (March 2015 - May 2017). Each identified skin reaction was examined to determine gender, chemotherapy type and cancer diagnosis. Quantitative data analysis provided descriptive statistics in percentages/counts and tests of proportions using the Pearson's chi square test.

Results:

The study found that of 416 PICCs inserted for chemotherapy administration, 74 recorded complications (18%) of which 29 (6.9%) were identified as skin reactions.

Gender distribution was 76% female and 24% male.

Skin reactions were seen in five identified cancer types: colorectal (48.3%, 4); ovarian (3.4%, 1); oesophageal (6.8%, 2); breast (37.9%, 11); and pancreas (3.4%, 1).

The types of chemotherapy given to the audit patients were identified as 8 different regimes: Doxorubicin (6.8%, 2); paclitaxel (27.6%, 8); and five regimens all containing a combination of drugs, one of which was 5FU in all cases (58.4%, 18).

The remainder of entries had unidentified drugs (6.8%, 2).

No significant associations were found between skin reaction and chemotherapeutic agent.

The main recommendations from this report were that a more rigorous audit be performed describing PICC complications, containing consistently recorded details including but not limited to diagnosis, treatment regimens, allergy status, interventions and results.

This report did not uncover a recognised assessment and intervention tool. The development of one would contribute to research and practice advancement that will improve patient outcomes.

Sue Morel, Gynae-oncology CNS, Christchurch Hospital

Reference: Alpenberg, S., Joelsson, G., & Rosengren, K. (2015). Feeling confident in using PICC lines: Patient's experiences of living with a PICC line during chemotherapy treatment. *Home Health Care Management and Practice,* 27 (3), 119-125.

Report from the chair

Welcome to this edition of Cancernet.

Welcome to this edition of the Cancernet. I am currently enjoying a few warm sunny days in Vietnam.

ICCN conference planning continues. I am so pleased that many of you are planning to attend. Some of you have received grants from the College education fund and we anticipate some wonderful conference reports. Further requests for grants will be reviewed at our next meeting August 31.

Moira and I are on both on the organising committee and the sponsorship committee. The programme sessions are full of exciting presentations and you will need careful planning as I learnt last year when I attended in Anaheim.

We and the Cancer Nurses Society of Australia are responsible for the first plenary session. We are focusing on global equity and access to cancer care and treatments and have invited an expert panel to give perspectives from their global area.

Thank you to Auckland Hospital for allowing conference attendees to visit the Cancer Centre. Their was immediate response for the limited registrations and it is hoped a second tour will be confirmed. Unfortunately we cannot accommodate all those wanting to attend.

Committee work remains a priority and I thank your committee members for their contributions and expertise to progress ongoing projects.

Enjoy this edition of the Cancernet and kind regards to you all.

Judy Warren
Chairperson, NZNO CNC

NEW CNC COMMITTEE MEMBER PROFILE

Kate Whytock

Kate is a southern-trained NZ nurse with almost 25 years experience, with the last 15 years spent growing both her paediatric and adult oncology expertise at Capital & Coast DHB in Wellington.

Kate has been a CNS Cancer Nurse Coordinator since the initiation of the Faster Cancer Treatment (FCT) Initiative in 2013. A key stakeholder in the development of CCDHB's FCT target data, she also designed process mapping used to audit the different tumour streams and identify system issues against the National Tumour Standards.

Kate provides care coordination, navigation, health literacy and support to patients and whanau with sarcoma and upper GI/HBP cancers. With a strong equity focus she works collaboratively across surgical and oncologic specialties, including inter-DHBs.

Currently she is contributing to design and development of an IT prospective tracking tool to track patients along their cancer pathway to improve timeliness to diagnostics and treatment.

During the 6 years as Clinical Nurse Educator at Wellington Blood & Cancer Centre, Kate trained, certified and supported nurses in chemotherapy administration.

She contributed to the EVIQ Anti-neoplastic drug administration (ADAC) pilot, becoming an EVIQ facilitator to provide a standardised evidenced-based chemotherapy certification.

She is currently affiliated with the National Upper GI Special Interest group and holds a PGDip in Clinical Nursing and will continue with her Master studies. Kate's other loves are snow-boarding, yachting and raising her daughter.

Kate is excited to be welcomed aboard the committee with a keen interest in developing national collaboration to advance cancer nursing in New Zealand, improve the patients/whanau experience and cancer outcomes.

CNC committee meeting report

The CNC committee meets 3-4 times annually, generally in Wellington. The last meeting was May and this provides a brief overview from that meeting.

There are a mix of standing items discussed along with new items which may have arisen since the previous meeting. Some of those covered at this meeting:

- *The ISNCC conference here in September. The CNC are considered the host for this and three CNC committee members have been working with the ISNCC conference committee to assist in organising this global cancer nurse meeting*
- *Discussion on the MECA negotiations with our professional nursing advisor (PNA) Anne Brinkman, Grant Brookes and Kerry Nuku*
- *Education grants to be given – 12 in total this meeting (great to see people applying for the grants)*
- *Work on developing and sustaining Memorandum of Understanding's (MOU's) with HSANZ and CNSA*
- *Discussion with Marilyn Head (NZNO) on the submission process (there are generally quite a number of consultation documents sent for us to consider if a submission from the CNC is relevant each quarter)*
- *Updates on the survivorship working group work, KSF review*
- *CNC website to be updated to a more user friendly format with sustainable resource to make changes in a timely manner*
- *Visit – Vanessa James from MoH cancer services to discuss work on developing a standard of care for cancer patients. This is in early stages and will align with the cancer strategy the new Minister of Health has asked for.*
- *Current membership: 612*

There will be a one day meeting August 31st.

Closed system drug transfer devices

Occupational exposure to hazardous drugs can decrease fertility and result in miscarriages, stillbirths, and cancers in healthcare staff. Several recommended practices aim to reduce this exposure, including protective clothing, gloves, and biological safety cabinets ('safe handling'). There is significant uncertainty as to whether using closed-system drug-transfer devices (CSTD) in addition to safe handling decreases the contamination and risk of staff exposure to infusional hazardous drugs compared to safe handling alone.

The Cochrane Work Group has published a new review, examining the evidence on the handling of hazardous medicines. Kurinchi Selvan Gurusamy, from UCL Medical School in London England, tells us what they found.

Click here to listen to the podcast

CNSA Annual Congress
Brisbane, June 2018

CONFERENCE REPORT

In June I had the opportunity to attend the CNSA Annual Congress in Brisbane. This is the Cancer Nurses Society of Australia annual meeting. This year is it was held in Brisbane and was the 21st Annual Congress.

I wish to acknowledge the New Zealand Cancer Nurses College who gave me a grant to help fund my attendance at the meeting. I wish also to thank my management of Therese Duncan and Lynda Dagg who also supported me to attend this meeting.

The themes of the congress were Science, Symptoms and Service Delivery. The program was diverse and the line-up of speakers included international and local Australian nursing experts. There was also a strong collaboration with industry partners to highlight improvement in outcomes for patients with cancer.

Glenn McGrath who is president of the McGrath Foundation presented the opening address. Glenn gave at times an emotional and personal account of the development and establishment of the McGrath Foundation. He spoke about the personal challenges that spurred him and his late wife to try and improve the support and care for families with breast cancer.

The McGrath Foundation supports families going through breast cancer and the foundation has led to the establishment of the McGrath Breast Care Nurses. Glenn participates on a voluntary basis. It was an inspiring and emotional start to the congress.

There was a diverse range of presentations at the meeting, including sessions on radiation therapy, models of care, service delivery improvements, immunotherapy and the latest developments in this new emerging field of treatment, survivorship and palliative care. The organising committee had attempted to provide a wide range of topics to cater for the many different aspects of cancer nursing.

There was quite a focus on radiation nursing which I was very please to see as often radiation nursing is seen as second class to medical oncology. Included in the radiation sessions were presentations on chemo/radiation, what it is and the increasing use and importance of timing of treatments. There was also focus on head and neck cancer and the management of these complex patients and discussion on best practice. At times these were stimulating sessions with diverse views been expressed?

Of particular interest is the development of a radiation knowledge and skills framework that the Australian Cancer Nurses are working on. I found this of particular interest and believe that the New Zealand Cancer Nurses College needs to follow these developments closely and work in conjunction with our Australian colleagues as this framework is being developed.

I do not have the ability to comment on all of the major sessions or presenters in a small report but Professor Christine Miaskowski from the University of California was inspiring and her two keynote presentations were a revelation. She is an international expert in pain and symptom management research. She is a nurse scientist whose field of research is in symptoms clusters and symptom burden. The use of genome technology analysis is ground breaking. She is researching this technology to identify those individual most at risk of symptoms from treatment and those patients who do not develop side effects and as a consequence of this work has lead the research in symptom cluster and symptom burden.

Her presentations were informative and inspiring. I understand her presentations will be online in the near future.

There was also a presentation on immunotherapy and understanding this modality and side effect management of these drugs. Other topical presentations were on financial toxicity, which I found interesting and relevant to our own context in New Zealand.

The congress was stimulating and interesting and it is good to know that New Zealand care is competing at the highest level.

Again I wish to thank the College and my managers for assisting me to attend this congress.

Jo Tuaine

ESTRO Basic *(or not!!)*
Clinical Radiobiology Course

I have worked within the Oncology/ Haematology environment for more than 12 years, having recently taken up a newly created 0.6FTE position of Clinical Nurse Specialist Radiation Oncology.

With a new position comes new learning; whilst developing and advancing clinical nursing knowledge, assessment and management of side effects and toxicities patients experience whilst undergoing radiotherapy, I identified gaps in my learning. How does radiotherapy work? What is occurring at a cellular level? What cellular processes are causing patient symptoms and toxicities – just to name a few.

I believe having an understanding of the above enhances one's ability to understand and predict certain symptoms and the timeliness of these occurring, thereby resulting in increased accuracy of nursing assessment and timely intervention.

There appears to be a paucity of educational opportunities in the arena of radiation oncology specifically directed at the nursing profession. Both the Oncology Nursing Society (ONS) and the European Oncology Nursing Society (EONS) view radiation oncology as an innovative and rapidly evolving discipline which poses specific challenges for nurses from an education perspective.

Therefore, with the goal of increasing my radiobiology knowledge this course was recommended to me by a clinical supervisor and with the support of NZNO Cancer Nurses College and Oncology Trust. I attended the European Society of Radiotherapy and Oncology (ESTRO) Basic Clinical Radiobiology course in Melbourne over 10th-13th May 2018.

Nearly 100 attendees from a variety of professions including radiation oncology registrars, physicists and radiation therapists attended.

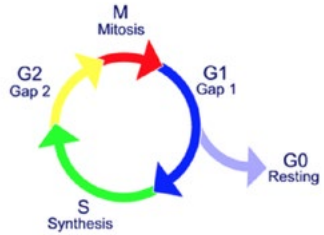
The course consisted of four full days of comprehensive learning led by an international faculty providing education on the underlying principles, latest developments and practical application of clinical radiobiology.

All four main presenters consistently reemphasised the basics of radiobiology focussing around the "R"s of radiobiology. Initially this started with four "R"s - Repair, Redistribution, Repopulation and Re-oxygenation, a fifth was later added - Radio-sensitivity, and a further three are now considered essential components of radiobiology - iRradiated volume, Restoration and re-iRradiation.

The first four "R"s are principles which explain the foundation behind fractionated radiotherapy and the dose-rate effect. Delivery of ionizing radiation can result in three types of cellular DNA damage – (1) lethal damage which is irreversible and irreparable and leads to cell death; (2) potentially lethal damage which could possibly result in DNA repair in certain environmental conditions; and (3) sub-lethal damage in which DNA repair can occur if sufficient time between dose and environment conditions are allowed.

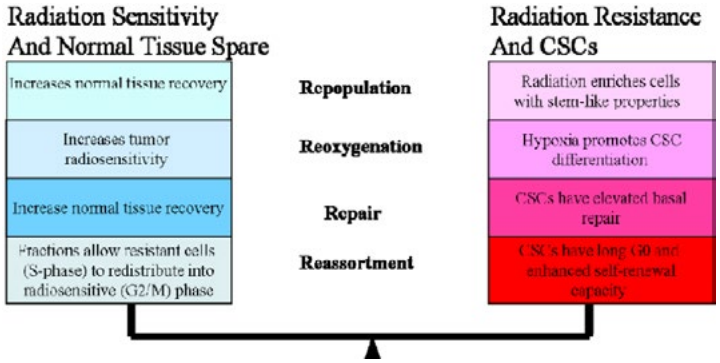
Cellular repair occurs via a complex series of pathways that relies on the ability of cells to recognise damage/injury and activate the repair pathways and cell cycle arrest.

Cells are most radiosensitive during the G2 and mitosis (M) phase of the cell cycle and most radio-resistant during the synthesis (S) phase, especially late S phase, of cell cycle. *Redistribution/ Reassortment* of proliferating cells can increase cell kill if cells are caught in a sensitive phase of cell cycle after each fraction of radiotherapy.



Cellular damage and death may induce an increased rate of cellular *proliferation/repopulation*, this is especially significant in tumours capable of rapid proliferation i.e. GI tract, skin, oral mucosa. It was reported that accelerated repopulation occurs approximately 2-4 weeks after commencement of radiotherapy, thereby providing a clear and proven rationale for conventional fractionation and current standard treatment times.

The presence of oxygen in malignant cells enhances lethal radiation damage, whereas DNA damage may be repaired in hypoxic cells. *Re-oxygenation* occurs as the tumour shrinks in response to radiotherapy and previously hypoxic cells become better oxygenated. It is of general consensus that hypoxia contributes to radiation resistance.



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ESTRO Basic *(or not!!)* Clinical Radiobiology Course

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This introduction led in nicely to the first of two presentations discussing cellular hypoxia; the first was by Dr Brad Wouters who spoke on hypoxia and the micro-environment.

He reported on a number of trials conducted that demonstrated hypoxia was a strong negative prognostic factor for overall survival in patients with cervical, uterine and head and neck cancers. It is thought that tumour cells respond and adapt to hypoxia which in turn, alters their biological properties by stimulating angiogenesis and metastasis thereby increasing the radiation resistance and malignancy of those cells.

Professor Karin Haustermans followed on by discussing current clinical approaches to modify tumour hypoxia. Many clinical trials have been conducted in an attempt to overcome the radiation resistance demonstrated in hypoxic cells, including the administration of supplementary high oxygen content breathing gas, chemical radiosensitisers, blood transfusions, erythropoietin's, all of which have shown mixed results.

A number of early studies including the MRC HBO trial demonstrated superior local control of disease in patients with stage III cervical cancer when radiotherapy was delivered concurrently with hyperbaric oxygen. These studies fell along the wayside with the introduction of bioreductive drugs such as nitroimidazoles which chemically radiosensitises hypoxic cells by mimicking the effect of oxygen.

The DAHANCA 5 study demonstrated concurrent Nimorazole and radiotherapy significantly improved loco-regional control in patients with pharynx and supraglottic carcinoma. As a result of this trial, Nimorazole is now part of the standard treatment schedule for head and neck tumours in Denmark; this drug is not currently licenced outside of Denmark.

Currently studies are continuing with trials reviewing the effectiveness of the use of Carbogen (a gas of 98% oxygen and 2% carbon dioxide) in head and neck cancers which are showing positive outcomes.

Multiple studies have demonstrated low haemoglobin levels are associated with reduced local-regional tumour control and poor prognosis.

The DAHANCA 5 trial additionally observed the effect of low haemoglobin and transfusion in patients with head and neck tumours, demonstrated that haemoglobin levels were raised with transfusion during radiotherapy. However, surprisingly, transfusion was unable to improve the effect of radiotherapy, local regional control and overall survival in this patient group.

A 2009 Cochrane review demonstrated that erythropoietin plus radiotherapy has a negative influence on outcome compared to radiotherapy alone; as a result it is recommended that erythropoietin should not be administered in addition to radiotherapy outside of the experimental setting in patients with head and neck cancers.

Dr Brad Wouters closed the presentations with a presentation on 'How do we continue to improve outcomes'. He controversially suggested that 'significant improvements will come from biology – not technology/physics'. He demonstrated the impact and advances physics has had on radiotherapy over the last 20 years and believes the future lies in combining molecular targeted therapies and immunotherapies to enhance radiotherapy.

I am exceptionally grateful for the support I received from my employer, Oncology Trust Fund and NZNO Cancer College that facilitated my attendance in Melbourne.

I found attending this workshop extremely valuable as an introduction to the basics of a very technical and comprehensive subject not traditionally taught to the nursing profession.

I believe as I continue to consolidate the knowledge gained from this workshop this will have positive implications to my nursing practice and care delivery to patients undergoing radiotherapy.

From here, I plan to incorporate basic radio-biology into the radiation oncology nursing orientation package, with the aim of providing nurses working within this ever evolving nursing speciality a more comprehensive understanding of radiation and its expected and potential side effects, thereby enhancing the patient centric nursing service available to oncology patients undergoing radiotherapy as a treatment modality for their cancer diagnosis.

It would be optimal if we, as a national speciality nursing group, could develop online modular education resources that could be used in conjunction with current local and international clinical resources.

References available if interested, feel free to contact me.

***Natasha Chisholm** RN MHSc – Nursing/Clinical*
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MEETING REPORT:

Haematology Working Group (HWG)

1. Pharmac update

An update on current funding applications was provided by two representatives from Pharmac. The specific details of this discussion remain confidential. However one of the clear messages from the clinicians was that priority focus should be given to at-risk population groups, where current funded therapies are absent or sub-optimal. Implications for nursing taken from the overall discussion with Pharmac, include the following:

- *New therapies within the context of haematology continue to be approved. This will impact clinical resources within the context of haematology, with hospital treatment centres already working at (and beyond!) capacity.*
- *Cancer nurses who are responsible for the administration and monitoring of patients receiving new therapies will need to develop their knowledge and have access to education opportunities for these new anti-neoplastic agents.*
- *A new oral anti-coagulant is about to be introduced on 1 August 2018. The HWG requested that Pharmac make it a priority to prepare a set of national clinical guidelines, that includes an approved antagonist, to be available to clinicians when this new agent becomes available.*
- *It is important that nurses working in haematology maintain an awareness of clinical trials activity. In particular - clinical trials often require inter-DHB travel. Therefore patient advocacy, navigation, care-coordination and communication are paramount.*

2. Ministry of Health - National Cancer Programme

Scott McFarlane provided an overview of the National Cancer Programme work plan. Scott described how the new government, means we have a new Minister of Health whom has requested a new cancer strategy is written by 30 June 2018.

Scott explained that this is the first opportunity we as stakeholders have to influence the national cancer service landscape since 2005. He went on to say that a new cancer service work plan will follow on from the release of the new cancer strategy. This will encompass a significant focus on equity, which the new government has as a key priority area. His broad ideas for such a work plan include an examination on the governance of cancer in NZ, better national connectivity, and a revision of the current 'standards of practice' to a philosophical shift that includes models of aligned thinking and practice.

Scott explained that the national tumour standards for service provision released in 2013 had varying uptake, and were never fully implemented, hence they are being re-examined. The tumour streams of bowel, lung and urology are a priority. Gaps exist for neurological tumours, and neuro-endocrine tumours.

Scott provided an update on the Cancer Health Information Strategy (CHIS). Activity continues particularly in the areas of clinical indicators and the cancer registry.

An agreement for a Radiation Oncology minimum data set has been reached. This includes data from the radiation oncology private sector, which will enable a more complete view to be available and will identify variance across service providers.

Jane Lyon presented an update on Faster Cancer Treatment (FCT). Jane explained that a review is happening which will consider what the next step is for the health targets from 1 July 2019. National achievement against the cancer health target is currently 93%. Jane outlined that work to standardise FCT reporting mechanisms nationally remains ongoing. Jane then went on to acknowledge the work of the Central Cancer Network in the area of survivorship - which includes the release of a national survivorship statement that focuses on quality, not merely duration.

3. BMT national service plan

The HWG discussed the draft document which Richard Doocey (HWG chair) has been developing. This is intended as a companion document to the original BMT national service plan written in 2011. The companion document provides updated data from the ABMTRR (Australasian Bone Marrow Transplant Recipient Registry) and resource modelling to inform national service planning in response to the growing demand in haematopoietic stem cell transplantation in New Zealand. This has service-wide implications, including workforce planning relevant to the whole multidisciplinary team, including nursing.

The group agreed with the current draft, which Richard will now submit for publication through the Ministry of Health, and will be available on the MoH website in due course.

4. Guidelines for National Haematology FSA Referral and FCT Data Reporting

The HWG discussed the draft document developed by Richard Doocey (HWG chair) and Anita Wootton (HWG Nursing representative). The document has been previously discussed and reviewed by the HWG. The group is in agreement with the latest iteration, which Richard will now submit for publication through the Ministry of Health, with a view to this being available to the MoH website in due course.

The group agreed to socialise the final document within their own regional departments. With the view that this document will support national consistency in haematology FSA referral management, which in turn will augment robust FCT data reporting within the haematological tumour stream. Nurses working in haematology services, particularly those dealing with FSA referral's and FCT will hopefully find this document helpful.

5. Access and delivery of privately funded drugs/therapies in public hospitals

The HWG discussed the combined public and private care of cancer patients in NZ. The topic was actively debated, largely through the use of anonymised clinical examples shared by the haematologists.

Concern was raised regarding treatment centres already at capacity. The group agreed that clarity around what the MoH's current official position statement is regarding this topic is required ASAP. This is important in the current landscape of novel therapies,

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MEETING REPORT:

Haematology Working Group (HWG)

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and clinical trials. Nurses working in haematology, as well as our medical colleagues can field questions from patients regarding private treatment, therefore will also benefit from being informed as to what this official MoH position on this topic is.

6. Iron infusions

The HWG discussed a draft memorandum developed by Richard Doocey (HWG chair) re: Iron infusion delivery at Haematology Departments in NZ hospitals. The memo is a position statement from the HWG, in response to the increasing demands placed on hospital haematology departments to provide intravenous iron infusions.

The memo recommends that referrals for intravenous iron infusions for non-haematological conditions are transferred to more appropriate services such as gastroenterology, general medicine, and gynaecology. The memo was endorsed by the group, and will be sent to DHB's nationally.

7. Dental interventions in the context of Haematology

The HWG discussed the draft document titled: 'NZ Haematology patients' Dental and oral health management'. Responses from the group indicated variability in access and service provision of dental care for haematology patients nationally. The group endorsed the document, which will be send to DHB's nationally to provide best practise recommendations accordingly.

8. Early Warning Score (EWS) Chart

The HWG discussed the national roll out of observation charts that include the EWS system. The general feedback was positive. Examples were given which described how the parameters could be modified within the context of haematology/oncology eg: to accommodate high temperatures in the febrile neutropenic patient. It was suggested that any modification to clinical parameters is authorised and documented by medical staff, and on a case by case basis.

9. Hospital Pharmacological Society Intrathecal Chemotherapy document

The HWG was attended by two representatives (Kim Brackley and Maxine Handford) from the New Zealand Healthcare Pharmacists Association. The two pharmacists gave a short presentation on their draft document titled: Recommendations for the safe administration of intrathecal chemotherapy in New Zealand.

Whilst the project is being driven by the pharmacists association, the document has implications across the MDT including medical and nursing staff. The HWG provided verbal feedback. The general consensus from the group was positive. Everyone was in agreement that evidenced-based guidelines based on best practice was a step in the right direction toward patient safety.

Kim and Maxine explained they will continue to develop the document accordingly and indicated they may look at establishing a work group that includes consultation with not only pharmacists, but also representation from medical and nursing sectors. This strategy was supported by the HWG.

10. Haematology Nursing Workforce

An Auckland-based Haematologist raised this item for discussion by the HWG, based on their experience that it is becoming a struggle to find 'suitably qualified' nurses.

This haematologist was at the meeting and explained that she was referring to nurses who were chemotherapy trained. This observation sparked a lively discussion among the HWG regarding the haematology nursing workforce in general. Several haematologists remarked that they thought EviQ was now the only chemotherapy training/certification used in New Zealand, but had since been informed that although EviQ had been adopted by many DHB's, there may be some cancer treatment centres who are not using this platform.

Several haematologists remarked on the different nursing skill sets required in different clinical settings eg: busy oncology inpatient units/BMT units versus ambulatory/day ward clinics. The group of clinicians expressed support for advanced nursing roles such as CNS, Nurse Practitioner, and the emerging role of RN prescribing within the haematology context.

A query shared by the haematologists appeared to be 'What is the scope of the CNS role?'. One doctor explained how she has been working alongside a nursing colleague who has developed a CNS-led haematology clinic for a specific patient population. She went on to explain that she is unclear on the distinction between an RN and CNS and was subsequently worried that she may have inadvertently caused her nursing colleague to be working beyond her scope of practice?

Anita Wootton (HWG nursing rep) provided some background commentary on nursing training and recruitment in the national haematology context. This included an overview of the haematology nursing workforce, scopes of nursing practice, and the current landscape of training opportunities.

The following items were discussed: Knowledge and Skills Framework 2014, National Nursing Standards for anti-neoplastic drug administration in NZ, ADAC: EviQ certification.

It was highlighted to the group that it is imperative any discussion on haematology workforce planning (particularly in the current climate of the projected increased demand for BMT) must also include consideration of the nursing workforce.

11. HAA/Blood 2020

The Australasian Haematology conference 'Blood' (formerly called HAA) will be held in New Zealand for the first time in 2020. This was not possible until now, as a new conference facility is being built at Auckland Sky City. This is a combined conference that encompasses medical, nursing, pharmacy and laboratory disciplines. HSANZ will be involved in forming a planning committee. EOI to join the committee can be addressed to HSANZ - Leanne Berkahn in Auckland is overseeing this.

12. Next HWG Meeting

The next HWG meeting will be held in Wellington in November 2018 - specific date TBC.

Anita Wootton,
HWG Nursing Representative

The theme is: Global Actions: Working Towards Unity and Excellence in Cancer Care

REGISTER ONLINE NOW!

The International Society of Nurses in Cancer Care (ISNCC) is pleased to announce the 2018 International Conference on Cancer Nursing (ICCN 2018) from Sunday 23 September to Wednesday 26 September 2018 at the SKYCITY Auckland Convention Centre, Auckland, NZ.

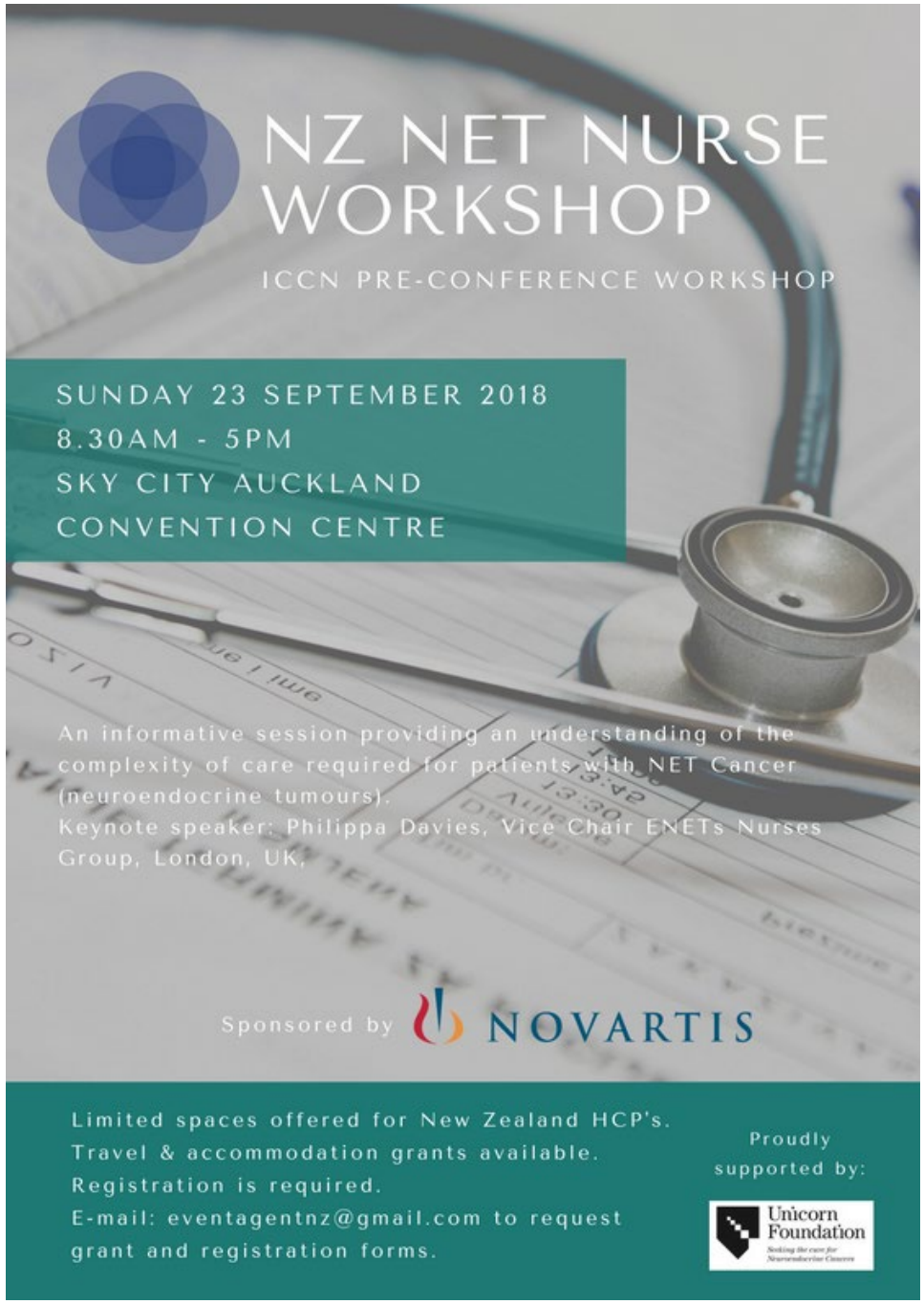
ICCN is the world's premiere meeting for leaders, and future leaders, in cancer nursing research and practice. Our conference provides you with the opportunity to engage with leaders in cancer nursing from around the globe and to participate in the conversations that will shape cancer nursing research and translate evidence-based cancer nursing education, practice and research into patient-centered care.

All of this will be offered in style in Auckland, New Zealand, where you will share lively, innovative discussions with new and existing friends and colleagues.

We look forward to seeing you here!

The learning objectives are:

1. **Discuss innovative ways for merging evidence and practice.**
2. **Engage practitioners and oncology nursing leaders in discourse around the global challenges in cancer care.**
3. **Provide and facilitate opportunities for nurses to network and collaborate to support innovative cancer nursing education, practice and research.**



Funding options to attend conferences or courses

Funding to attend conferences or courses is becoming increasingly hard to source. Apart from your local DHB, here are some funding options that you may not have thought of. To apply for funding you need to be organised with many groups having funding rounds and deadlines throughout the year.

- *For members, the NZNO offers several funding streams. These include NERF, Florence Nightingale, Thomas Tippet award, just to name a few. For further information including criteria and closing dates:*

Visit the Scholarships section on the NZNO website

- *Roche provides individual "Roche Education Grants" to nurses working in the fields of Oncology and/or Haematology to support their attendance at appropriate medical education events paid for in 2018. The key goal for these grants is to support nurses in accessing continuing education opportunities in their field of expertise and to share the information gained with their colleagues.*

Visit the Grants & Awards section on the NZNO website

- *The Cancer Research Trust NZ has various award rounds throughout the year to support health professionals working within cancer care to attend courses or conferences. For further information on criteria and closing dates go to:*

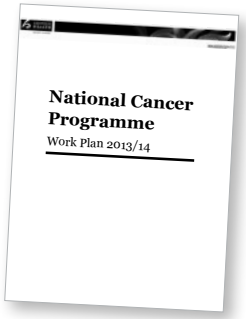
Visit the Grant Application section on the Cancer Research Trust NZ website

- *The Blood Cancer NZ and the Cancer Society offer grants for health professionals to attend conferences or courses. They usually have funding rounds. For further information contact the Cancer Society or Leukaemia and Blood Cancer NZ.*

If you are aware of other funding streams that are available and you want to publicise them, please contact us on cancernursesnz@gmail.com

National Cancer Programme update

The Ministry leads a national work programme which provides a strategic focus for cancer control and for system-wide improvements across the spectrum of cancer services.



Keep up to date on the National Cancer Programme

Online cancer learning

www.cancerlearning.gov.au

www.cnsa.org.au

www.ons.org

www.isncc.org

www.eviq.org.au

www.nccn.org

www.asco.org

The Cancer Nurses College committee **INVITES ALL MEMBERS** to join us on the new 'Cancer Nurses College NZNO' Facebook Group.

Ask questions, share thoughts, ideas, research, innovative practice, or concerns.

Click here to visit the page...

Click the 'Join Group' button and one of our lovely Admins will add you. Easy as that! Hope to see you there!

GUIDELINES FOR
CONTRIBUTING TO CANCERNET...

Why contribute? Why publish?

- *To share knowledge*
- *To advance your field of practice*
- *To disseminate key findings or opinions*
- *To contribute to policy debates*

Introduction

Cancernet is a newsletter that is published three times a year by the New Zealand Nurses Organisation Cancer Nurses College. Cancernet aims to inform and encourage nurses managing people with cancer to share opinion, resources, clinical practice and continuing professional development.

Types of articles

All types of articles are welcomed and can include;

- *Opinion*
- *Clinical practice*
- *Case studies*
- *Continuing practice development*
- *Literature review*
- *Advanced study (e.g. BSc or MSc) write-ups*

Submitting your work

- Articles should be submitted in Microsoft Word via email to *cancernursesnz@gmail.com*
- Acknowledgement of receipt of your submission will then
- Acknowledgement of receipt of your submission will be sent by email.

Word count

Opinion articles should be between 700–1000 words long. However, clinical-based articles and literature reviews and advanced study articles, these can range from between 1,500 and 3,500 words, including references.

Illustrative and images

Authors must obtain permission for the use of illustrative material or images and ensure that this material is labeled and captioned.

Referencing

A recognised referencing system to be used. If the reference list is long, the reference list is available on request from the author.

Important diary dates

24th-25th August 2018, Queenstown
New Zealand Society for Oncology (NZSO) Conference
Find out more information

18th - 20th September 2018, Wellington
NZNO Conference and AGM 2018
Find out more information

23rd-26th September 2018, Auckland
International Society of Nurses in Cancer Care ICCN Conference
Find out more information

2nd-3rd November 2018, Auckland
Melanoma Summit 2018
Find out more information

3rd-4th November 2018, Auckland
Introducing Aromatherapy in Palliative Care
Find out more information

5th November 2018, Auckland
Aromatherapy for Emotional and Spiritual Care
Find out more information

The 2017-18 Cancer Nurses College **COMMITTEE**

Back row Left to right:
Fiona Sayer, Sarah Ellery, Judith Warren, Moira Gillespie
Front row left to right:
Kate Whytock, Joseph Mundava, Kirstin Unahi, Felicity Drumm (insert bottom right)

We welcome contributions to Cancernet. Interesting stories, notices and photos relevant to our nursing community are always appreciated. Email us at
cancernursesnz@gmail.com

Cancer Nurses College badges are now available for purchase for $8 each.

They can be purchased from CNC committee members or by emailing the committee on *cancernursesnz@gmail.com* and using internet banking.

Cancer nurses **committee**

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