Cancer Nurses College
NEW ZEALAND NURSES ORGANISATION

COMMUNICATING & NETWORKING FOR HAEMATOLOGY & ONCOLOGY NURSES ACROSS NEW ZEALAND

JUNE 2019

cancernet

Editor's note

Kia ora and welcome...

I can't believe it is June already, the year is flying by! In this second edition of Cancernet for 2019 we have two of our amazing RN prescribers describe their experiences with becoming an RN prescriber and how it contributes positively to the care they provide.

We have a snippet on Rosie Howard nurse practitioner in haematology (the only one in the country!) who has been one of the recent additions to the national committee as a secondment.

Natasha Chisholm has been busy writing for us as she has also provided an update on the recent Radiation Oncology Working Group meeting, she and Katie are our new nursing representatives on this clinical advisory group to the Ministry of Health.

We hope to bring you more in the next edition on what is happening in the radiation arena – a growing area with big potential for cancer nursing in New Zealand.

Jochie Pantelon has provided an interview on her experience in moving between cancer services.

Jane Wright has provided an extensive summary of the Current Trends in Immuno-Oncology meeting held in Auckland and Amanda Keen her experience at pushing personal boundaries to attend a breast disease management course in the UK.

And as a final mention the Save the Date for our conference in collaboration with NZSO is on page 9 of Cancernet so please put it in your diary now. Call for Abstracts is now open for oral or poster presentations. Poster presentations will be considered for the CNC programme, oral presentations will be considered for the full NZSO programme. Submissions for the PHARMAC awards are also welcome.

Find out more on the conference website

Happy reading! And as always we are happy for your suggestions and contributions.

Sarah Ellery
Cancernet Editor

Registered Nurse prescribing in a radiation oncology outpatient clinic

by Natasha Chisholm, Oncology Clinical Nurse Specialist, CDHB

There is a plethora of international literature and evidence demonstrating the benefits of Registered Nurse (RN) prescribing.[1] In September 2016, Nursing Council of New Zealand (NCNZ) introduced authorisation and extended scope of practice for RN prescribing in primary health and specialty teams. This allowed authorised registered nurses to prescribe from a limited list of prescription medicines for long-term and common conditions within a collaborative team.

Registered nurses are known as 'designated prescribers', which NCNZ define as "a person who can prescribe medicines within their scope of practice, for patients under their care, from the list of medicines specified in their designated prescriber regulations".[2]

Working in Radiation Oncology outpatient department as a clinical nurse specialist, I work closely with patients undergoing concurrent chemotherapy and radiation for head and neck cancers, reviewing them in clinic each week or more frequently as needed. A large component of my role involves assessment and intervention and advice for symptom management along with education for treatment related toxicities. Being able to prescribe a select range of medications after assessing the patient provides a significant benefit in continuity, timeliness and completing an episode of care.

Having previously completed a clinical masters which included the required level 8 papers of advanced assessment and diagnostic reasoning, pathophysiology, pharmacology and a prescribing practicum, I was able to apply for RN Prescribing in primary health and specialty teams via the alternative pathways route. This involved obtaining a prescribing mentor whom provided supervision and mentorship through the assessment and application process.

Dr Iain Ward (Radiation Oncologist) kindly agreed to act as my mentor. We developed a learning plan which involved working collaboratively in clinic together for three months, providing me the opportunity to develop, consolidate and demonstrate competent and safe assessment, clinical reasoning and prescribing practice. During this time, I maintained a clinical log of all patient assessment and prescribing, case studies, and pharmacology reports which provided both Dr Ward and NCNZ evidence of prescribing competence within the oncology outpatient clinical arena.

Once prescribing authorisation is obtained annual recertification with NCNZ is required and involves supplying evidence of prescribing competence and professional development related to prescribing.

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In this issue:

Registered Nurse prescribing in a radiation oncology outpatient clinic (continued from front page)

I have been prescribing for nine months now in a collaborative team environment and have access to a wider multidisciplinary team including radiation and medical oncologists and trainee medical practitioners, an oncology nurse practitioner, palliative care team and pharmacists that I can (and do regularly) approach for support, guidance and advice. The team has provided me vital support as I have continued to develop and consolidate prescribing experience and confidence. Communication between myself and the wider clinical team is essential; in Christchurch we use a shared patient record on MOSAIQ on which I document a patients episode of care including assessment and prescribing decisions.

I have developed a personal formulary of 20-25 drugs that I am very familiar with and prescribe regularly which include anti-emetics, analgesia (including select controlled drugs), aperients and normal saline for rehydration. I regularly utilise resources such as NZ Formulary, the Pink Book and Hospital Health Pathways for dosing and side effect profiles of less familiar drugs. The current medicines list is very broad and appears more focused on primary/community health than a specialist area such as oncology.

NCNZ will undertake a review including a consultation process of RN prescribing which I believe will provide an opportunity to review the current medicines list and a chance to broaden the formulary available to suit more specialist areas.

Benefits of RN prescribing that I have experienced include:

- *Enhanced care for patients – able to incorporate appropriate symptom management, including medication education into nurse appointment*
- *Improved access to care - timely access to prescriptions for patients, not needing to wait for appointment to see a doctor*
- *Increased clinical autonomy and professional job satisfaction on my part whilst making better use of nurses' skills and knowledge base*
- *Allows doctors to focus on more complex patients and spend more time with patients.*

With the ever increasing patient numbers attending oncology units around New Zealand, there is abundant opportunity and scope for advance RN practice roles including RN prescribing.

References

1. Ministry of Health (2016). Registered nurse prescribing.

2. Nursing Council of New Zealand (2018). Guidelines for registered nurses prescribing in primary health and specialty teams.

Thoughts from one of New Zealand's first RN presrcibers

When I was first approached to write this article, I wondered what on earth I could contribute to the RN Prescribing conversation. Surely most nurses are familiar with RN prescribers? After all our diabetes colleagues have been prescribing for a while, however the more I talked to various groups and spoke in favour of nurse prescribers the more obvious it became that people know very little about RN prescribing and less about the process and what the role involves.

Speciality teams prescribing... the journey...

Near the end of 2016, the NZ Nursing Council opened the role of RN prescribing to those who worked in specialty teams and in 2017 I was a member of the inaugural RN prescriber course at Massey University. Sitting in a class of only 7, it became apparent that despite being successful overseas, RN prescribing was a long way off becoming the norm here in NZ.

In order to become a prescriber, one has to have passed a health assessment and pathophysiology paper and obtain at least a B+ in pharmacology. Having already completed these I just needed to do the prescribing practicum as one of my master's papers. An alternative route is to complete the papers to gain prescribing rights by ways of a post grad diploma.

I was the only oncology/haematology Registered Nurse in my class and flying solo made the journey seem more daunting. I put my feelers out to the Cancer Nurses College to see if there were any other cancer nurses in the same position but alas I appeared to be the only one (thankfully that has now changed somewhat!)

Many hours were spent examining patients, organising tests, diagnosing illness/disease and

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Thoughts from one of New Zealand's first RN presrcibers (continued from previous page)

recommending a course of action. After many case studies, written and oral presentations and hours of "fake prescribing" I put forward a mini folder of information (CV, case notes etc) to the NZ Nursing Council along with letters of support from my employer. Soon after (with a minimal fee) I was granted the rights to prescribe under supervision for 12 months.

Thereafter the expectation remains that nurses will work within their collaborative team in order to maintain their prescribing rights.

It is important to understand that the scope of the RN prescriber differs from our nurse practitioner colleagues. Firstly, we must work in a collaborative model and only prescribe from a set list (approx. 240 medications). We are unable to issue verbal or standing orders or provide repeat scripts for a patient we have not assessed face-to-face.

So why prescribe?

Firstly, no I didn't want to become a doctor! Unfortunately, this is still a common question asked of most RN prescribers and I imagine nurse practitioners.

For me personally it came after spending many a time waiting for a doctor (who was often stuck in clinic) to prescribe basic needs for patients (anti-emetics, laxatives, anti-diarrhoeal etc). I wanted to be able to assess the patient and provide a script then and there - no waiting, no faxing or posting of scripts to pharmacies.

For me personally, it naturally completed the assessment cycle and allowed doctors to remain in clinic and not relying on hearsay regarding what a patient needed in terms of medications.

It is also an integral part of what we do as nurses whether we recognise it or not. How many of you out there have recommended a treatment for a patient be it a change in antiemetics to a doctor? Or persuaded (either subtly or with a sledgehammer) a doctor to chart a medication you determined through clinical insight would improve the clinical outcomes for your patient? Essentially you were prescribing - it just wasn't your signature on the script.

RN prescribing allows for nurses to take autonomy over patient care episodes and gives them the responsibility to ensure that prescribed medications are taken as directed and having the desired effects- something research has demonstrated nurses are better at doing in comparison to their medical colleagues.

Personally, RN prescribing in the broader sense has the potential to change the way in which patients are managed in both community and outpatient settings. Instead of kids at risk of rheumatic fever sitting at home struggling to get in to see a GP for strep throat, they can see a RN prescriber and be placed on appropriate antibiotics in less time.

Patients who are vulnerable or isolated will have greater access to prescriptions because they will be able to see nurses for general, non-complex issues have in place some measure of follow-up.

Riding the waves – the ups and downs of RN prescribing.

Although RN prescribing has an important role in the collaborative team, it has not been without its fair share of critics or lack of role understanding.

One of the initial concerns was that nurses would not be safe prescribers. However, there is much evidence worldwide that disputes this claim. In fact, more research has shown that RN prescribers and their Nurse Practitioner counterparts are less likely to prescribe due to patient pressure (think antibiotics for that common cold), more likely to conduct a thorough assessment and follow up patients they have prescribed for.

RN prescribers have also experienced criticism from peers who see no place in their role as a nurse to prescribe, that in partaking in such roles means that focus has shifted from the art of nursing to the science.

In NZ, perhaps the greatest obstacle to nurse prescribing is that it remains in its infancy. With diabetes nurses working under a very strict scope, the reins have been let off somewhat for those in primary care and specialty teams. Unfortunately, this has meant that some prescribers have found DHBs to be lagging in regard to setting up their own management and support systems to oversee them.

Like any new initiative it will take time for people to learn the ropes of RN prescribing and how it will impact the wider service. Because of this, RN prescribers are having to rely on each other for support and guidance or seek out Nurse prescribers for ongoing prescription support which can be difficult if you do not know anyone in the wider cancer setting.

It is hoped that as numbers grow a more formal support network will be established.

So, thinking about joining the prescribing ranks?

Like anything in nursing, prescribing takes a lot of study, hours outside of work and hours lost to a computer typing assigsnments.... but don't let that put you off (there is always wine for support!).

The role of the RN prescriber is still growing but will soon become the norm in GP practices and eventually throughout our hospital services.

If you have completed the required papers, then you are only a practicum away.

For those who think they are too old, or the thought of study terrifies you then I can reassure you that you are not alone in thinking this, however plenty of support and resources are there to guide you (and age is just a number!).

Some people will support you; others may not understand the need for RN prescribers and be critical of it however if you have the desire and passion then go for it!

RN prescribing is paving way for more RNs to work at the top of their scope and provides patients with greater access to timely and effective assessment and treatment.

Anything that improves patient care and outcomes is worth supporting.

Report from the chair

Welcome to the May edition of Cancernet.

I am busy writing this as I get organised for our committee meeting tomorrow.

The committee has been working hard on various projects over the last few months and will have much to cover. We will be developing a work plan tomorrow and setting priorities for the committee for the coming year.

High on the agenda will be the BGM and conference which is being held this year in conjunction with the New Zealand Society of Oncologists (NZSO) in October. This will help substantially with funding and hopefully mean we are able to keep the cost down for NZNO members. I would really like to encourage you to consider attending this, we will have a strong nursing programme in addition to the sessions provided by NZSO giving you great opportunities for professional development. Attending the college BGM also gives you an opportunity to voice your ideas and opinions and have a hand in how the college is run. We will be calling for remits to the college rules around July. I strongly encourage you to get your applications for funding into the college early to allow us time to process them.

PHARMAC are considering developing a cancer nursing study day as part of their seminar series. At present this will initially focus on health professionals working in oncology and haematology but it is likely this will be extended to include a day for health professionals working with cancer patients in primary care settings. It's early days but I am excited about this prospect as these study days are currently part funded by PHARMAC reducing the cost to the individual and have good uptake.

We are also lobbying to be involved in the work PHARMAC are doing around medical devices, as this will impact on the procurement and implementation of Closed System-Transfer Devices (CSTDs). It is a recommendation of the National Nursing Standards for Antineoplastic Drug Administration (endorsed by the Ministry of Health), that CSTDs are used in the administration of cytotoxics to protect nursing staff and others, from cytotoxic exposure. Currently there is no single brand of CSTDs recommended and we are aware that some DHBs are not using them due to cost. Having PHARMAC involved in negotiations will hopefully reduce the cost and strengthen the case for implementation.

The Ministry of Health work on a national cancer plan and the gathering drive amongst the cancer care community for a national cancer agency remains on our radar. We will be endeavouring to continue conversation with the Ministry of Health and articulate the nursing voice in this.

The committee has also been pushing for clinical supervision for nurses as a MECA issue, having submitted a remit at the NZNO AGM a couple of years ago which was unsuccessful due to a number of issues around NZNO process and structure. As a committee we will be discussing strategies for getting this included in MECA negotiations.

Other work the committee will be focusing on in the coming months includes the college website update, audit of the National Nursing Standards for Antineoplastic Drug Administration in New Zealand, completing the knowledge and skills framework review, releasing a monoclonal antibodies safe handling position statement and the WorkSafe NZ review of the Guidelines For The Safe Handling Of Cytotoxic Drugs.

Finally I would like to extend a warm welcome to our newest committee member Mary-Ann Hamilton from Waikato DHB who has been seconded on. She has a background in nursing management and quality improvement which will be an asset to the committee.

Phew see told you we've been busy! Wishing you all well.

Kirstin Wagteveld (Unahi)
Chairperson - CNC

NEW COMMITTEE MEMBER

Rosie Howard

Nurse Practitioner Haematology, Auckland District Health Board

I have always believed the umbrella term of 'cancer' covers all malignant disease, therefore am delighted to be representing my haematology nursing colleagues as a member of the cancer nurses college committee.

Currently I am working as a Nurse Practitioner within Blood and Cancer Services at Auckland Hospital. I work with post allograft BMT patients; the Nurse Practitioner role in Haematology is very new so I am in a very fortunate position to be designing how the role will integrate/ streamline and improve the patient journey in the short and long term/ late effects follow up of the post BMT allograft patient population.

Bone Marrow Transplant and post cancer treatment 'late effects' is a developing field, which has implications for all services that are delivering chemotherapy and radiotherapy treatments in how, where, when and by whom, our patients will get long term follow up post their treatment. I am excited to be part of the challenges that developing these new pathways will bring.

I have been a qualified nurse for 26 years, 23 of these working within the speciality of haemato/oncology both here in NZ and in the UK. My passion is within haematology nursing, specifically BMT. I emigrated to NZ with my husband and then 8 year old twins back in 2008 and have never looked back, I love it here!

The inaugural Association of Breast Surgery
Advanced Management of Breast Disease Course

27 – 29 MARCH, 2019,
SELWYN COLLEGE, CAMBRIDGE

Prior to leaving for this course to Cambridge I was excited at the opportunity for learning and exploring the global context of breast care in general, but I was also very nervous. I didn't know what to expect, I have never travelled that far, and I didn't know what would be expected of me. I was worried that I would not be enough and thought that someone else would be better placed to go, but I was also determined to make the most out of this experience.

What I discovered when I was there, is that others in the group had the same sort of feelings. The point was we were all there on a journey of learning and working to make things work better for our patients, and that was something to be proud of.

It was amazing to see and experience the passion and knowledge shared amongst the group from consultants to nurses and learning new ways of doing things in fact working better in a more connected way. The course was around building networks and relationships and discussing case studies utilising clinical expertise in developing treatment plans and good holistic outcomes.

The course offered the opportunity to learn about current and advancing technologies in breast diagnosis, multidisciplinary team working, and breast cancer pathology, controversies in treatment, medico legal aspects and common problems of benign breast disease. The course was aimed at senior breast trainees, newly appointed consultants, advanced nurse practitioners and specialist nurses with either a background in breast or plastics.

The content covered the following learning objectives:

- Understanding and implementation of a cutting edge approach to disease management
- Confidence in decision-making for the delivery of clinical care
- Critical analysis of current research for management of breast disease
- Evaluating the efficacy of different assessment methods for breast cancer.

The college was steeped in history and academia (VERY 'Harry Potter').
The lectures were interactive and delivered by leading experts in their field and were lively with the use of real-life scenarios.

In addition, the course provided the opportunity to expand my network of expert colleagues with a common interest in breast disease management. The course also had the emphasis on imparting broad evidence-based knowledge and the development of decision-making skills that optimized clinical and patient outcomes.

In summary the opportunity to attend this course has both informed and validated my clinical practice of breast disease management and has allowed me the opportunity to network with a variety of colleagues in an international setting. Thank you for assisting me in attending this course and I would be happy to share my learning/experience at an individual level.

Amanda.keen@lakesdhb.govt.nz

Radiation Oncology Working Group (ROWG)
SUMMARY OF MEETING

18TH FEBRUARY 2019

Attended by Natasha Chisholm (CNS) Canterbury District Health Board, first meeting in tenure. Please join me in welcoming Katie Keir (CNS) Wellington District Health Board as a nursing representative on the ROWG.

1. Process to address variation in radiation oncology services.

Continued discussion and process looking at variations in current clinical practice nationally. Proposed ongoing and new collection of meaningful data to enable accurate audit reporting, specifically around:

- Rectal cancer – variations in short course versus long course fraction and intervention rates
- Palliative fractionation for bone metastases, five fractions versus single fraction
- Breast, brain, lung and bone cancer treatment courses

NURSING CONTEXT – reduced variation in radiotherapy treatment plans would assist oncology teams provide fair and equitable access to evidence based radiation oncology treatment to achieve optimal outcomes for patients across New Zealand.

2. ACC Treatment safety

Dr Peter Jansen and Bridget Thompson attended the meeting to discuss ACC treatment injury claims related to radiotherapy. Key points of discussion included:

- Definition of "treatment injury" is key but the legislation is not clear for oncology/ radiotherapy. There are several excluded criteria.
- Approximately half of claims for radiotherapy and oncology are accepted.
- >40% of declined claims, the injury is an ordinary consequence of the treatment.
- RWOG to provide feedback on the ACC draft Treatment Injury Claim Lodgment Guide

NURSING CONTEXT - Nursing knowledge of the ACC Treatment Claim criteria could assist nurses in identifying appropriate patient symptoms/injuries that maybe eligible for ACC funding/cover.

3. Nursing Roles within Radiation Oncology Centres in New Zealand

RWOG had requested an overview of nursing roles within radiation oncology.
An overview statement was provided for review and discussion, however due to time constraints this was carried over to the next meeting.

NURSING CONTEXT – Katie and Natasha will talk to this at the next meeting and will feedback in the next issue.

Tash Chisholm

CONFERENCE REPORT

The meeting facilitated by MSD New Zealand attracted medical professionals from around New Zealand involved in treating patients with immune-oncology (IO) therapies.

Day 1 commenced with speakers reflecting on two years of real-world experiences of immunotherapies in New Zealand. Dr Bernie Fitzharris presented his experience of long-term follow-up of immunotherapy treatments in patients with advanced melanoma.

Results of clinical audit from PD-1 audits from Auckland, Bay of Plenty and Capital and Coast DHBs were presented by Dr Alsiter Wickham and Dr Vanessa Durandt presented results from a PD-1 clinical audit along with a case study. Current practice appears to assess and treat with immunotherapy until disease progression or unacceptable side effects and decision to stop without evidence of progressive disease is on a case-by-case basis.

The afternoon session was split into concurrent sessions for nurses and pharmacists. The nurses session focused on best practice implementation and ongoing nurse development in the clinic setting. Michelle Davidson gave an overview of the melanoma patient journey at Auckland DHB outlining their processes for management around scheduling, monitoring and long-term follow-up. Her cautions were side effects can be chronic and protracted and are often difficult to recognise as can have a non-specific or subtle presentation. Generally, the immunotherapies are well tolerated but very important to educate patient to notify treating team of any new or worsening symptom. Her thoughts for the future will be that the majority of the patients receiving treatment will be elderly which will involve managing co-morbidities and long-lasting side effects.

Janele Van der berg, a psychologist from Tauranga hospital, gave a detailed talk on understanding the person with cancer mindset. She shared her experiences of what the patient's level of understanding was as they are dealing with a cancer mindset. This appears dependant on many variables such as type of cancer, new diagnosis or recurrence, stage of cancer curative or palliative and treatment options available along with the patient's level of understanding. There can be a flight/fright traumatic stress response in some and she reminded us to be aware of the medical language we use and the impact of family and friends on a patient's mindset.

In the next session "DHB sharing – Lets collaborate" Karen Palmer, Fiona Sayer, Linda Dagg and Kirsty McAlister, all nurses involved in the administration of IO drugs in outlying chemotherapy administration units, discussed their experiences, opportunities and challenges in providing at a distance from a larger cancer centre.

The themes that emerged from all the presentations were logistics around transportation of short-expiry drugs and weather adversity, ensuring staff are well trained and supported and the safety of patient in areas with limited medical cover. Some of the strategies that have been developed to address these issues include 24hr phone support from larger centres, development of pre-treatment and triage tools.

In one area, all patients are given a "pill in the pocket" prescription of prednisone to have on hand so after consultation with the cancer centre it can quickly be commenced for immune-mediated adverse events.

The after dinner symposium took the form of panel presentation with Dr Natasha Leight an oncologist from the Princess Margaret Cancer Centre in Canada as the panel expert. Hearing patient stories is always a powerful and heart-tugging event. John Ashton, a university pharmacologist, talked of his experience of being diagnosed with lung cancer four years ago. Initial standard chemotherapy was given with a low expectation that it would impact on his disease and he was significantly unwell. Through a chance reading of a magazine article on clinical drug trials called an unfunded drug that would cost 13,000 dollars a month. He was fortunate to receive the drug on compassionate grounds from the drug company and continues to live an active working life.

Representatives from the lung cancer foundation Professor Chris Atkinson and Philip Hope advocated strongly for more research and better availability of Immunotherapy treatments for lung cancer In New Zealand. Lung cancer as the biggest cause of cancer deaths lacks the profile other cancers have and is the least funded according to Philip.

The foundation is currently lobbying national health to declare lung cancer a national priority and to approve additional budget for Pharmac to fund lung cancer immunotherapy treatments for all New Zealanders with advanced lung cancer, irrespective of socio-economic status.

Representatives from MSD spoke on the Australian perspective of immunotherapy namely pembrolizumab (Keytruda). It is now registered in New Zealand as first- and/or second-line treatments or combination therapy in nine types of cancer: advanced melanoma, advanced NSCLC, non-squamous NSCLC, squamous NSCLC, classical Hodgkin's lymphoma, urothelial, and head and neck squamous cell carcinoma. It is currently only funded in New Zealand for advanced melanoma. From a policy perspective a New Zealand Rapid Access Scheme proposal is being explored which involves a separate fund that is available to fund these immuno-therapies that is capped, time limited and risk shared between the public funding agencies and the pharmaceutical companies. The aim would be to by-pass the lengthy process currently needed to gain funding.

Day two dawned with a panel discussion around New Zealand trial barriers and solutions. Derek Sieger from MSD discussed the current and upcoming clinical trials their company was undertaking. Their products

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pembrolizumab and olaparib are currently being evaluated in a number of clinical trials for multiple types of cancers.

Dr's Marion Kuper, Nicky Lawrence and Richard North discussed solutions to enhance clinical trial recruitment in NZ. Audience participation was robust and highlighted the geographical barriers to recruitment of patients, the debate around the need for a more centralised trial centre or more support for research and trials to be spread demographically.

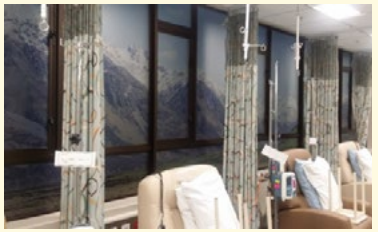
New indications for immunotherapy agents in NZ were presented by Dr Giuseppe Sasso for head and neck SCC and Dr Alvin Tan summarised his experience of the use of immune checkpoint inhibiters in advanced urothelial cancer as a treatment option for patients with metastatic UC in the first- or second-line setting if platinum ineligible and that the response rates remain low overall. His thoughts were that we require a better understanding/biomarkers to guide better therapy.

Associate Professor Chris Hemmings presented on the impact of biomarkers on immunotherapy choices. She discussed possible biomarkers for Io predictive for response in immuno-oncology. Challenges remain with assessing multiple antibodies and staining platforms, methods of scoring along with and the types of sampling (biopsy vs resection and histology vs cytology. The technical aspects of testing is very much driven by technical expertise, rigorous standardisation which is complicated by variation in methodologies and commercially available kits, validation and quality control with a reminder that no test is 100% sensitive, specific and accurate. Interpretation of the tests is partly subjective and relies on experience with preference to concentrate expertise.

The report is a reflection of most of the presentations and alludes to both the potential benefits of introducing novel therapies but the angst of patients and health professionals in overcoming the hurdles of gaining access.

As a rural nurse the highlight for me attending these sessions are the opportunities to meet and network with other nurses working in oncology. The chance to share our stories, receive up-to-date research and patient stories and the opportunities to reflect, improve our practice and ultimately patient care. The forum increased my knowledge around the biology of cancer and the identification and management of immunotherapy side effects.

Jane Wright



40 fantastic projects funded from DRY JULY

Dry July is a fundraiser that encourages you to go alcohol-free in July to raise funds for people affected by cancer. The Canterbury Regional Cancer and Haematology Service (CRCHS) has been participating in the Dry July campaign since 2013. In the initial three years those participating in Dry July who selected the CRCHS as the beneficiary managed to fundraise over $360,000 for our patients. This money has been allocated to over 40 different projects over the past five years.

Examples of projects include:

- *Electronic recliner chairs, beds, wall murals and an exercycle for the Bone Marrow Transplant Unit.*
- *Wall murals throughout Oncology, Oncology Day Unit, Radiation Treatment Bunkers and Brachytherapy Suite at Christchurch Hospital.*
- *Radiation Therapy Patient Information video*
- *Refurbishment of AYA room on Oncology Ward and in Radiation Oncology Outpatients*
- *Furniture, fittings and entertainment facilities for the Medical Day Stay Unit in Ashburton*
- *Airpal mattress for Oncology Ward and Hospice*
- *Artwork, furniture and fittings for Chemotherapy Suite and Whanau kitchen at Nelson Oncology Service*
- *Pilot for the healing touch complimentary therapy programme*
- *Lazy boys, air pressure chair/bed, massage vouchers, magazines and resources for Greymouth Oncology Service*
- *iPads and iPods for paediatrics, AYAs and chemotherapy patients. Individualised backpacks for AYAs.*

In 2019 Dry July NZ will be supporting the community-based Look Good Feel Better workshops across New Zealand.

For those of you in the Canterbury, South Canterbury, West Coast and Nelson Marlborough regions then please contact ***Philippa.Daly@cdhb.health.nz*** regarding the application process for funding if there are any large or small projects/ideas on improvements that staff have raised that could make a difference for our oncology patients either in the community or hospital environment.

From small town to bright lights of Melbourne

I recently caught up with a colleague Jochie Pantelon who had worked in our Medical Day Stay Unit at Ashburton Hospital and had made the move to Melbourne. She has now been working in oncology/haematology ambulatory services at Sunshine Hospital, Melbourne for the last six months.

Sunshine Hospital is a large acute hospital of 600 beds. I was interested to hear about her transition from a small outreach oncology service to a large city chemotherapy provider....

Tell me about your unit?

We have 15 chairs, a large room with 7 and 2 smaller rooms with 4 each. Two shifts one starting at 0800 and the other at 0900 and open five days per week. We have six nurses on the floor, one in charge and a 2IC. We also have a nurse manager and an associate nurse manager, she is often the nurse in charge on the floor. There is also a flow nurse who checks bloods, checks patients are coming for appointments and well enough for chemo, referral nurse who manages the referrals and an urgent review nurse who does all the education, takes the phone calls and sees patients for urgent review.

Our average is around 45 treatments per day and we would generally have 3 patients at any one point. Our biggest day since I've been there was 80 but they were short treatments. We administer chemotherapy and biotherapies and also the supportive oncology infusions such as blood and bisphosphonates. We can do blood transfusions very quickly with a half hour turn-around. Also we give blood at a rate of 25mls for 15 minutes and the rest over an hour so we can easily do blood and then their chemo.

How is your chemotherapy managed?

We have our own oncology pharmacy. The MABs are made up the day before but all other chemotherapy is made on the day. In the morning we have a handover first thing which the pharmacist is at and we confirm who's having treatment and then they go away and start making it up. Patient arrives and then we pre-med them and wait for chemo to arrive. We have short expiry on our drugs.

Do you use Mosaiq as your patient management system?

We use Bookwise to book patients which is like the Mosaiq calendar for allocating times of treatment. We are always on time as we can't have patients holding up the chairs. We use EMR for documentation and paper prescription charts. We have a registrar in our unit all day and part of his job is to prescribe the chemotherapy for the next day and make adjustments on the day if needed.

We also have a hospital in the home as well. We go into the patient's home and give treatments like gemcitabine, 5FU Herceptin. It has to be a treatment that takes no longer than an hour and after the third cycle. I tried doing that as they thought with my district nursing experience it would be a good fit for me but I couldn't handle the driving. It was so stressful on the motorways and I didn't know my way around Melbourne. They do a maximum of 8 patients each. The nurses wear a GPS tracker on their body so they know where they are at all times.

Are many central lines used?

We use lots of ports more than PICCS and this is generally patient choice. We have lots of patients on clinical trials. The research nurses administer the first cycle and then they come to us. The research nurses still do all the pre chemotherapy assessments so they come to our rooms ready for treatment.

How was your orientation and support into the unit?

I had to do the EVIQ package, 3 supervised treatments and three cannulations 3 ports and 3 PICCS and then I was away. If you don't have any experience its much longer. It's pretty busy the first month I was exhausted at the end of the shift. We put all the short treatments and PICC dressings in the afternoons.

Was the transition what you thought it would be like?

I didn't have much time to breathe just with the sheer numbers. I got to know the patients on a much deeper level in Ashburton whereas here as you don't have the same patient each time. I do miss that.

Are you happy you made the change?

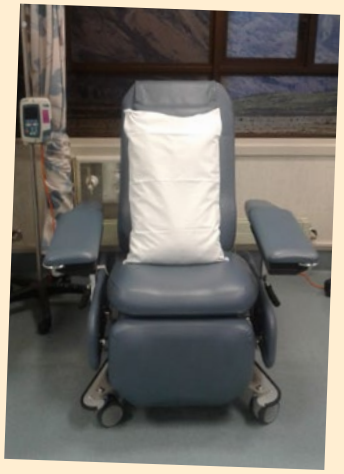
I am actually because it's a different kind of exposure and stepping into a different world. It was at first a culture shock for me because coming from a slower pace. Instead of walking you are running and once I got my head around how they work it's been great. I generally work in a small room by myself so can practice independently but have lots of support if needed. It's good to meet another bunch of nurses and I have never heard any of them complain about how busy it is.

If somebody was thinking of moving to Australia to work in an oncology unit what would be your advice?

They need to have some experience because it's hard to get into oncology without it and it is very busy. If you didn't have any exposure it would be very difficult. You would probably have to start in a smaller unit and then come to one like this.The younger ones that come have usually worked in the oncology ward first.

CHALKY CARR TRUST
BOUND TOGETHER BY CANCER

Chalky's Trust is a charitable organisation established by the late Kevin 'Chalky' Carr, with the help of whanau and friends. Chalky's vision was to provide practical support for patients during their cancer journey in the Canterbury region.



The Trust generously provided bespoke treatment chairs for patients in the Oncology Outpatient Day Ward and The Medical Day Unit.

These chairs are best described as being the business class version of treatment chairs thus providing optimal patient comfort. In addition they enable timely treatment of patients during an emergency situation.

In 2018 the Chalky Carr Trust sought to add more support and now offer fully funded taxi chits (aka Chalky's Cars) to patient who experience the barrier of either have limited financial resources or social supports. Patients are identified by various members of the Nursing team and are approached discreetly to ensure that their dignity is maintained. The feedback from patients is overwhelmingly positive as transportation and parking is particularly challenging in Christchurch.

You can find out more about the Chalky Carr Trust or visit the Facebook page.

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.


National Cancer Programme Update

A word from the Manager, Cancer Services

Cancer Care at a Crossroads Conference and workshops

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

New Zealand Society for Oncology

Save the date!

CNC NZNO Conference & BGM in conjunction with:

New Zealand Society for Oncology Conference

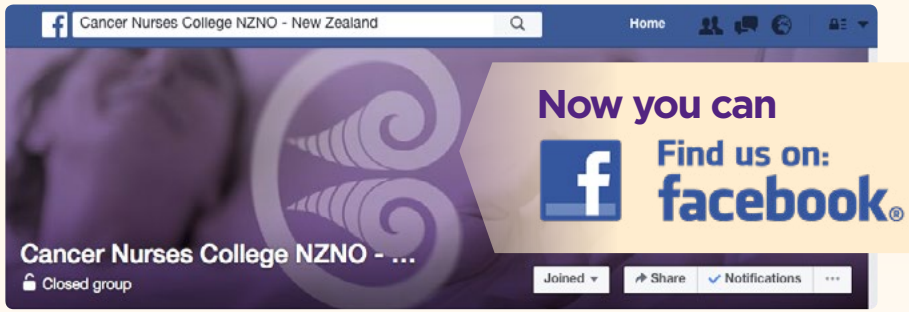
25 - 26 October 2019

Harbourside Function Centre, Wellington

Further details to be announced soon!

Cancer Nurses College
NEW ZEALAND NURSES ORGANISATION

Keep an eye on the NZSO website for further information
http://www.nzsoncology.org.nz/



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 labelled 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.

20 – 22 JUNE, 2019
MELBOURNE, AUSTRALIA
Cancer Nurses Society of Australia 22nd Annual Congress
Click here for more information

21 – 23 JUNE, 2019
SAN FRANCISCO
MASCC/ISOO Annual Meeting
Click here for more information

7 SEPTEMBER, 2019
BARCELONA, SPAIN
6th Lung Cancer & Mesothelioma Satellite Workshop
Click here for more information

27 SEPTEMBER – 1 OCTOBER, 2019
BARCELONA, SPAIN
SAVE THE DATE: ESMO 2019 Congress
Click here for more information

25-26 OCTOBER, 2019
WELLINGTON, NEW ZEALAND
CNC NZNO Conference & BGM in conjunction with: NZSO Conference
Click here for more information

The Cancer Nurses College **2019-20 COMMITTEE**

Left to right: *Jane Wright, Sarah Ellery, Rosie Howard, Kirstin Unahi, Katie Whytock, Felicity Drumm, Mary-Ann Hamilton, Anne Brinkman*

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.

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