Ordinary Days. Extraordinary People.

20th Annual CANO Conference, September 14-17, 2008

Des journées ordinaires. Des êtres extraordinaires.

20e Conférence Annuelle de l'ACIO Septembre 2008
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For more information, please contact the CANO / ACIO Management Office:
375 West 5th Avenue, Suite 201, Vancouver, B.C., V5Y 1J6
(604) 874-4322, CANO@malachite-mgmt.com
I am pleased to extend my warmest greetings to everyone attending the 20th Annual Canadian Association of Nurses in Oncology (CANO/ACIO) Conference being held in St. John’s.

As highly skilled and specialized health care workers, oncology nurses play a vital role in the well-being of individuals facing a cancer diagnosis and treatment. Originally established in 1984, CANO/ACIO supports Canadian oncology nurses in their efforts to prevent and treat cancer, and is committed to fostering excellence in oncology nursing practice, education, research and leadership.

This year’s conference offers the opportunity to meet with your colleagues from across Canada and to share your knowledge and experiences with one another. I am certain that you will enjoy the many information sessions and educational workshops planned for this event, which will focus on the latest developments in your profession and enhance the exceptional level of care and compassion you provide to your patients.

On behalf of the Government of Canada, I wish you all a productive meeting, as well as every success in meeting the challenges of the years to come.

Ottawa, 2008

The Rt. Hon Stephen Harper, P.C., M.P.
Dear Colleagues and Guests,

On behalf of the CANO / ACIO Board, I’m thrilled to welcome you to the 20th Annual National Conference of the Canadian Association of Nurses in Oncology / L’association canadienne des infirmières en oncology in beautiful St. John’s, Newfoundland and Labrador. You will be inspired and enriched as you share your knowledge and expertise with peers, and celebrate achievements.

The 2008 conference theme, “Ordinary days. Extraordinary people.” symbolizes our shared passion to deliver the highest standard of care to extraordinary people on ordinary days. Together, we work to find new solutions to the challenges of every day practice.

The Local Planning Committee, the Scientific Program Committee, and the Conference Planning Steering Committee have created an excellent program of clinical, research, education and professional development opportunities to foster your learning. The Newfoundland Beach Party and Boat Tour promises a great way to enjoy good food, good friends, and good times.

You’ll notice some exciting changes to the conference program this year. Workshops are now integrated into the conference program. Round table sessions have been added; they offer small group exchange of ideas and knowledge on specific, relevant topics in oncology nursing today. You’ll also notice that the Council of Chapters meeting has a dedicated place within the conference program that does not conflict with other meetings or sessions. The Council of Chapters is a key membership meeting for communicating with your board and exchanging ideas with colleagues. Our membership voice is extremely important to us. So important that we wanted to ensure that members have dedicated time during the conference to make their voice heard.

We are especially honoured to have Terry Kelly, Elizabeth Davis, and Laurie Anne O’Brien present keynote addresses. We look forward to learning from their local and national perspectives of cancer care.

A conference of this magnitude would not happen without the work of many dedicated people. Thank you to the many people who make this conference possible, the Local Planning Committee co-chaired by Sharon Pippy and Bernadine O’Leary, the Scientific Planning Committee under the leadership of Kathy Fitzgerald, the Conference Planning Steering Committee, our valued volunteers, and the CANO/ACIO staff. I would also like to thank our sponsors and speakers for their support. Most important, I want to thank you for participating in the conference. It is your support of CANO/ACIO, your dedication to patient care, and your commitment to oncology nursing that makes the conference the success it is.

Have a wonderful conference!

Sincerely,

Kim Chapman
President
CANO/ACIO
Hello, and welcome to the 20th Annual CANO/ACIO National Conference. The local Planning Committee is so excited to host you in our charming home.

**Ordinary Days. Extraordinary People.**

Oncology Nurses. Extraordinary people. We will come together over the next few days to learn from and reflect on the many experiences of our ordinary days, marked by nursing other extraordinary people: individuals with cancer and their families. The local planning committee discovered this theme in the song Ordinary Days by local recording artists Great Big Sea. We found meaning, inspiration and a sense of hopefulness in these words. Our hope is that you may find the same.

The local planning committee was impressed with the outstanding number of abstracts submitted for our conference. We thank you for your interest and congratulate you all on your extraordinary work and dedication to oncology nursing. We are pleased to offer you a Conference Program that highlights and celebrates the finest in Canadian Oncology nursing practice, education and research as well as three noted keynote speakers from our host province.

You are here, finally! Now enjoy this place, our home. There is so much for you to see, do and say!! We look forward to hosting you on Tuesday night to a true Newfoundland time that will capture all the sights, sounds and flavors found only in this beautiful place.

September can often bring warm and sunny days to Newfoundland. However, like all coastal areas, as the sun goes down, it does tend to get cool. So remember to bring some wind and rain gear, and comfortable footwear, especially for our social Beach Party night.

Many thanks for coming to share with us. Enjoy!

Bernadine O-Leary and Sharon Pippy
Local Planning Committee

O’Leary, Bernadine, RN, MN, CON(C) Co-Chair
Pippy, Sharon, RN, MN Co-Chair
Baker, Pamela, RN, MN, BScN
Collins, Carmel, RN, CHPCN(C)
Downey, Charlene, RN, MN-ACNP, CON(C)
Fitzgerald, Kathy, RN, BN, CON(C)
Ledwell, Elaine, RN, BN, MEd
Mackey, Carol, RN
Reddick, Martina, RN, Lymphadema Therapist

Conference Planning Steering Committee

Chapman, Kimberly, RN, BN, MScN, CON(C) Chair
Grieve, Vanessa, RN, CON(C), SRN/SCRN (UK), SCM (UK)
Hershon, Linda, RN, BSc
MacDonald, Donalda, RN, CON(C), OCN
O’Leary, Bernadine, BN, MN, CON(C)
Pippy, Sharon, RN, MN
Swidzinski, Marika, RN, MEd, BA, CON(C)

Scientific Program Committee

Fitzgerald, Kathleen, RN, BN, CON(C) Chair
Baker, Pamela, MScN, RN, BScN
Cummings-Winfield, Cindy, RN, BScN
Pippy, Sharon, RN, MN
Skrutkowski, Myriam, RN, CON(C)

CANO/ACIO Board of Directors

President, Kim Chapman, RN, BN, MScN, CON(C), River Valley Health, Fredericton, NB
Vice-President, Jennifer Wiernikowski, RN, MN, ACNP, CON(C), Juravinski Cancer Centre, Hamilton, ON
Treasurer, Donalda MacDonald, RN, CON(C), Mount Sinai Hospital, Toronto, ON
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Director-at-Large, Internal Relations, Jeanne D. Robertson, RN, BSc, BA, MBA, Children’s Hospital of Eastern Ontario, Ottawa, ON
Director-at-Large, Membership, Deborah Gravelle, RN, BScN, MHST, SCO Health Service, Ottawa
Director-at-Large, Education, Vanessa Grieve, RN, CON(C), SRN/SCRN (UK), SCM (UK), St. Joseph’s Hospital, Comox, BC
Director-at-Large, Professional Practice, Tracy L. Truant, MScN, RN, British Columbia Cancer Agency, Vancouver, BC
CONJ Editor, Heather Porter, RN, PhD, Waterloo, ON
Philosophy: The Canadian Association of Nurses in Oncology (CANO) recognizes the responsibilities and mandate of nurses to promote the highest standards of care for individuals and families who are experiencing cancer or who are at risk of developing cancer. Cancer is a chronic illness with acute phases, which affects people at all stages of the life cycle. Nurses in all practice settings are involved with the process of cancer care: prevention, detection, treatment, rehabilitation and palliative care. Recognizing that individuals with cancer have complex needs, nurses, are aware that a specialized body of knowledge and skills is basic to the provision of high quality care. Our national organization for nurses in oncology fosters the maintenance of high standards of nursing care for people with cancer.

Purpose: The purpose of the Association shall be to promote prevention of cancer, promote optimal care of individuals with cancer and to provide for the nurses caring for them.

Mission: Leading nursing excellence in cancer control for Canadians.

Cancer Control: Aims to prevent cancer, cure cancer, & to increase survival rates & quality of life for those who develop cancer by converting cumulative knowledge gained through research, surveillance & outcome evaluation into strategies & action (CSCC, 2002).

Vision: By 2010, CANO/ACIO will be an international nursing leader in cancer control.

Value Statements:
- Every nurse is a leader.
- Canadians deserve specialized oncology nurses.
- Evidence-based care is the foundation for excellence in nursing.
- The specialty of oncology nursing is an essential component of health care services across the cancer continuum.
- Collaborative relationships further the health, well-being and quality of life of Canadians.
- Ongoing learning is essential for the professional and personal development of oncology nurses.
- CANO/ACIO is committed to supporting its members and all oncology nurses.

Membership Benefits: CANO/ACIO members receive the following benefits of membership:

- Canadian Oncology Nursing Journal (CONJ). The Canadian Oncology Nursing Journal is a peer-reviewed journal provided to members 4 times per year, complete with stimulating articles, practice and association updates, book reviews and upcoming conferences.

- Access to Members Area of CANO/ACIO Website. Visit the member's area of the CANO/ACIO website (www.cano-acio.ca) to access membership lists, AGM agendas and minutes, annual reports, board minutes, policies and more.

- CANO/ACIO Meetings. Network with oncology nurses at local chapter meetings within your province, at the annual national conference and internationally every two years at the International Conference in Cancer Nursing. As a CANO/ACIO member, you may be eligible for travel grants to attend these conferences.

- Annual Conference. Opportunity to meet with other nurses providing cancer care and share your own or institutional initiatives in cancer nursing. Provide input into the development of the organization through participation in annual general membership meeting. Annual conference held across Canada moving from east to west to ensure an equal opportunity to oncology nurses nationally to participate.

- Special Interest Groups. Dialogue with nurses in your specialty practice area through Special Interest Groups such as Palliative Care and Advanced Practice Nurse (APN).

- Certification in Oncology Nursing. Opportunity to participate in study groups at the local chapter level to prepare you to become a Canadian certified oncology nurse through the Canadian Nurses Association.

- Standards and Guidelines for Practice. Access to current CANO/ACIO Standards and Guidelines for Practice.

- Awards and Educational Grants. CANO/ACIO recognizes some of the outstanding achievements of Canadian oncology nurses through an awards program that is administered by the Recognition of Excellence Committee and supported by a range of corporate sponsors. Please see the CANO/ACIO website for a list of awards and educational grants available to CANO/ACIO members.

Scholarship and Educational Grants: CANO/ACIO provides educational scholarships and research grants.
The 20th Annual CANO/ACIO Conference is Made Possible by the Generous Support of the Following Organizations

PLATINUM
Roche

GOLD
Wyeth

SILVER
sanofi aventis
GlaxoSmithKline
Merck Frosst
Bristol-Myers Squibb Canada

BRONZE
Abraxis BioScience
Baxter Corporation
Eli Lilly
Ortho Biotech
Purdue Pharma
Carmel Pharma
Bayer Healthcare
AstraZeneca
Novartis Oncology

CONFERENCE SUPPORTERS
ICU Medical
Bard Canada
Schering-Plough Canada
Pfizer
Trudell Medical Marketing
Abbott Oncology
Cardinal Health
Look Good Feel Better
Canadian Cancer Society

LOCAL SUPPORTERS
ST. JOHN’S
Target
Brand Architects
Listing By Company

17  Abbott Oncology
34  Abraxis BioScience Canada
14  APN Community of Practice and McMaster University
23  AstraZeneca Canada
31  Bard Canada
39  Baxter Corporation
36  Bayer Healthcare Pharmaceuticals Oncology
29  Bristol-Myers Squibb
12  Canadian Cancer Society
27  Canadian Nurses Association (CNA)
28  Canadian Oncology Nursing Journal (CONJ)
8   CANO Information Booth
26  Cardinal Health
24  Carmel Pharma
30  Eli Lilly Canada
16  GlaxoSmithKline
10  ICU Medical
33  Look Good Feel Better
22  Merck Frosst Canada
25  Novartis Oncology
38  Oncology Nursing Society (ONS)
35  Ortho Biotech
32  Pfizer Canada
20  Purdue Pharma
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<td>Merck Frosst Canada Ltd Breakfast Symposium (begins at 0630)</td>
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Saturday, September 13
0800 – 1600  Board of Directors Meeting (Executive Boardroom)

Sunday, September 14
0800 – 1200  Board of Directors Meeting (Executive Boardroom)
1330 – 1600  CONJ Editors’ AGM (Governor Gower)
1700 – 1830  CANO APN SIG (Governor Ducksworth)
1700 – 1830  Complementary Medicine SIG (Governor Gower)
1700 – 1830  Research Committee (Governor LeMarchant)
1700 – 1830  Surgical Oncology SIG (Governor Cochrane)

Monday, September 15
1400 – 1515  CANO/ACIO Council of Chapters Meeting (Placentia Bay Room)

Tuesday, September 16
0815 – 0945  CANO/ACIO Annual General Meeting (Marconi Hall)
Tentative CANO/ACIO Annual General Meeting Agenda  
Tuesday, September 16, 2008 0815-0945

**Chair:** Kim Chapman

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<tr>
<th>Time Range</th>
<th>Item</th>
<th>Presenter(s)</th>
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<tr>
<td>1.0</td>
<td>Call to Order</td>
<td>Chapman</td>
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<td>Adoption of Agenda</td>
<td>Chapman</td>
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<td>3.0</td>
<td>Approval of AGM Minutes October 30, 2007, Vancouver</td>
<td>Chapman</td>
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<td>Business Arising</td>
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<td>Introduction of Board Members</td>
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<td>4.2</td>
<td>President’s Report</td>
<td>Chapman</td>
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<td>4.3</td>
<td>Treasurer’s Report &amp; Audited Financial Statements</td>
<td>MacDonald</td>
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<td>New Business</td>
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<td>Management Contract</td>
<td>Chapman</td>
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<td>5.2</td>
<td>Strategic Plan Update</td>
<td>Wiernikowski</td>
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<td>5.3</td>
<td>Five Year Financial Plan</td>
<td>MacDonald</td>
<td>10 mins</td>
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<td>5.4</td>
<td>Budgets for 2008 &amp; 2009</td>
<td>MacDonald</td>
<td>10 mins</td>
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<td>5.5</td>
<td>Appointment of Auditor</td>
<td>MacDonald</td>
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<td>5.6</td>
<td>6th Annual Oncology Nursing Day</td>
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<td>Questions / Discussion</td>
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<td>Award Presentations (if applicable)</td>
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<td>Recognitions – outgoing Board</td>
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<td>Invitation to 2009 AGM to be held in Montreal, QC</td>
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<td>Adjournment</td>
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Standing Rules for the CANO/ACIO Annual General Meeting

Rule 1
In order to be admitted to the CANO/ACIO Annual General Meeting or educational sessions, members are required at all times to wear a badge issued upon registration.

Rule 2
A member desiring to address the convention shall rise, go to the microphone designated, address the chair, and state his or her name and province of residence. He or she must await recognition by the chair before addressing the convention.

Rule 3
No member shall speak in debate more than twice to the same question, nor longer than two minutes, without permission of the members in attendance granted by a two-thirds vote without debate. Members may not speak for a second time during debate until all those wishing to speak for a first time have been recognized.

Rule 4
An emergency resolution shall (a) be submitted to the Board of Directors by noon on the day prior to the Annual General Meeting, (b) be of a subject matter or content that was unknown to the presenter prior to the deadline to submit resolutions, and (c) be adopted only with a two-thirds vote of the members present and voting.

Rule 5
Total debate of any item of business shall not exceed 10 minutes.

Rule 6
Non-members at the Annual General Meeting will have designated seating areas.

Rule 7
Cell phones shall be turned off or to vibrate during Annual General Meeting.

Rule 8
No one may enter or leave the room during a vote.

Rule 9
The Board of Directors shall approve the minutes of the meeting. Approved minutes shall be submitted to members.
About the Council of Chapters Meeting, Monday, September 15, 2008, 1430-1515

The CANO/ACIO Council of Chapters is a forum for the identification, discussion and resolution of member and Chapter issues. CANO/ACIO would like to encourage all members to attend this meeting to provide their input on membership and chapter initiatives. This meeting serves as a forum for communication and information sharing between members, Chapters and the CANO/ACIO Board.

Agenda

1. Call to Order and Roll Call
2. Approval of Agenda
3. Approval of Minutes
4. 2009 Oncology Nursing Day
5. Chapter Grants
6. CANO/ACIO Board of Directors nominations for 2009
7. Chapter Structure
8. Chapter Reporting
9. New Initiatives
10. Other Business
11. Next Meeting
Every door opened could be a discovery made.

Lilly Oncology is a proud sponsor of
The CANO / ACIO Conference

Lilly Oncology

No two cancer patients are alike. That’s why Lilly Oncology is committed to developing treatment approaches as individual as the people who need them. We’ve made many contributions toward improved patient outcomes and—with each door we open—we take another step forward. But helping today’s cancer patient isn’t enough. Even with over 40 drug targets in development, our quest to help you provide tailored therapy is just beginning.

Making science personal.

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**Conference Day One**  
**Sunday, September 14, 2008**

**0700–2200**  
Registration and Information Desk is open (Lobby Foyer)

**CONCURRENT SESSION I**

**0900-1130**  
**Workshop Session I-01 (Avalon Salon C)**  
*Ontario Oncology APN eMentorship: An Experience for Professional Development for all Oncology Nurses!*

Grace I. Bradish, RN, MScN¹, Maureen McQuestion, RN, MSc², David Wiljer, PhD², Denise Bryant-Lukosius, RN, PhD², Esther Green, RN, MSc(T)³, Stephanie Luxton¹, Lynne Penton, RN, MN³, Gail McCartney, RN, MScA³, Ontario Oncology APN eMentorship Project Team³, Mary M. Wheeler, RN, MEd, PPC³, Michelle Cooper, RN, MScN³, ¹London Health Sciences Centre, London, ON, ²Princess Margaret Hospital, Toronto, ON, ³McMaster University, Hamilton, ON, ⁴Cancer Care Ontario.

**0900-1130**  
**Workshop Session I-02 (Avalon Salon D)**  
*Train the Trainer: Moving from Ordinary to Extraordinary Healthcare Training*

Corinne C. Walsh, MA, LLM (Cand.), Platinum Leadership Inc., London, ON, Canada.

**0900-1130**  
**Workshop Session I-03: Facilitating Respect (Harbourview Salon E)**  
*Facilitative Leadership: Supporting Extraordinary Oncology Leaders*

Sherrol Palmer Wickham, RN BScN CON(c), Yvette Matyas, Manisha Gandhi. Odette Cancer Centre, Toronto, ON, Canada.

**0900-1130**  
**Symposia Session I-04 (Marconi Hall)**

**A. Nurses’ Collaboration Produces Extraordinary Results for Patients with Malignant Pleural Effusions**

Lynn Kachuik, RN, BA, MS, CON(C), CHPCN(C)¹, Laura Giannantonio, RN, BScN¹, Suzanne Madore, RN¹, Sheila Bauer, RN, MBA², Sophie Parisien, RN, BScN², Kayvan Amjadi, MD, FRCPC¹, Greg Doiron, BSc, MHA¹. ¹The Ottawa Hospital, Ottawa, ON, Canada, ²Champlain Community Care Access Centre, Ottawa, ON, Canada.

**B. Extraordinary Success: Managing Malignant Pleural Effusions in the Outpatient and Community Settings**

Lynn Kachuik, RN, BA, MS, CON(C), CHPCN(C)¹, Laura Giannantonio, RN, BScN¹, Suzanne Madore, RN¹, Sheila Bauer, RN, MBA², Sophie Parisien, RN, BScN², Kayvan Amjadi, MD, FRCPC¹, Greg Doiron, BSc, MHA¹. ¹The Ottawa Hospital, Ottawa, ON, Canada, ²Champlain Community Care Access Centre, Ottawa, ON, Canada.

**C. Looking Forward: Extraordinary Results of the Regionalization of a Malignant Pleural Effusion Program**

Lynn Kachuik, RN, BA, MS, CON(C), CHPCN(C)¹, Lorraine Cake, RN, BScN, CON(C)¹, Laura Giannantonio, RN, BScN¹, Sheila Bauer, RN, MBA², Sophie Parisien, RN, BScN², Kayvan Amjadi, MD, FRCPC¹, Greg Doiron, BSc, MHA¹. ¹The Ottawa Hospital, Ottawa, ON, Canada, ²Champlain Community Care Access Centre, Ottawa, ON, Canada.
0900-1130 Workshop Session I-05 (Harbourview Salon F)
*Here are the Clues - Can You Solve the Mystery? Issues in Vascular Access*
Inara H. Karrei, RN, BScN, MEd, CON(C), The Ottawa Hospital Cancer Center, Ottawa, ON, Canada.

0900-1130 Workshop Session I-06 (Harbourview Salon G)
*Cancer Treatment Related Pain: An Inter-Professional, Systematic Approach to Diagnosis and Effective Management*
Cindy Shobbrook, RN, MN CON(C), CHPC(C)¹, S. Lawrence Librach, MD, CCFP, FCFP², Kim Stefaniuk, BSP, RPEBC¹, David Warr, MD, FRCP(C)¹. ¹Princess Margaret Hospital, Toronto, ON, Canada, ²Temmy Latner Centre for Palliative Care, Mount Sinai Hospital, Toronto, ON, Canada.

CONCURRENT SESSION II
Note: Presenting authors are indicated in bold text

1300-1700 Workshop Session II-01 (Avalon Salon C)
*Practice Standards and Competencies for the Specialized Oncology Nurse*
Lynne A. Penton, Mt Sinai Hospital, Toronto, ON, Canada.  
This session has been made possible through funding from CANO/ACIO.

1300-1530 Symposia Session II-02 (Marconi Hall)
A. *Secondary Lymphedema in Cancer Survivors: Ordinary Consequence, Extraordinary Challenge*
Susan L. G. Bowles, BScN RN., Odette Cancer Centre, Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

B. *Secondary Lymphedema in Cancer Survivors: Ordinary Consequence, Extraordinary Challenge*
Martina A. Reddick, RN., Dr. H. Bliss Murphy Cancer Centre, St. John’s, NL, Canada.

1300-1530 Workshop Session II-03 (Avalon Salon D)
*Cancer Emergencies: From Novice to Expert*
Nanette Cox-Kennett, Cross Cancer Institute, Edmonton, AB, Canada.

1300-1530 Workshop Session II-04 (Harbourview Salon E)
*Difficult People & Difficult Situations: Transforming Tough Conversations into Collaborative Dialogue*
Corinne C. Walsh, MA, LLM (Cand.), Platinum Leadership Inc., London, ON, Canada

1300-1530 Workshop Session II-05 (Harbourview Salon F)
*The ABC’s of Interdisciplinary Teamwork: the Extraordinary Role of Nurses...*
Anne Plante, M.Sc.inf., CSIO, CSIP¹, Inara H. Karrei, RN, BScN, MEd, CON(C)². ¹Regional Cancer Center, Hôpital Charles LeMoyne, Greenfield Park, QC, Canada, ²The Ottawa Hospital Cancer Center, Ottawa, ON, Canada.
1600-1700 Delegate Orientation Session
First time and returning conference participants are invited to participate in the delegate orientation session. This session will give the delegate an overview of the conference program, and ample opportunity to ask questions. Some items to be covered are meeting room locations, evaluation forms, conference breaks and meals.

1700-1830 Committee and SIG Meetings

1830-2000 Welcome and Keynote Address I (Marconi Hall), presented by Ortho Biotech
Blind since the age of two, Terry Kelly is an accomplished musician, athlete, and professional speaker who uses his own life experiences to motivate others. Terry has won seven East Coast Music awards and has been nominated for four Canadian Country Music awards and a JUNO. In the athletic field, this Newfoundland native is the third blind person in the world to run a sub-five minute mile; was a double-silver medallist at the 1979 Canadian Track Competition; and was a member of the Canadian Track Team that competed in the 1980 Paralympics. In recognition of his significant achievements, Terry Kelly has received the 2005 Canadian Country Music Association’s Humanitarian Award; the prestigious King Clancy Award; honorary doctorates from the University of King’s College and Saint Mary’s University; and has been invested into the Order of Canada.

2000-2200 Welcome Reception (Marconi Hall Foyer), sponsored by sanofi-aventis.
0615-1930  Registration and Information Desk is open (Lobby Foyer)

0645-0745  Breakfast Symposium Sponsored By Roche (Marconi Hall)
Cardiac Management during Adjuvant Trastuzumab Therapy

The learning objectives of this satellite symposium are:
1. Obtain a greater understanding of HER2 and the trastuzumab.
2. Review key studies that contribute to the efficacy of trastuzumab.
3. Discuss and review the national recommendations from the Canadian Trastuzumab
   Working Group on cardiac monitoring and management during adjuvant trastuzumab
   therapy in breast cancer patients.
4. Discuss the practical implementation of these recommendations into the clinical setting.

0800-1000  Opening Ceremonies and Keynote Address II (Marconi Hall Foyer)

Elizabeth M. Davis is a member of the Congregation of the Sisters of Mercy of Newfoundland and Labrador. She serves as the Chairperson of the Canadian Health Services Research Foundation, as Past President of the Medical Council of Canada, and as a member of the Board of the Royal College of Physicians and Surgeons of Canada, the Board of Regis College (Toronto School of Theology) and the Mercy International Research Commission sited in Dublin, Ireland. She taught high school in Newfoundland (1969-1982), and served as Executive Director of St. Clare’s Mercy Hospital (1986-1994) and as the first President and Chief Executive Officer of the Health Care Corporation of St. John’s (1994-2000). She was appointed as a Member of the Order of Canada (May 2004), awarded the 2006 Leadership Achievement Award from the University of Toronto Society of Graduates in Health Policy, Management & Evaluation; and received the Canadian Federation of Nurses’ Unions Bread and Roses Award (2007).


1000-1600  Exhibit Area Open (Avalon Salon AB)
1000-1600  Poster Area Open (Ballroom Foyer)
1015-1045  Abraxis Health Break and Exhibits, Poster Group 1-A
CONCURRENT SESSION III

Note: Presenting authors are indicated in bold text

1045-1215
A. Concurrent Session III-01: Finding Meaning (Marconi Hall)
   When There is No Cure: A Hermeneutic Exploration of Life with Incurable but Treatable Cancer
   Linda C. Watson, RN, BScN, MN, CON(C), Tom Baker Cancer Center, Calgary, AB, Canada.

B. Help! I Need Somebody Help! Not Just Anybody… Building Relationships in Cancer Care
   Kate Butler, RN, Cheryl Howe, RN BN CON(C), Tom Baker Cancer Centre, Calgary, AB, Canada.

C. A Demonstration of the Use of the Participatory, Patient-Centered, Evidence-Based Framework (PEPPA) in a Northern Ontario Cancer Program
   Theresa M. MacKenzie1, Barbara Ballantyne, RN, BNSc1, Tracie Parks, RN, BSc, BScN1, Bertha Paulse, MHA1, Esther Green, RN, Msc (T)2.
   1Regional Cancer Program, Sudbury, ON, Canada, 2Cancer Care Ontario, Toronto, ON, Canada.

1045-1215
A. Concurrent Session III-02: Advanced Practice (Avalon Salon C)
   Collaborating for Comprehensive Patient-Centred Care Closer to Home: an Advanced Practice Nurse Outreach Model of Care
   Barbara Godfrey, RN, MScN1, Lia Kutzscher, RN(EC), MScN, CINA(C), CON(C), AOCNP, PhD(in progr2. 1Princess Margaret Hospital, Toronto, ON, Canada, 2Royal Victoria Hospital, Barrie, ON, Canada.

B. Collaborative Nursing Roles Across a Regional Cancer Surgery Program: Academic and Community Hospital Perspectives
   Beth Brownlee, BScN1, Robin Morash, BNSc., MHS2, Susan Freed, BScN3. 1Pembroke Regional Hospital, Pembroke, ON, Canada, 2The Ottawa Hospital, Ottawa, ON, Canada, 3Queensway Carleton Hospital, Ottawa, ON, Canada.

C. Role Clarity for Advanced Practice Nurses in Oncology: Making the Extraordinary a Little More Ordinary
   J. Colleen Johnson1, Cindy Murray, RN, MN/ACNP2. 1Trillium Health Centre, Mississauga, ON, Canada, 2Princess Margaret Hospital, Toronto, ON, Canada.

1045-1215
A. Concurrent Session III-03: Quality Radiation Therapy (Placentia Bay Room)
   Perfexion™ Gamma Knife Radiation Treatment: When the Extraordinary Becomes the Ordinary.
   Sandra Chapman, RN1, Barbara Willson, RN, MS, CON(C)1, Anne Bradwell, RN2, Leela Kessavan, RN1. 1Princess Margaret Hospital/University Health Network, Toronto, ON, Canada, 2Toronto Western Hospital/University Health Network, Toronto, ON, Canada.

B. Ordinary Treatment with Extraordinary Potential: MammoSite Brachytherapy for Breast Cancer
   Kathy Fitzgerald, Eastern Health, St John’s, NL, Canada.
1045-1215 Concurrent Session III-03: Quality Radiation Therapy cont’d. 
   C. Using Patient Satisfaction Results to Improve Patient Outcome: Medical Radiation Oncology Unit
   Eleanor Miller, PCM, RN, BScN, Gerry Beaudoin, MSW, Audrey Moore-Garcia, RN, BScN, Nancy Siddiq, RN, BScN, Elsa McKie, RN, Barbara Jackson, B.Sc.O.T, William Ford, B.A., M.Div., Dr. Anita Chakraborty, MC. CCFP, Nadine Walters, BCom, Philiz Goh, BSc, BScN(C), Margaret Fitch, RN, PhD, Kate Harmer, Family member, Sunnybrook Health Sciences Centre – Odette Cancer Centre, Toronto, Ontario, Canada

1045-1215 Concurrent Session III-04: Outcomes in Practice (Avalon Salon D) 
   A. Malodourous Fungating Malignant Wounds. A Patient Quality of Life Issue.
   Pamela Savage, MAEd, CON (C), University Health Network, Princess Margaret Hospital, Toronto, ON, Canada.

   B. Ordinary Problem... Extraordinary Results: Development of a Lymphedema Program
   Martina A. Reddick, RN., Dr. H. Bliss Murphy Cancer Centre, St. John's, NL, Canada.

   Karen Janes, MSN¹, Patti Taschuk, BScN RN², Janice L. Chobanuk, I, MN CON(C) CHPCN(C).²
   ¹BC Cancer Agency, BC, BC, Canada, ²MACO, ACB, Edmonton, AB, Canada, ³ACB, Edmonton, AB, Canada.

1045-1215 Concurrent Session III-05: Innovation and Evidenced Based Practice (Harbourview Salon E) 
   A. Ordinary Surgical Site Infections? - An Extraordinary Interprofessional Quality Improvement Initiative Benefiting Surgical Oncology Patients
   Shari L. Moura, RN, MN, CON(C), CHPCN(C).
   Odette Cancer Centre - Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

   B. Reaching New Heights in Patient Safety
   Kim Chapman, RN, BN, MScN, CON(C), Brenda Grant, River Valley Health, Fredericton, NB, Canada.

   C. Women’s Experiences with Breast Prosthesis
   Margaret I. Fitch, RN PhD. Alison McAndrew, BA RAP, Andrea Harris, James D. Anderson, BSc DDS MScD., Odette Cancer Centre, Toronto, ON, Canada.

1045-1215 Concurrent Session III-06: Mentoring, Coaching and Certification: Makes for a Healthy Workplace? (Harbourview Salon F)
   A. Coaching and Cancer Care - a Success Story in Systemic Therapy Program Efficiency
   Cindy A. McLennan, RN, BScN, CON(C), CPN(C), Greg Doiron, MHA, Leslie Cameron, RN, Joanne Ready, RN, Maura Eleuterio, RN, BScN, Angela Blasutti, RN, BScN.
   The Ottawa Hospital, Ottawa, ON, Canada.
1045-1215  Concurrent Session III-06: Mentoring, Coaching and Certification: Makes for a Healthy Workplace? cont’d.

B. Career Development Perspectives among Nurses in Obtaining Specialty Certification in Oncology

Jayesh Patel, RN, BScN, MN1, Maurene McQuestion, RN, APN, BA, BScN, MSc, CON(c)2, Doris Howell, RN, BScN, MScN, PhD3, Karen Gayman, RN, BScN, MN (c)4, Janice Stewart, RN, BScN, ONC(c)5, Kelly McGuigan, RN, BScN6, Catriona Buick, RN, BScN, MN(c), CON(c).

1Systemic Therapy Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 2Radiation Medicine Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 3Chair, RBC Oncology Nursing Research, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 4PMH Administration, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 5Systemic Therapy, Apheresis, & Photopheresis Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 6Community Interlink, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada.

Recruiting and Mentoring Novice Oncology Nurses - Supporting the Professional Development of Novice Oncology Nurses through a Mentorship Program.

Carole Beals, RN, BScN, CON(C), Shelley Debison, RN CHPCN(C), Dana Naylor, RN BScN MN, Royal Victoria Hospital, Barrie, ON, Canada.

Concurrent Session III-07: Novel Prescriptives (Harbourview Salon G)

A. Cancer Screening: Barriers, Attitudes and Behaviors in a Subpopulation of Afro-Caribbean Adults Living in Toronto.

Mary Glavassevich, Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

B. Recruiting the Novice, Retaining the Experienced: a Pilot Educational Program to Support Oncology Nursing Practice

Susan King, RN, BScN, CON(C), Cynthia Cummings-Winfield, RN, BScN, CON(C), Cross Cancer Institute, Edmonton, AB, Canada

Survivors Debate: The Past Decade in Ovarian Cancer

Pamela J. West1, Sandi Pniauskas2, Carolyn Benivegna3. 1Rouge Valley Health System, Toronto, ON, Canada, 2No Institution - patient, Whitby, ON, Canada, 3No Institution - patient, Novi, MI, USA.

Concurrent Session III-08: Round-Table Discussion (Bonavista Bay Room)

Solving Safety Dilemmas: Strategies for Safe Chemotherapy Administration

Caroline Devereux, RN, CONC(C) South East Regional Health Authority, Moncton, NB Sherrol Palmer-Wickham, RN, BScN, CON(C) Odette Cancer Center, Toronto ON

1230-1345 Luncheon Symposium sponsored by Bristol-Myers Squibb (Marconi Hall)

Cancer Therapy Innovation 2008: Current focus on an individualized patient approach

Dr. Derek Jonker
FRCPC
Medical Oncologist, Ottawa Hospital Cancer Centre, Head Clinical Trials Department, Ottawa Hospital Cancer Centre Assistant Professor of Medicine, University of Ottawa

Targeted therapy is quickly becoming standard of care in many cancer disease areas.
This is most apparent in colorectal cancer. Today, Dr. Derek Jonker from the Ottawa Hospital Cancer Center and national principal investigator for an important NCIC trial, will be discussing a new therapy for colorectal cancer, which will be soon available for your patients here in Canada. (for Head and Neck tumors also)

Come and learn how this therapy will offer an individualized approach for a serious disease.

1430-1515 CANO/ACIO Council of Chapters Meeting (Placentia Bay Room)

1530-1600 Health Break and Exhibits (Avalon Salon AB) Poster Group 2-A, 2-B (Ballroom Foyer)

1600-1715 Schering-CANO/ACIO Lecture (Marconi Hall)

The Clinical Nurse Specialist as Nurse Navigator: Ordinary Role Presents Extraordinary Experience

Patti Marchand, RN,MN,CON(C), RS McLaughlin Durham Regional Cancer Centre, Oshawa, ON, Canada.

CONCURRENT SESSION IV

Note: Presenting authors are indicated in bold text

1730-1900 Concurrent Session IV-01: Beyond the Overpass: What’s Outside City Centres (Marconi Hall)

A. Community Cancer Support Networks

Janice L. Chobanuk, MN, CON(C), CHPCN(C), Miriam Dobson, BScN, CHPCN(C), ACB, Edmonton, AB, Canada.

B. Exploring the Uniqueness of Specialized Oncology Nursing Practice in the Small Rural Community: the Challenges, Trials, and Dynamics of Caring for Those in Your Neighbourhood

Wayne Enders, RN. Alberta Cancer Board, Edmonton, AB, Canada.

C. Bringing Extraordinary People Together: A Provincial Nursing Oncology Network


1730-1900 Concurrent Session IV-02: Diverse Technologies (Avalon Salon C)

A. Development of a Systemic Therapy Nursing Workload Tool

Janice D. Stewart, RN, BScN, CON(c)¹, Esther, Green, RN, MSc(T)², Colin Preyra., MA. MSc, PhD³, Kathy Beattie, RN, CON(C)⁴, Marcia Langhorn, RN CON(C)⁵, Rosemary Bland, RN BScN CON(c) CHPCN(C)⁶, Cindy McLennan., RN, BScN⁷, Tracy McQueen., RN⁸.

¹Princess Margaret Hospital, Toronto, ON, Canada, ²Cancer Care Ontario, Toronto, ON, Canada, ³Institute for Clinical Evaluative Sciences, Toronto, ON, Canada, ⁴Odette Cancer Centre, Toronto, ON, Canada, ⁵London Regional Cancer Program, London, ON, Canada, ⁶Juravinski Cancer Centre, Hamilton, ON, Canada, ⁷The Ottawa Hospital Regional Cancer Centre, Ottawa, ON, Canada, ⁸Cancer Centre of Southeastern Ontario, Kingston, ON, Canada.

B. Experiences with the Development, Implementation and Evaluation of a Web-Based Nursing Education Resource

Joy Bunsko, RN, BSN., BC Cancer Agency, Fraser Valley, BC, Canada.
Concurrent Session IV-02: Diverse Technologies cont’d.
C. Questioning Practice: Finding Evidence to Support Best Practice in Skin Care for Patients Receiving Radiation Therapy
Donna J. Gies, RN, CON(C), CHPCN(C), Tom Baker Cancer Centre, Calgary, AB, Canada.

Concurrent Session IV-03: Innovative Practice Opportunities (Avalon Salon D)
A. New Innovative Roles for Oncology Nurses; Participation in a Selection Process for a New Provincial Vendor
Jayesh Patel, RN, BScN, MN¹, Barbara Godfrey, RN, BScN, MScN², Janice Stewart, RN, BScN, OCN(c)³, Diana Incekol, RN, BScN, CON(c)¹, Raquel Lopez, BASc, MASC⁴.
¹Systemic Therapy Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, ²Leukemia Outreach Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, ³Systemic Therapy, Apheresis, & Photopheresis Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, ⁴Healthcare Human Factors Group, Centre for eHealth Innovation, University Health Network, Toronto, ON, Canada.

B. PYNK - Young Women with Breast Cancer Program: Building a Program for Extraordinary Women
Stephanie Burlein-Hall, Margaret I. Fitch, RN BScN MEd CON(C), Ellen Warner, MD MSc FRCPC FACP, Odette Cancer Centre, Toronto, ON, Canada.

C. The Needs of Young Adults with Cancer
Jennifer Parkins, Grand River Regional Cancer Centre, Kitchener, ON, Canada.

Concurrent Session IV-04: Working Together in New Ways (Avalon Salon E)
A. Integrating RN and NP Practice into Outpatient Oncology Clinics
Stephanie M. Hubbard, RN, MN, NP, CONC, Cheryl Howe, RN, BN, CONC, Tom Baker Cancer Center, Calgary, AB, Canada

B. Partners in Care: Improving Breast Cancer Care Together
Angela Leahey, RN, BScN, MN, Sharon Lemon, RN, BScN, CON(c), Sunnybrook Odette Cancer Centre, Toronto, ON, Canada.

C. Two Nurses are Better than One! The Collaborative Practice of a Primary Nurse and an Advanced Practice Nurse
Rosemary Davidson, RN, Wendy A. Gillis, MScN., London Health Sciences Centre, London, ON, Canada.

Concurrent Session IV-05: Symptoms and Side Effects (Avalon Salon F)
A. Controlling Complex Oncology Pain: a Retrospective Review of Patients Managed on Combined Opioids / Ketamine Infusions
Sylvie Bruyere, RN, BScN, CON(C), CHPCN(C), Lynn Kachiuk, RN, BA, MS, CON(C), CHPCN(C), Ottawa Hospital, Ottawa, ON, Canada.

B. The Scoop on Poop. New Options in Managing Refractory Opioid-Induced Constipation
Cindy Shobbrook, RN Advanced Practice Nurse, Princess Margaret Hospital, Toronto, ON, Canada.
Concurrent Session IV-05: Symptoms and Side Effects cont’d.

C. The Incidence of Taxane-Induced Myopathy (Arthralgia/Myalgia) in Patients Receiving Chemotherapy for Early Stage Breast Cancer
Barbara Fitzgerald, Julie Napolskikh, Nadia Salvo, George Dranitsaris, Ali Val, Sophie Kim, Christine Simmons, Malgorzata Tyszka, Mark Clemons, Princess Margaret Hospital, Toronto, ON, Canada.

Concurrent Session IV-06: Learning Is What Counts (Harbourview Salon G)

A. Continuing Education as a Strategy for Nursing Recruitment and Retention
Marika Swidzinski, RN, MEd, BA, CON(C), Liz O’Hagan, RN., CON(C), Nancy Hutchison, MSc (A)N, CON(C).
McGill University Health Center, Royal Victoria Hospital, Montreal, QC, Canada.

B. Perceived Barriers to Pap Smear Screening Among Women of Newfoundland and Labrador
Kathy Fitzgerald, Eastern Health, St John’s, NL, Canada.

C. Creating a Culture of Continuous Learning: A Shared Responsibility
Linda C. Watson, RN, BScN, MN, CON(C), Tom Baker Cancer Center, Calgary, AB, Canada.

Concurrent Session IV-07: Exploring Quality Care (Placentia Bay Room)

A. A Regional Chemotherapy Home Infusion Program: Enhancing Quality, Safe, Accessible Care to Patients
Cindy A. McLennan, RN, BScN, CON(C), CPN(C), Carrie Liska, RN BScN, Joanne Ready, RN, Leslie Cameron, RN, Cathy DeGrasse, RN MScN., The Ottawa Hospital, Ottawa, ON, Canada.

B. There’s Always Room for Improvement: Delivering Nursing Care within Radiation Oncology
Frankie Goodwin, RN, BN., BCCA, Vancouver Centre, Vancouver, BC, Canada.

C. Head and Neck Oncology Case Manager: Addressing the Gaps in Care
Karen H. M. Woodworth, RN, BN, CON (c), Victoria L. Sullivan, BN, RN, MHS, CON(c).
Capital District Health Authority Cancer Care Program, Halifax, NS, Canada.

Concurrent Session IV-08: Round-Table Discussion (Bonavista Bay Room)

Patient Navigation! What’s it all About?
Joanne Cumminger RN, BScN,CON(C), Charlene Porter RN, BScN, CON(C), Guysborough Antigonish Strait Health Authority, NS

Dinner Symposium Sponsored by Roche (Marconi Hall)
The Changing World of Oncology Nursing: Managing Out-Patients on Oral Therapies

This symposium explores the challenges and potential solutions to managing cancer patients being treated in the out-patient world. With the ever increasing number of oral cancer therapies being developed and utilized, new challenges are being faced by both health care professionals and patients. As nurses, you play a critical role in the management of oral therapies in the out-patient world. Education on side effects and other adverse events helps patients more smoothly transition to treatment at home. This session will present key ideas around the treatment of patients on oral therapies in GI, Breast and Lung cancers.
0630-1800  Registration and Information Desk is open (Lobby Foyer)

0630-0800  Breakfast Symposium Sponsored by Merck Frosst Canada Ltd. (Marconi Hall)
Reviewing the evidence and identifying challenges in the prevention and management of Chemotherapy-Induced Nausea and Vomiting

Speaker: Scott Edwards

Scott Edwards graduated in 1994 from Memorial University of Newfoundland with a B.Sc. (Neuroscience) and in 1997, obtained a B.Sc (Pharmacy). In 2005, he graduated with a Doctor of Pharmacy degree from the University of Washington. Currently, Scott is the clinical oncology pharmacy specialist at the Dr. H. Bliss Murphy Cancer Center in St. John’s, NL and is an assistant professor at Memorial University School of Pharmacy. He is active in clinical cancer research in the area of chemotherapy toxicities, supportive care and seamless care.

Description and learning objectives
• Chemotherapy induced nausea and vomiting is a common adverse effect of chemotherapy which impacts patients’ quality of life. This program is designed to improve the ability of nurses to assess and manage patients at risk of experiencing CINV. Case studies will stimulate an interactive discussion on the appropriate treatment of CINV.

Participants will be able to:
• Discuss importance of prevention and treatment of CINV and its relationship to quality of life
• Summarize the neurophysiology of Chemotherapy-Induced Nausea and Vomiting
• Review the latest consensus guidelines for the treatment of CINV
• Describe common clinical challenges in the management of CINV and the evidence for managing these problems
• Develop treatment plans for managing CINV by solving case study problems

0815-0945  CANO/ACIO Annual General Meeting (Marconi Hall)

0930-1530  Exhibit Area Open (Avalon Salon AB)

0930-1530  Poster Area Open (Ballroom Foyer)

0930-1015  Health Break and Exhibits (Avalon Salon AB) Poster Groups 3-A, 3-B, 3-C (Ballroom Foyer)

CONCURRENT SESSION V

1015-1145  Concurrent Session V-01 : Finding Meaning (Avalon Salon C)

Margaret I. Fitch, RN PhD\(^1\), Fran Turner, MS\(^2\), Sherri Magee, PhD\(^3\), Alison McAndrew, BA RAP\(^4\), Elisabeth Ross, MHSc\(^5\). \(^1\)Odette Cancer Centre, Toronto, ON, Canada, \(^2\)Ovarian Cancer Canada, Toronto, ON, Canada, \(^3\)Independent Researcher, Vancouver, ON, Canada.
1015-1145 Concurrent Session V-01: Finding Meaning cont’d.
B. 10 Years of Reflective Practice. What Have We Learned? Eva Pathak, RN, MEd, MN, Alda Steprans, RN, MEd, Doris Howell, RN, PhD. Princess Margaret Hospital, Toronto, ON, Canada.

C. Survive ‘n’ Thrive Pamela J. West, Heather L. Cameron, BSW, MSW, RSW, Lorna Moore. Rouge Valley Health System, Toronto, ON, Canada.

1015-1145 Concurrent Session V-02: Mentorship (Avalon Salon D)
A. Intergenerational Workplaces: a Collision Course for Canadian Cancer Care Cindy A. McLennan, RN, BScN, CON(C), CPN(C), Kelly Anne Baines, RN, Mychelle Rheumme, RN BScN, Joanne Ready, RN, Leslie Cameron, RN, Greg Doiron, MHA. The Ottawa Hospital, Ottawa, ON, Canada.

B. Implementing a Clinical Expert Oncology Nursing Model across the Continuum Lana Bols, Shelley McIntyre, The Ottawa Hospital, Ottawa, ON, Canada.

C. Transforming Ordinary Nurses to Extraordinary Oncology Nurses: A Mentorship / Preceptorship Strategy Katherine Winters, RN, CON(C), Lorna McBride, RN, Mario DaPonte, RN BScN. The Ottawa Hospital, Ottawa, ON, Canada.

1015-1145 Concurrent Session V-03: Quality Improvement: Nursing Practice (Marconi Hall)
A. Building an Environment of Safety when Using Ambulatory Infusion Pumps Patricia Murphy-Kane, BScN, BA, Laura L. Rashleigh, BScN, CONC(C). PMH, UHN, Toronto, ON, Canada.

B. Extraordinary Oncology Nurses/Extraordinary Documentation: Competencies to Guide Practice Marcie Flynn-Post, RN, BA1, Theresa MacKenzie, RN2. 1Carlo Fidani Peel Regional Cancer Centre at the Credit Valley Hospital, Mississauga, ON, Canada, 2Regional Cancer Program, Sudbury, ON, Canada
1Trillium Health Centre, Mississauga, ON, Canada, 2Princess Margaret Hospital, Toronto, ON, Canada

C. Is Extraordinary Communication Possible? Implementing Change on an Inpatient Surgical Oncology Unit. Shawne Gray, BScN, RN, Anne Li Ting Guan, BScN, RN, Miranda Lamb, BScN,RN, Shari Moura, RN, MN, CON(C), CHPCN(C), Elizabeth Yabbour, BScN, RN. Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

1015-1145 Workshop Session V-04: Advanced Practice (Conception Bay Room)
Making the Ordinary and Extraordinary Work Done by Advanced Practice Nurses More Visible: What Data should be Collected and Who in your Leadership Team Needs to Know J. Colleen Johnson, RN, MN/ACNP, CON(C)1, Cindy Murray, RN, MN/ACNP2. 1Trillium Health Centre, Mississauga, ON, Canada, 2Princess Margaret Hospital, Toronto, ON, Canada.
1015-1145 Concurrent Session V-05: Symptom Management / Supportive Care
(Harbourview Salon E)
A. Cancer Rehabilitation Improves Sleep
Siobhan M. Carney, BScN, Margaret Eades, N. MSc (A) CON(C), Virginia Lee, N. PhD, Pasqualina Di Dio, PhD, Rajesh Sharma, MD, McGill University Health Centre, Montreal, QC, Canada.

B. Experiences of Family Caregivers of Patients with Advanced Head and Neck Cancer Receiving Enteral Tube-Feeding
Jamie L. Penner, RN, BN, BPE., Faculty of Nursing, University of Manitoba, Winnipeg, MB, Canada.

C. Managing Sleep-Wake Disturbances in Oncology Patients: Putting Evidence into Daily Practice
Barbara D. Hues, RN, MN, CON(C), Erin E. Elphee, RN, BN, CON(C), Anne Katz, RN PhD, Rebecca Pritchard, RN, BN.
CancerCare Manitoba, Winnipeg, MB, Canada.

1015-1145 Concurrent Session V-06: Evidenced Based Practice (Harbourview Salon F)
A. Comprehensive Psychosocial Care: an Innovative Nursing Approach
Montreal General Hospital, McGill University Health Centre, Montreal, QC, Canada.

B. Effectiveness of Knowledge Translation Interventions to Improve Cancer Pain Management: a Systematic Review
Greta G. Cummings1, Neil Hagen2, Robin Fainsinger1, Carla Stiles2, Susan Armijo-Olivo1, Lesa Chizawsky, RN MN1, Alison Connors, RN BN1, Patricia Biondo, PhD2.
1University of Alberta, Edmonton, AB, Canada, 2Alberta Cancer Board, Calgary, AB, Canada.

C. “Ordinary Days, Extraordinary People”: Living the Caring
Corsita T. Garraway, MSN - FNP, CON(C), CHPCN(C), Princess Margaret Hospital, Toronto, ON, Canada.

1015-1145 Concurrent Session V-07: Patient Safety and Quality Care (Harbourview Salon G)
A. Algorithms for Prevention, Treatment and Follow-up after Antineoplastic Agents Extravasation in Children and Adolescents: a Simple Strategy for a Safer Nursing Care
Daniella Chanes, BSN, Maria Gaby Gutiérrez, BSN, MSN, PhD, Mavilde L. G. Pedreira, BSN. PhD. Federal University of Sao Paulo, Sao Paulo, Brazil.

B. Decreasing Waiting Times: A Chemotherapy Unit Makes an Extraordinary Change
Sherrol Palmer Wickham, RN BScN CON(c), Kathy Beattie, RN CON(c).
Odette Cancer Centre, Toronto, ON, Canada.

C. Improving the Diagnostic Process for Patients with Suspicious Breast Abnormalities
Bridgette Lord, Naomi Miller, Karina Bukhanov, David McCready, Princess Margaret Hospital,
Toronto, ON, Canada.

1015-1145 Concurrent Session V-08: Round-Table Discussion (Bonavista Bay Room)
Challenges Associated with the Management of Central Venous Access Devices
Tammy Coffey-Hickey, RN, MN, Eastern Health, St. John’s, NL

1015-1145 Concurrent Session V-09: Round Table Discussion (Placentia Bay Room)
Living with Leukemia: Getting Back on Track. Open discussion with 5-member panel for needs of Hematology nurses and potential Hematology Special Interest Group. This session will focus on CML.
Speaker / Moderator: Nancy Pringle, RN, Case Manager, Malignant Hematology, Princess Margaret Hospital, Toronto, ON
Panel: Charlene Downey RN, MN,NP Con(c) Newfoundland/ Labrador
Tanis Nelson, RN, Gordon and Leslie Diamond Health Centre Vancouver, British Columbia
Cheryl-Anne Simoneau, President CML Society of Canada, Montreal, QC
Lea Greenwood Patient Services Manager Leukemia/Lymphoma Society, Toronto, ON
This round table discussion has been made possible through the support of Bristol Myers Squibb

1200-1315 Luncheon Symposium Sponsored by GlaxoSmithKline (Marconi Hall)
Notes From an Oncology Nurse and Breast Cancer Survivor: Confronting the Challenges of Care of Breast Cancer

In her career as an oncology nurse, Lillie Shockney has been applying her experiences with breast cancer patients to her approach to nursing. At the age of 38, her professional and personal worlds collided when she was first diagnosed with breast cancer and acquired a patient perspective on care. Since then, her nursing methodology has focused on blending her personal experience with providing better patient care.

Mrs. Shockney’s presentation will critically review breast-cancer diagnosis and treatment over the past four decades, and address the personal experiences that have shaped her widely respected approach to the challenges of caring for breast cancer patients.

CONCURRENT SESSION VI

Note: Presenting authors are indicated in bold text

1330-1500 Concurrent Session VI-01 : Palliative Care (Marconi Hall)
Empowering Nurses to Practice at Full Scope: the Palliative Care Nurse Consultant Model
Wendy Petrie, RN, MScN, CON(C), CHPCN(C), Lynn Kachuik, RN, BA, MS, CON(C), CHPCN(C), The Ottawa Hospital, Ottawa, ON, Canada.

A. Extraordinary People: Oncology Nurses Removing Barriers to Improve Transition from Cancer Care to Palliative Care
Deborah L. Gravelle, RN, BScN, MHS1, Frances Legault, RN BScN MN PHD2, Lynn Kachuik,, RN BA Msc, CON (c) CHPCN2, Lilian Locke, RN BScN, MPA1.
1SCO Health Service, Ottawa, ON, Canada, 2University of Ottawa, Ottawa, ON, Canada, 3The Ottawa Hospital, Ottawa, ON, Canada.
1330-1500
Concurrent Session VI-01: Palliative Care cont’d.
C. Facing your Own Death: the Transition Experiences of Adult Patients in a Tertiary Care Hospital, Palliative Care Unit
Nancy Lee Brown, MSc(A)1,2. 1McGill University Health Centre, Montreal, QC, Canada, 2Inova Health System, Falls Church, VA, USA.

1330-1500
Concurrent Session VI-02: Palliative Care / Supportive Care (Avalon Salon C)
A. End-of-Life Care in the Acute Care Setting
Katrina Longfield, Patricia Murphy-Kane, Princess Margaret Hospital, Toronto, ON, Canada.
B. Improving Access, Integration and Patient-Centered Care for Gynaecologic Oncology Patients Via Sustainable Process Re-Design Strategies at UHN
Sherida P. Chambers, MSN, University Health Network-Toronto General Hospital, Toronto, ON, Canada.
C. Cancer Patient Navigation
Janice L. Chobanuk, MN, CON(C), CHPCN(C)1, Debbie Benoit, RN2, Lue Petruk, BN3, Arlene Throness, RN4. 1ACB, Edmonton, AB, Canada, 2ACB, Drumheller, AB, Canada, 3ACB, Lloydminster, AB, Canada, 4ACB, Grande Prairie, AB, Canada.

1330-1500
Concurrent Session VI-03: Paediatrics and Quality Care (Avalon Salon D)
A. Linking it all Together; Practice and Patient Outcomes
Christine Gervais, BScN, Colleen Graham, BScN, Pat Bieronski, BScN, Jane Burns, BScN, Donna M. Holmes, BHScN. Grand River Regional Cancer Centre, Kitchener, ON, Canada.
B. The Use of the ESAS Tool to Empower RNs in the Oncology Ambulatory Care Setting
Cathy Comerford, BScN, CON(C), Anne Roberts, BScN, CON(C). The Ottawa Hospital, Ottawa, ON, Canada.

1330-1500
Concurrent Session VI-04: Patient Safety (Harbourview Salon E)
A. Making a List and Checking it Twice: Recommendations on the Development and Design Components of a Document for Checking High Risk Medications
Pamela Savage, RN, MAEd.,CON(C)1, Kathy Trip, RN, MN, APN1, Rachel White2, Diana Inczékol, RN, BScN, CON(C)1, Heather Colbert, BSc, PEng2, Sylvia Hyland, BScPhm, MHSc3, Salima Ladak, RN, MN, APN4, Anthony Easty, PhD, PEng, CCE2. 1University Health Network, Princess Margaret Hospital, Toronto, ON, Canada, 2University Health Network, Centre for Global eHealth Innovation, Toronto, ON, Canada, 3Institute for Safe Medication Practices, Toronto, ON, Canada, 4University Health Network, Toronto, ON, Canada.
B. While I Am Away: Hand Over Communication for Planned and Unplanned Nursing Absences in an Ambulatory Cancer Centre
Mary Jamieson, RN, BScN, CON(c), Tracey Das Gupta, RN, MN, CON(c). Sunnybrook Odette Cancer Centre, Toronto, ON, Canada.

1330-1500
Concurrent Session VI-05: Perceptions in Cancer Nursing (Conception Bay Room)
A. Oncology Patients’ and Nurses’ Perceptions of Caring
Patricia A. Poirier, PhD, RN, Ann Sossong, PhD, RN. University of Maine, Orono, ME, USA.
1330-1500  Concurrent Session VI-05: Perceptions in Cancer Nursing cont’d.
  B. *Psychosocial Issues in Screening for Hereditary Cancers: Implications for Cancer Nurses*
     Margaret I. Fitch, RN PhD., Odette Cancer Centre, Toronto, ON, Canada.

1330-1500  Concurrent Session VI-06: Information Needs and Perceptions of Patients
  (Harbourview Salon F)
  A. *It's not going to Ruin our Relationships - or will it?: Smoking, Lung Cancer and Family Dynamics*

  B. *Les Besoins Informationnels d’Hommes Atteints de Cancer de la Prostate Localisé, ceux de leurs Partenaires de Vie et ceux Identifiés comme Essentiels par les Professionnels de la Santé*
     Nicole Tremblay, MSN, CHUM, ANJOU, QC, Canada.

  C. *Making Treatment Decisions about Adjuvant Endocrine Therapy for Breast Cancer*
     Melissa TeBrake, RN, Yolanda Madarnas, MD, Deborah Feldman-Stewart, PhD, Marianne Lamb, RN, PhD, Joan Tranmer, RN, PhD., Queen’s University, Kingston, ON, Canada.

1330-1500  Concurrent Session VI-07: Clinical Approaches to Quality Care and Survivorship
  (Harbourview Salon G)
  A. *A New Approach to Meeting the Needs of Colorectal Cancer Patients*
     Karin T. Runnalls, BScN, Marlene M. Mackey, BNSc, Michele A. Holwell, MSW. The Ottawa Hospital, Ottawa, ON, Canada.

  B. *Multidisciplinary Evidence Informed Practice Change for Assessing and Managing Dyspnea in Patients with Lung Cancer: a CANO/Eli Lilly Mentorship Award Summary*
     Lorraine Martelli-Reid, RN, MN¹, Denise Bryant-Lukosius, RN, MN, PhD¹².
     ¹Juravinski Cancer Centre, Hamilton, ON, Canada, ²McMaster University, Hamilton, ON, Canada.

  Clinical Approaches to Quality Care and Survivorship :
  Factors Influencing Men Undertaking Active Surveillance for the Management of Low Risk Prostate Cancer
  B. J. Davison, PhD, RN¹, John Oliffe, PhD, RN¹, Tom Pickles, MD2, Larry Mroz, PhD (c)¹. 1UBC, Vancouver, BC, Canada, 2BC Cancer Agency, Vancouver, BC, Canada

1330-1500  Concurrent Session VI-08: Round-Table Discussion (Bonavista Bay Room)
  The Value of Debriefing in Oncology Nursing
  Valarie Barrington, M.S.W., R.S.W. Dr. H. Bliss Murphy Cancer Centre, Eastern Health, St. John’s, NL

1500-1530  Health Break and Exhibits (Avalon Salon AB) Poster Group 4-A, 4-B, 4-C, 4-D (Ballroom Foyer)
1530-1700  Helene Hudson Memorial Lectureship and Awards Ceremony (Marconi Hall)
*Hereditary Breast Cancer - How My Family Made Decisions*
Patricia Benjaminson, RN, CON(C), CancerCare Manitoba, Winnipeg, MB, Canada

1745-2300  Newfoundland Beach Party and Boat Tour
The St. John's Branch of CANO/ACIO is looking forward to hosting our colleagues and friends to a fine Newfoundland time! We'll begin our evening by taking you away to the province's scenic southern shore (20 min bus ride)! On the beautiful sea shore of Bay Bulls we'll enjoy a genuine Newfoundland Beach Party, complete with crackling bonfire, the sounds of the Atlantic surf, a mussel “boil–up,” dinner buffet of traditional Newfoundland dishes and lively, local entertainment! Not a lover of the great outdoors? Not too worry, we have an indoor banquet room with ocean view and dance floor where you can enjoy the evening, kick up your heels and celebrate!! What better way to enjoy good food, good friends and good times. Remember! Optional guided boat tour of Bay Bulls harbor and nearby islands is also available. Can’t wait to share all this with you!!
0630-1530 Registration and Information Desk is open (Lobby Foyer)

0930-1130 Exhibit Area Open (Avalon Salon AB)

0930-1130 Poster Area Open, Poster Group 5-A, 5-B (Ballroom Foyer)

0815-0945 Keynote Speaker Presentation III (Marconi Hall), presented by Wyeth

Wyeth

Laurie Anne O’Brien has been with palliative care in NL since the 1970’s. She completed initial palliative care training in Montreal and came back to help open the first PCU east of Montreal in St John’s NL in 1979. Laurie Anne has continued her palliative care career through working in various roles such as being an executive of National Hospice Palliative Care (HPC) Nurses Group, past president of the NLPCA, past president of the local Bereavement Association. She was a NL representative in the development of national HPC Norms plus HPC Nursing standards and CNA HPC certification exam preparation. She also serves on several national committees. Since April 2006, she is seconded as regional palliative consultant to help develop a regional palliative end of life care program, rural and urban, across all sectors from acute care, community and long term care.


0945-1015 Health Break and Exhibits (Avalon Salon AB)

Concurrent Session VII

Note: Presenting authors are indicated in bold text

1015-1145 Concurrent Session VII-01: Supporting Patients and Families (Marconi Hall)

Extraordinary People: Oncology Nurses working Together to Provide Advanced Palliative Care Education

Deborah L. Gravelle, RN, BScN, MHS¹, Lei, Elaine, RN, BSN, CHPCN(c)², Maryse Bouvette,, RN BScN MEd, CHPVN³, Lynn Kachuik,, RN BA Msc, CON (c) CHPCN⁴.

¹SCO Health Service, Ottawa, ON, Canada, ²Hospice May Court, Ottawa, ON, Canada, ³The Ottawa Hospital, Ottawa, ON, Canada.
Concurrent Session VII-01: Supporting Patients and Families cont’d.
B. The Patient Passport Initiative: a Tool for People with Cancer to Call their Own
Myriam Skrutkowski, M.Sc.N., Andreanne Saucier, M.Sc.N.
McGill University Health Center, Montreal, QC, Canada.

C. The Not So Ordinary Days after an Extraordinary Experience - The Supportive Care
Needs of Patients 3-6 Months Following Treatment for Head & Neck Cancer
Maureen A. McQuestion, RN, BScN, MSc, CON(C)1, Doris Howell, RN, PhD1,2, Lucy Ruggiero, RDW, MSW1.1Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 2RBC Financial Group Chair in Oncology Nursing Research, University Health Network, University of Toronto, Toronto, ON, Canada.

Concurrent Session VII-02: Information to Support Patient Decision Making
(Conception Bay Room)
A. The Complementary Medicine Education and Outcomes (CAMEO) Research Program: Meeting the Extraordinary Needs of Cancer Patients
Lynda G. Balneaves, RN, PhD1, Tracy L. O. Truant, RN, MSN2, Marja J. Verhoef, PhD2, Alison S. A. Brazier, PhD1.
1UBC School of Nursing, Vancouver, BC, Canada, 2BC Cancer Agency, Vancouver, BC, Canada.

B. Human Papillomavirus Vaccine, Separating the Myths from the Facts
Catriona J. Buick, RN, BScN, CON(c), MN(C)1,2.
1Princess Margaret Hospital, Toronto, ON, Canada, 2University of Toronto, Toronto, ON, Canada.

C. A Potentially Shocking Ethical Dilemma: End-of-Life Care of a Patient with an Implanted Cardiac Defibrillator (ICD)
Susan J. Collins, RN, MScN, ACNP, CON(C), Robin L. Moffatt, RN, BScN.
London Health Sciences Centre, London, ON, Canada.

Workshop Session VII-03 (Avalon Salon C)
Exercise and Cancer: Let’s Get Moving!
Jan Park Dorsay, BAA(N), MN, ACNP(D), Oren Cheifetz, BScPT, MPT.
Hamilton Health Sciences, Hamilton, ON, Canada.

Concurrent Session VII-04: Partnerships and Linkages (Avalon Salon D)
A. The Comprehensive Breast Cancer: a Multidisciplinary and Multi-Jurisdictional Approach to Enhancing the Patient Care Path
Janet E. Bates, BScN1, Barb Rocchio, RN, BScN, MEd2, Cathy Duong, BScPhrm1.
1Alberta Cancer Board, Edmonton, AB, Canada, 2Innovative Health Care Consulting Inc., Edmonton, AB, Canada.

B. Transition Services in Ambulatory Cancer Care: Navigating Between Two Systems
Sonya Caruth, RN, BN1,2, Linda C. Watson, RN, BScN, MN, CON(C)1.
1Tom Baker Cancer Center, Calgary, AB, Canada, 2Calgary Health Region, Calgary, AB, Canada.
1015-1145  Concurrent Session VII-04: Partnerships and Linkages cont’d.
   C. Thinking Outside of the Box: Bringing Radiation Therapy to North Simcoe Muskoka
      Tracey A. Keighley-Clarke, Garth Matheson, B. Comm., M.B.A..
      The Royal Victoria Hospital of Barrie, Barrie, ON, Canada.

1015-1145  Workshop and Oral Presentation Session VII-05: Symptom Management
           (Harbourview Salon E)
           A. Chemotherapy Induced Cardiotoxicity
              Valarie M. Ali, RN, BA, CON(c)1, Alison M. Nasu, RN, BN, OCN2.
              1Princess Margaret Hospital, Toronto, ON, Canada, 2Credit Valley Hospital, Mississauga, ON, Canada.

           B. Teaching Patients to Breathe Offers a Breath of Fresh Air
              Cathy A. Kiteley, RN, BScN, MSc, CONc, CHPCNc1, Jennifer Parkins, RN, BScN, MNc, CONc2.
              1The Peel Regional Cancer Centre, Mississauga, ON, Canada, 2Grand River Regional Cancer Centre, Kitchener, ON, Canada.

1015-1145  Concurrent Session VII-06: Professional Nursing Issues (Harbourview Salon F)
           Growing your CANO Chapter... Meeting by Meeting
           Carole Beals1, Lynne Penton, MN.
           1Royal Victoria Hospital, Barrie, ON, Canada.

1145-1315  Lunch

CONCURRENT SESSION VIII

1330-1500  Workshop Session VIII-01 (Marconi Hall)
           What is Manuscript Reviewing? What is the Role of the CONJ Reviewer?
           Heather B. Porter, CONJ, Waterloo, ON, Canada.
           This session has been made possible through funding from CANO/ACIO.

1330-1500  Concurrent Session VIII-02: Ongoing Nursing Education (Avalon Salon C)
           An Innovative Approach to Palliative Care Education: an E-learning Module on Managing Pain Together
           Deborah L. Gravelle, RN, BScN, MHS1, Margaret Lerhe1, Emma Stodel2, Maryse Bouvette, RN BScN, MEd, CHPCN (c)1.
           1SCO Health Service, Ottawa, ON, Canada, 2Excellence4Learning, Ottawa, ON, Canada.

           B. From Watson & Crick to the Clinic - the Development of a Genetics Tutorial for Oncology Nurses
              Kathryn R. Calder, BScN1,2, Brenda Cameron, RN, PhD2, Cindy Cummings Winfield, BScN, CON(C)1,2, Karin Olson, RN, PhD1,2.
              1Cross Cancer Institute, Edmonton, AB, Canada, 2Faculty of Nursing, University of Alberta, Edmonton, AB, Canada.
1330-1500 Concurrent Session VIII-02: Ongoing Nursing Education cont’d.
C. Planning with the End in Mind: a New Approach to Oncology Nursing Curriculum Design
Cynthia Cummings-Winfield, RN, BScN, CON(C), Susan King, RN, BScN, CON(C), Anne-Marie Stacey, MMus, MEd. Cross Cancer Institute, Edmonton, AB, Canada.

1330-1500 Concurrent Session VIII-03: Professional Nursing Issues (Avalon Salon D)
Exploring the Relationship between Rotating Shift Work and Melatonin Levels: A Transdisciplinary Research Program
Ann Grundy, Joan Tranmer, Harriet Richardson, Charles Graham, Kristan Aronson. Queen’s University, Kingston, ON, Canada.

1330-1500 Concurrent Session VIII-04: Supporting Women with Cancer (Harbourview Salon E)
Extraordinary, Multidisciplinary Group Client Information Sessions: Preparing Breast Cancer Clients for their Pre and Post Op Journey
Lisa A. Albensi, MSN, Jo-Anne L. Marion, BN. WRHA-Breast Health Centre, Winnipeg, MB, Canada.

B. Abnormal Breast Screening Results: the Psychological Consequences Experienced by Women and the Social Supports They Access
Patti Marchand, RN, MN, CON(C)
1, Manon Lemonde, RN, PhD2. 1RS McLaughlin Durham Regional Cancer Centre, Oshawa, ON, Canada, 2University of Ontario Institute of Technology, Oshawa, ON, Canada.

C. Changing the Way We Meet the Supportive Care Needs of Women Living With Ovarian Cancer and their Families
Shari Moura, RN, MN, CON(C), CHPCN(c)1, Tracey DasGupta, RN, MN, CON (c)2, Elaine Avila, RN, BScN1, Lynn Faltl, RN2, Mary Glavassevich, RN, BA, MN1, Brenda Leung, RN, BScN1, Alison McAndrew, BA, RAP2, Cynthia Robinson, MSW, RSW1, Terry Russell, Ph.D.1, Marilyn Sapsford, BA, MDiv1, Kalli Stilos, RN, MN, CHPCN(C)1. 1Sunnybrook Health Sciences Centre, Toronto, ON, Canada, 2Sunnybrook Odette Cancer Centre, Toronto, ON, Canada, 3Ovarian Cancer Canada, Toronto, ON, Canada.

1330-1500 Workshop and Oral Presentation Session VIII-05: Communicating the E-Way (Harbourview Salon F)
A. Pioneering eCommunication in Palliative Care
Lisa Streeter, RN, BN, Simone Stenekes, RN, MN, CHPCN(C), Mike Harlos, MD, CCFP, FCFP, Canadian Virtual Hospice, Winnipeg, MB, Canada.

B. Clinical Electronic Communication: Using E-mail to Share Patient Information Between Collaborating Advanced Practice Nurses
Barbara Godfrey, RN, MScN1, Lia Kutzsch, RN(EC),MScN,CINA(C),CON(C),AOCNP,PhD(in progress)2. 1Princess Margaret Hospital, Toronto, ON, Canada, 2Royal Victoria Hospital, Barrie, ON, Canada.
1330-1500 Concurrent Session VIII-06: Leukemia: Treatment, Sexuality and Survivorship (Harbourview Salon G)

A. **Planning and Implementing an Ambulatory Management Strategy for Acute Myelogenous Leukemia (AML) Patients Undergoing Consolidation Chemotherapy: Experience of an Inpatient Oncology Unit**
   Jeannette Mallay, RN BScN, Jane Keown, RN, Regional Cancer Program, Sudbury, ON, Canada.

B. **Sexuality and Sexual Function after Hematopoietic Stem Cell Transplantation: Nursing Implications**
   Samantha Mayo, RN, MN, Kelly Metcalfe, RN, PhD. University of Toronto, Toronto, ON, Canada.

C. **Beyond Survival: Managing Late Effect Complications of Allogenic Stem Cell Transplantation**
   Janice A. Wright, MS, Nancy-Anne Pringle, RN. Princess Margaret Hospital, Toronto, ON, Canada

1515-1545 Closing Ceremonies and Invitation to the 21st Annual CANO/ACIO Conference (Marconi Hall)
17 Abbott Oncology

Pioneering. Achieving. Caring. Enduring. Those are Abbott values. They represent our core vision. They create our drive. They guide our commitment. This is why our involvement in oncology has included every level of the field and why we endeavor to create a treasure zone in oncology.

34 Abraxis BioScience Canada

Abraxis BioScience Canada, Inc., based in Mississauga, Ontario, is committed to the global development of innovative next generation cancer therapeutics, such as ABRAXANE®, that target biological pathways. Driven by compassion and care for patients, Abraxis BioScience is challenging standards of care through rigorous research and innovative science. For more information about the company and its products please visit www.abraxisbio.com.

14 Advanced Practice Nurses Community of Practice and McMaster University

Research shows that oncology Advanced Practice Nurses (APNs) in Ontario face many challenges and require guidance from more experienced health care professionals, researchers, and administrators. This research provided the background to develop and evaluate a provincial e-based mentorship program to meet the role development needs of Ontario oncology APNs. Features of the program include:
- A national inventory of intra and inter professional mentors
- Two-day face to face workshop
- Online application forms for mentors and mentees
- A rigorous and confidential process to match mentees with high-quality mentors
- Access to a dedicated and password-protected website with an electronic toolkit of resources for the mentoring relationship
- Online discussion forums to enhance matched pairs communication
- Quarterly program newsletters

Expanding this program to a national level looms on the horizon with exciting opportunity for broadening the pool of interdisciplinary mentors and including Oncology APNs across Canada!

23 AstraZeneca Canada

AstraZeneca is pleased to feature information and value-added resources regarding our medicines in oncology and welcomes members of CANO/ACIO to drop by and visit our booth.

31 Bard Canada

C.R. Bard Inc. is a leading multinational developer, manufacturer and marketer of innovative, life-enhancing medical technologies. We are the market leaders in the field of vascular access devices. We create products that have a positive impact on people's lives. We develop, manufacture and distribute medical devices used by an array of practitioners on the process of gaining access to the circulatory and other select systems for the purpose of delivering chemotherapy, blood products, antibiotics, drugs or nutrition. Our products also deliver oncology treatments for the detection, treatment and management of various cancers. For more information on our ports and related services, please visit our website at http://www.portadvantage.com.
39  Baxter Corporation

As a subsidiary of Baxter International Inc., Baxter Corporation (Canada) develops, manufactures and markets products that save and sustain the lives of people with hemophilia, immune disorders, cancer, infectious diseases, kidney disease, trauma, and other chronic and acute medical conditions. As a global, diversified healthcare company, Baxter applies a unique combination of expertise in medical devices, pharmaceuticals and biotechnology to create products that advance patient care worldwide.

36  Bayer Healthcare Pharmaceuticals Oncology

Bayer HealthCare Pharmaceuticals is among the top five specialty pharmaceutical companies in Canada and is a leader in the field of oncology.

Despite significant advances in the fight against cancer, there remains a great medical need for therapies that can extend and improve the quality of life. We are combining passion with purpose to improve the lives of individuals touched by cancer.

As our understanding of the various mechanisms behind each type of cancer deepens, so does our ability to develop innovative approaches to combat uncontrolled cell growth and proliferation. We are focusing on developing targeted therapies to combat solid tumors and hematologic malignancies.

We are deeply committed to providing Canadians with the best medicine and continue to invest in the research and development of innovative pharmaceutical products to improve the lives of patients.

29  Bristol-Myers Squibb

Bristol-Myers Squibb Canada is an indirect wholly-owned subsidiary of Bristol-Myers Squibb Company, a global pharmaceutical and related health care products company whose mission is to extend and enhance human life. Bristol-Myers Squibb is a leading provider of medicines to fight cancer, cardiovascular and metabolic disorders, infectious diseases (including HIV/AIDS), nervous system diseases and serious mental illness.

12  Canadian Cancer Society

Information and Peer Support Programs from a source you can trust

The Canadian Cancer Society is committed to providing excellent cancer information and support to Canadians.

Information: People can access information in print, online, and over the phone. We provide comprehensive, tailored information about all types of cancer, treatments and potential side effects, complementary therapies, prevention and support options. Trained information specialists give people the time they need so their questions are answered clearly, in terms they understand.

Peer support: Adults diagnosed with cancer and their caregivers can be matched with a trained volunteer who has been through a similar cancer experience. Volunteers provide an empathetic ear and practical coping suggestions. Matches are based on factors that are important to the individual. With over 1200 volunteers to choose from we are able to match on many variables and provide support for all types of cancer.
27 Canadian Nurses Association (CNA)

CNA is the national professional voice of Registered Nurses, supporting them in their practice and advocating for healthy public policy and a quality, publicly funded, not-for-profit health system. In pursuit of its vision and mission, CNA has established the following goals:

1. CNA advances the discipline of nursing in the interest of the public.

2. CNA advocates public policy that incorporates the principles of primary health care (access, interdisciplinary practice, patient and community involvement, health promotion including determinants of health and appropriate technology/roles/models) and respects the principles, conditions and spirit of the Canada Health Act.

3. CNA advances the regulation of registered nurses in the interest of the public.

4. CNA works in collaboration with nurses, other health-care providers, health system stakeholders and the public to achieve and sustain quality practice environments and positive client outcomes.

5. CNA advances international health policy and development in Canada and abroad to support global health and equity.

6. CNA promotes awareness of the nursing profession so that the roles and expertise of registered nurses are understood, respected and optimized within the health system.

The Canadian Nurses Association is a federation of 11 provincial and territorial nursing associations and colleges representing more than 133,700 registered nurses and nurse practitioners.

9 Canadian Oncology Nursing Journal (CONJ)

The Canadian Oncology Nursing Journal is the official publication of the Canadian Association of Nurses in Oncology, and is directed to the professional nurse caring for patients with cancer. The journal supports the philosophy of the Association. In addition, the journal serves as a newsletter conveying information related to the Association; it intends to keep Canadian oncology nurses current in the activities of their national association. Recognizing the value of the nursing literature, the editorial board will collaborate with editorial boards of other journals and indexes to increase the quality and accessibility of nursing literature.

28 CANO/ACIO 2009

We are pleased to invite you to the CANO/ACIO 2009 Conference in Montreal. For more information, please visit our booth.

8 CANO Information Booth, featuring Oncology Standards and Competencies

Join us at the CANO Information Booth, featuring Oncology Standards and Competencies. Visit this booth to meet CANO’s board of directors and discuss CANO’s strategic plan, chemo administration project and membership information (for times that the board will be available, please see schedule at the registration desk). As well, Lynne Penton, project leader of the Oncology Standards and Competencies initiative will be available to talk with delegates. Oncology nursing is a specialty area of nursing practice. The competencies associated with
this practice were published in 2006. The Practice Standards and Competencies for Specialized Oncology Nurses have been utilized in documentation, professional development, clinical practice and performance review.

26  Cardinal Health

Cardinal Health Canada is a market leader in product and service solutions for safe medications delivery, monitoring and diagnosing of critically ill patients, implementing infection control practices and efficient supply chain management in the operating room and throughout the chain of care.

24  Carmel Pharma

Carmel Pharma’s sole focus is on the quality of life of those people who prepare, administer and dispose of hazardous drugs. With dedicated resources toward this effort, this means our customers will receive unparalleled service and clinical support. The PhaSeal System for the safe handling of hazardous drugs is the only clinically proven closed-system drug transfer device (CSTD) available today, with more than 10 independent, peer-reviewed, published clinical studies currently available. Its airtight Expansion Chamber and leakproof Double Membrane make it the only system that meets the National Institute for Occupational Safety and Health (NIOSH) and International Society of Oncology Pharmacy Practitioners (ISOPP) definition of a true CSTD. Distinguished by prominent thought leaders as the “Gold Standard” in the safe handling arena, PhaSeal also features an intuitive design that enables the retrieval of all drug product from the vial.

30  Eli Lilly Canada

Eli Lilly is a leading innovation-driven pharmaceutical corporation. We are developing best-in-class – often first-in-class – pharmaceutical products by applying the latest research from our own worldwide laboratories, by collaborating with eminent scientific organizations, by making use of the most up-to-date technological tools, and by providing exceptional customer service.

16  GlaxoSmithKline

At the GlaxoSmithKline (GSK) booth, we will be sharing information pertaining to products in the GSK Oncology pipeline, including upcoming vaccines and breast cancer treatments and distributing patient support materials.

10  ICU Medical

Publicly held ICU Medical, Inc. (www.icumed.com) is a leader in proprietary, disposable medical products for IV therapy applications. Built on landmark needle-free connector technologies, such as the CLAVE® Connector, ICU’s new line of closed Chemotherapy delivery devices includes the Spiros(TM) Closed Male Connector and the Genie(TM) Vial Access Device. ICU’s commitment to better patient care and safer clinical practice is evident in its innovative devices and unique manufacturing systems that provide custom IV products in record delivery times.

33  Look Good Feel Better

Look Good Feel Better is Canada’s only charitable cancer program dedicated to empowering women to manage the appearance-related effects of cancer and its treatment. Created from the belief that if a woman with cancer
can be helped to look good, chances are she will feel better, her spirits will be lifted and she will be empowered to face her illness with greater confidence.

A free, two-hour hands-on cosmetic and hair alternatives workshop for women with cancer is at the heart of Look Good Feel Better. Offered in over 100 hospital and cancer care facilities across Canada, the workshops are led by industry-trained cosmetic advisors and hair alternative specialists who donate their time and expertise. Women learn simple tips and techniques to look and feel a little more like themselves again. They feel empowered, confident and able to reclaim their sense of self.

For more information, call 1-800-914-5665 or visit lookgoodfeelbetter.ca or bellebiendanssapeau.ca.

22 Merck Frosst Canada

At Merck Frosst, patients come first. Merck Frosst Canada Ltd. is a research-driven pharmaceutical company discovering, developing and marketing a broad range of innovative medicines and vaccines to improve human health. The Merck Frosst Centre for Therapeutic Research, one of the largest biomedical research facilities in Canada, has the mandate to discover new therapies for the treatment of respiratory diseases, inflammatory diseases, diabetes, osteoporosis and hypertension. Merck Frosst is one of the top 25 R&D investors in Canada, with an investment of close to $110 million in 2007.

Merck Frosst is a recognized leader in the treatment of asthma, diabetes, osteoporosis, HIV/AIDS, glaucoma, prostate disease, migraine and infectious diseases. The Company also markets an extensive line of cardiovascular products for high blood pressure, elevated cholesterol and heart failure as well as a broad range of vaccines. Based in Montreal, Quebec, Merck Frosst employs more than 1,300 people including 300 of the world’s leading scientific personnel. More information about Merck Frosst is available at http://www.merckfrosst.com.

25 Novartis Oncology

Novartis Oncology provides a broad range of innovative therapies for cancer patients. We have products for the treatment of many different cancers and cancer complications. Research and development in this disease area is aimed at the discovery and development of innovative approaches to the treatment of cancer. Novartis ranks as one of the largest and fastest-growing pharmaceutical companies in the oncology area. Key products include Gleevec to treat certain forms of life-threatening gastrointestinal stromal tumors and chronic myeloid leukemia, while Femara is a leading treatment in certain types of breast cancer. Zometa is a novel treatment for certain cancers that have spread to the bones. Sandostatin LAR is utilized as treatment for the symptoms of carcinoid tumors. Exjade is used in the treatment of chronic overload due to blood transfusion. Novartis supports patients through access programs for each medication and we are committed to providing for patients in need.
38 Oncology Nursing Society (ONS)

The Oncology Nursing Society (ONS) is a professional organization of over 35,000 registered nurses and other healthcare providers dedicated to excellence in patient care, education, research, and administration in oncology nursing. ONS is also the largest professional oncology association in the world.

ONS traces its origin to the first National Cancer Nursing Research Conference, supported by the American Nurses Association and the American Cancer Society (ACS) in 1973. Since its official incorporation in 1975, ONS has become a leader in cancer care and now includes 224 chapters and 30 special interest groups. ONS provides information and education to nurses around the world. In addition, the Society plays an active role in advocacy activities at the local, state, national, and international levels.

35 Ortho Biotech

Ortho Biotech, a division of Janssen Ortho and a member of the Johnson and Johnson group of companies, is a leading pharmaceutical company devoted to helping improve the lives of patients with cancer and with anemia due to multiple causes including chronic kidney disease. The company’s products include Eprex for the treatment of chemotherapy induced anemia and Velcade for the treatment of multiple myeloma and mantle cell lymphoma. For more information, please visit www.Janssen-Ortho.com.

32 Pfizer Canada

Pfizer Canada Inc. is the Canadian operation of Pfizer Inc, the world’s leading pharmaceutical company. Pfizer discovers, develops, manufactures and markets prescription medicines for humans and animals. Pfizer Inc invests more than US$7 billion annually in R&D to discover and develop innovative life-saving and life-enhancing medicines in a wide range of therapeutic areas, including arthritis, cardiovascular disease, endocrinology, HIV/AIDS, infectious disease, neurological disease, oncology, ophthalmology and smoking cessation. For more information, visit www.pfizer.ca.

20 Purdue Pharma

Purdue Pharma is a leading pharmaceutical manufacturer whose mission is to advance health care through research, education and pharmaceutical innovation. Purdue, a member of RX&D, specializes in controlled release medications for the treatment of pain, ADHD, OAB and other conditions such as respiratory and gastrointestinal disorders.
21 Roche

Roche is recognized as a global leader in providing pharmaceutical and diagnostic solutions that make a profound difference in people’s lives. As an innovator of products and services for early detection, prevention, diagnosis and treatment of acute and long-term diseases, Roche contributes on a broad range of fronts to improving people’s health and quality of life. As an integral part of the health care team, oncology nurses are respected and recognized for the extensive knowledge and value they provide in clinical practice. With a sincere commitment to, and belief in the importance of continuing education, Hoffman-La Roche is proud to sponsor the CANO/ACIO conference.

13 sanofi-aventis Canada

sanofi-aventis Canada Inc. is an affiliate of the global sanofi-aventis organization, one of the world’s leading pharmaceutical companies.

The company is headquartered in Laval, Quebec, and employs 1,140 people across the country. The Laval site is also home to a world-class manufacturing facility that produces medications for use by patients in Canada, the United States and other countries around the world.

sanofi-aventis Canada provides medications in the areas of cardiology, thrombosis, oncology, cardiometabolism and internal medicine. It is headquartered in Laval, Quebec, and employs 1,140 people across the country.

11 Schering-Plough Canada

Schering-Plough Canada is dedicated to investing in cancer research and to discovering new therapies and new uses for our existing drugs. The heart of our work is scientific innovation and this commitment to science is helping us advance medical treatment for Canadians living with cancer.

15 Trudell Medical Marketing

Trudell Medical Marketing Limited (est 1922) is a leading Canadian sales and marketing company servicing the hospital, homecare and long-term care markets. TMML offers Respiratory/Apnea and Critical Care products from top tier global suppliers to Canadian customers via three regional distribution centers.

18, 19 Wyeth Pharmaceuticals

Wyeth is one of the world’s largest research-driven pharmaceutical and health care products companies. It is a leader in the discovery, development, manufacturing and marketing of pharmaceuticals, vaccines, biotechnology products and non-prescription medicines that improve the quality of life for people worldwide.
SCHERING-CANO/ACIO LECTURE

THE CLINICAL NURSE SPECIALIST AS NURSE NAVIGATOR: ORDINARY ROLE PRESENTS EXTRAORDINARY EXPERIENCE

Patti Marchand, RN,MN,CON(C).RS McLaughlin Durham Regional Cancer Centre, Oshawa, ON, Canada.

Patients encounter many health professionals and multiple hospital departments as they engage in seeking resolution to a health concern. The information gathering and the necessary decision-making a health challenge demands, can be overwhelming. Patient navigation is a concept first introduced in the United States in the early nineties with the goal to improve access to cancer screening, address delays in clinical follow-up and the barriers to cancer care that poor people encounter (Freeman, 2004). This presentation will explore the application and growth of the concept, navigation, within the Canadian health care system. A detailed example of the development of a breast assessment program and the introduction of a nurse navigator role will be shared: challenges and successes alike. Three case studies will aid in the illustration of the diversity of the patient and nurse experience. The presentation will suggest how the domains of practice of the Clinical Nurse Specialist are exemplified in the navigator role. The navigator is an evolving role in cancer care and is gaining recognition among many different disease sites and areas of practice. The oncology Clinical Nurse Specialist, as navigator, opens the opportunity continuity and consistency in the delivery of knowledge and support throughout a patient's journey.

HELENE HUDSON MEMORIAL LECTURESHPH

HEREDITARY BREAST CANCER - HOW MY FAMILY MADE DECISIONS

Patricia Benjaminson, CancerCare Manitoba, Winnipeg, MB, Canada.

One in nine women will develop breast cancer in her lifetime (Canadian Cancer Society, 2007). Hereditary breast cancer accounts for only five to ten percent of all breast cancers, however women carrying a single high penetration gene mutation have a forty to eighty percent chance of developing breast cancer (Nat. Rev. Cancer, 2007). Most of these breast cancers occur in women under the age of fifty. The BRCA 1 gene mutation was first reported in 1994 and the BRCA 2 gene mutation in 1995.

The BRCA 2 gene mutation is often carried in males and accounts for approximately six percent of male breast cancer. Women with this gene mutation have a lifetime risk of developing breast cancer of between fifty and eighty-five percent, a second breast cancer of between thirty and fifty percent, and ovarian cancer between ten and twenty percent. Each parent with the BRCA 2 gene mutation has a fifty percent chance of passing this gene mutation to their children (NCI, 2006) The emotional impact of receiving cancer risk information such as this is difficult to predict. When presented with information about risk reduction surgery, chemoprevention, risk avoidance, and increased screening how does one make decisions?

Walk with me as I share how my family discovered we carry the Icelandic founder gene mutation, the steps we took together during the testing process, and the decision-making by the family members who tested positive. We’ll focus on my sister Rita - ordinary days, an extraordinary woman.
I-01
ONTARIO ONCOLOGY APN MENTORSHIP: AN EXPERIENCE FOR PROFESSIONAL DEVELOPMENT FOR ALL ONCOLOGY NURSES!

Grace I. Bradish, RN, MScN¹, Maureen McQuestion, RN, MSc², David Wiljer, PhD², Denise Bryant-Lukosius, RN, PhD³, Esther Green, RN, MScCT⁴, Stephanie Luxton¹, Lynne Penton, RN, MN, Gail Mccartney, RN, MScA⁵, Ontario Oncology APN e Mentorship Project Team⁶, Mary M. Wheeler, RN, MEd, PPC⁷, Michelle Cooper, RN, MScN.¹¹ London Health Sciences Centre, London, ON, Canada, ²Princess Margaret Hospital, Toronto, ON, Canada, ³McMaster University, Hamilton, ON, Canada, ⁴Cancer Care Ontario, Toronto, ON, Canada, ⁵The Ottawa Hospital, Ottawa, ON, Canada, ⁶donnerwheeler Career Planning and Development Consultants, Brampton, ON, Canada, ⁷Integral Visions Consulting Inc, Toronto, ON, Canada.

Concept to Implementation: Evidence documenting Advanced Practice Nurse (APN) role development needs provided the background for the development of the Ontario Oncology APN Interprofessional e-Mentorship Program. A national inventory of intra and inter professional mentors accessible to APNs across Ontario was created. A two-day face to face workshop was provided and e-based resources supported the development and maintenance of positive mentoring relationships. Rigorous processes to recruit, screen and link high quality mentors to suitable mentees were developed. To date the program has over 120 participants. Evaluation data support mentorship as a role development and career enhancing strategy applicable to all nurses working in oncology. Although this project was piloted with APNs, the skills introduced in this session can be applied to any nursing mentoring relationship.

Practical Application: As part of the development of the e-Mentorship Program, Cooper and Wheeler created the Five Phase Mentorship Relationship Model©. This model provided the basis for a Mentorship Workbook and a two-day Mentoring Orientation Workshop. Facilitators conducted the Workshop in an interactive participatory manner that led to the genesis of 33 mentoring relationships! Evaluation of the program identified the workshop was critical for preparing mentors and mentees for effective mentorship. These same workshop facilitators will present an overview of strategies for creating positive mentoring relationship providing an introduction to basic concepts and the Five Phase Model. A Pair’s Perspective: This portion of the workshop will explore the experience of one matched mentor and mentee pair. They will describe strategies used to identify goals and develop a practical mentorship plan. Mentor and mentee roles and responsibilities for promoting and maintaining a positive mentoring relationship will be outlined along with examples of time management and communication strategies used to keep the mentorship plan on track. The presentation will also highlight how the mentor and mentee benefited from this relationship and career directions that have evolved as a result of this initiative.

Sustainability: An electronic platform was developed to ensure the program was accessible to APNs across Ontario and so that mentees could connect with mentor experts in a variety of disciplines from across Canada. In this section of the workshop, we will provide tips and strategies for how to get the most out of mentorship through the effective use of electronic communication tools and resources. With the development of technological capabilities, taking this project to a National level looms on the horizon with exciting opportunity for the broadening our pool of interdisciplinary mentors possible. Stay tuned!

I-02
TRAIN THE TRAINER: MOVING FROM ORDINARY TO EXTRAORDINARY HEALTHCARE TRAINING

Corinne Walsh, MA, LLM (Cand.). Platinum Leadership Inc., London, ON, Canada.

Are you interested in learning new ways to engage adult learners? Would you like to transform your training from the ordinary to the extraordinary? If yes, consider this workshop to enhance your teaching through experiential lesson design and active training techniques. This workshop will bolster your understanding of the processes of facilitation design and equip you to provide interactive and learner-centered healthcare training. In this hands-on workshop, participants will explore:
- the fundamentals of experiential learning;
- a framework for planning interactive, learner-focused training; and,
- active training techniques to engage learners without lecturing!

During the workshop, participants will practice the skills presented by mapping an interactive lesson plan for a future training event.

I-03
FACILITATING RESPECT: FACILITATIVE LEADERSHIP: SUPPORTING EXTRAORDINARY ONCOLOGY LEADERS

Sherrol Palmer Wickham, RN BScN CON(c), Yvette Matyas, Manisha Gandhi. Odette Cancer Centre, Toronto, ON, Canada.

As a leader, how do you address your continuing education needs? How do you get support when faced with those difficult conversations, challenging meetings and tense feedback sessions? In the summer of 2007, a small team led by the Cancer Centre Director started planning a retreat day for the leaders, both practice and management. The objective was to build an explicit culture of facilitative leadership and enhance our leadership skills. The Skilled Facilitator approach was used because it uses the core values of valid information, free and informed choice, internal commitment and compassion, which underlie the ground rules to help groups increase their effectiveness. It is a value-based approach that anyone can use, at anytime, with anyone or any group. The full day retreat consisted of providing an explanation of the primary concepts of facilitative leadership, interactive exercises, role playing and sharing of personal experiences. The learning and practicing of facilitative leadership concepts continues with monthly lunch-and-learn sessions where leaders describe how they use the concepts and through adoption of the core values, are gradually changing how they “think”. The goals of this 90-minute workshop are: first, to present the facilitative approach and the primary concepts. Secondly, the participants will describe how they will take this example back to their own institutions and support leadership growth and development for themselves and their colleagues. Attendees will participate in exercises demonstrating the facili-
Patients with advanced malignancies often develop complications resulting in reduced quality of life, and increased morbidity and mortality. Malignant pleural effusions (MPE) are common complications for patients diagnosed with cancers of the lung, breast and lymphoma. Based chart review, the estimated the yearly incidence of MPEs treated at our cancer centre was approximately 120 cases. Standard inpatient management of malignant pleural effusions often resulted in temporary symptom relief with an extended hospital stay (mean = 16 days). With the introduction of a pleural catheter (PleurX) designed for community use, our cancer centre, in collaboration with our community partners, developed, implemented and evaluated a pilot outpatient MPE program. Limiting inpatient hospital days by managing MPEs in the community could improve patient outcomes and reduce costs and potential risks associated with prolonged hospitalization and pleurodesis. This presentation will focus on the pilot (n = 104) of this innovative program including structure, processes and outcomes. It will describe structural program supports developed by an advanced practice nurse, an oncology expert, and community nurses across settings. The successful pilot program is now the standard of care for MPE across our region.

I-04-B

NURSES’ COLLABORATION PRODUCES EXTRAORDINARY RESULTS FOR PATIENTS WITH MALIGNANT PLEURAL EFFUSIONS

Lynn Kachuik, RN, BA, MS, CON(C), CHPC(C)1, Laura Giannantonio, RN, BScN1, Suzanne Madore, RN1, Sheila Bauer, RN, MBA1, Sophie Parisien, RN, BScN1, Kayvan Amjadi, MD, FRCP(C)1, Greg Doiron, BSc, MHA1. 1The Ottawa Hospital, Ottawa, ON, Canada, 2Champlain Community Care Access Centre, Ottawa, ON, Canada.

Malignant pleural effusions (MPE) are common complications in advanced malignancies, associated with substantial morbidity (30-day mortality rate 29 - 50%, mean survival of < 6 months). Current therapies do not contribute to quality of life and maintaining palliative patients in their home settings, we collaborated with community partners to establish the MPE Program. Although catheter insertion and removal would occur at the cancer centre, it was imperative to collaborate with our community nursing partners since post-insertion care would transferred to community nurses. This presentation will focus on the collaboration amongst partners across the continuum in the development, design, implementation and evaluation of the outpatient MPE program. Benefits of this nurse-led partnership included: the sharing of expertise; development of common tools (clinical pathways, preprinted orders, decision algorithms); networking and support of clinical nurses across settings. The successful pilot program is now the standard of care for MPE across our region.

I-05

HERE ARE THE CLUES - CAN YOU SOLVE THE MYSTERY? ISSUES IN VASCULAR ACCESS

Inara H. Karrei, RN, BScN, MEd, CON(C). The Ottawa Hospital Cancer Center, Ottawa, ON, Canada.
Intravenous therapy is a critical part of care delivery to oncology patients across many settings. Expert nursing care of patients with vascular access devices requires excellent assessment, clinical and advocacy skills, as well as highly developed critical thinking. Timely nursing management of peripheral and central venous access devices spares the veins of the patient, minimizes complications and makes infusion of chemotherapy and supportive care medications safer for the patient. In this highly interactive workshop, participants will be presented with real-life clinical scenarios (“clues”) and will be invited to discuss and share their experiences with the group. The workshop facilitator will provide evidence-based theoretical information (“evidence to solve the mystery”) as identified in respected practice guidelines such as those developed by the Registered Nurses’ Association of Ontario, the Oncology Nursing Society and the Canadian Vascular Access Association. Topics will include venous anatomy, appropriate device selection, prevention and management of complications, infection control issues, and nursing considerations when administering parenteral chemotherapy. This workshop will benefit novices, experts and everyone in-between!

I-06
CANCER TREATMENT RELATED PAIN: AN INTER-PROFESSIONAL, SYSTEMATIC APPROACH TO DIAGNOSIS AND EFFECTIVE MANAGEMENT

Cindy Shobbrook, RN, MN CON(C), CHP(C)1, S. Lawrence Librach, MD, CCFF, FCFP2, Kim Stefaniuk, BSP, RPEBC3, David Warr, MD, FRCP(C)1.

1Princess Margaret Hospital, Toronto, ON, Canada, 2Temmy Latner Centre for Palliative Care, Mount Sinai Hospital, Toronto, ON, Canada.

Over the years, the number of “cancer survivors” has increased. This increase arises from an aging population as well as decreasing mortality in some tumors due to earlier detection and new therapies. A multi-modal approach to cancer treatment may come with the price of morbidity, one of which is CTRP. Older literature taught us that pain was largely due to recurrent cancer. In contrast, a recent survey of ambulatory patients at a major cancer centre found that one half of “cancer pain” occurred in the absence of demonstrable recurrence. Therefore, CTRP might be responsible for a substantial amount of the pain in patients living with cancer, or be the underlying cause of chronic pain. For several reasons, CTRP deserves attention:

- It can be as severe as cancer pain
- It may limit treatment delivery.
- It may be confused with cancer as the underlying source of pain.
- It is a source of morbidity that may limit function and quality of life.
- It is often neuropathic in origin requiring the use of adjuvants that are unfamiliar to oncologists.

This interactive, case-based workshop reviews common presentations of CTRP and an inter-professional approach to assessment and management. Participants will be able to:

1. Describe the etiology of CTRP.
2. Discuss an approach to assessment of CTRP including common presentations.
3. Describe an approach to managing CTRP, especially a systematic approach to neuropathic pain.

II-01
PRACTICE STANDARDS AND COMPETENCIES FOR THE SPECIALIZED ONCOLOGY NURSE

Lynne A. Penton, Mt Sinai Hospital, Toronto, ON, Canada.

In 2006 the Canadian Association of Nurses in Oncology (CANO) published Practice Standards and Competencies for the Specialized Oncology Nurse. Using the nine standards of care and core role competencies identified in the foundation document (CANO Standards, 2000) seven domains of practice were established and competencies for achieving the standards described. Several organizations have effectively implemented the Specialized Competencies into their setting. Clinical practice, documentation standards, performance review and orientation are just some of the innovative ways that the competencies have been incorporated into practice. The last two workshops offered at the national conference were well attended and the evaluation feedback indicated a strong interest and ongoing need for opportunities to share in the strategies and successes for integrating these competencies into the context of organizational culture.

To support the ongoing dissemination of the document it is proposed that a workshop be conducted at the national conference in 2008. The themes of practice and documentation will be re-introduced as well as other new applications in oncology settings.

II-02-A
SECONDARY LYMPHEDEMA IN CANCER SURVIVORS: ORDINARY CONSEQUENCE, EXTRAORDINARY CHALLENGE

Susan L. G. Bowles, BScN RN, Odette Cancer Centre, Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

Many cancer patients will develop a side effect of treatment, lymphedema, and not be aware of what it is. Lymphedema develops in the region of the body where the lymphatic drainage has been affected by cancer treatment or the cancer itself. Estimates for lymphedema incidence after breast cancer treatment range from 6 to 30 percent. Lymphedema of an upper extremity following nodal dissections in melanoma patients is now being reported. Estimates of lower limb edema are rarely cited in the literature following pelvic surgeries, although reference is made to “swelling” by many patients, male and female. Since the reporting of lymphedema is not consistent, experts agree that the incidence is likely higher than reported. Health care professionals often dismiss the significance of lymphedema. For some patients, it is a daily challenge to live with the limitations resulting from their lymphedema. To prepare the oncology nurse to better understand lymphedema, this session will review the anatomy and physiology of the normal functioning lymphatic system and the pathophysiology of lymphedema. A review of recent literature and research will be presented. Existing services in each province will be outlined. Future directions in lymphedema care will be explored. Strategies to assist the nurse to assess and care more effectively for patients with lymphedema will be presented.
**II-02-B**

**SECONDARY LYMPHEDEMA IN CANCER SURVIVORS: ORDINARY CONSEQUENCE, EXTRAORDINARY CHALLENGE**

Martina A. Reddick, RN, Dr. H. Bliss Murphy Cancer Centre, St. John's, NL, Canada.

Secondary Lymphedema is a potentially serious consequence of cancer surgery and its treatments. It often results in a painful, debilitated and swollen limb. Despite its long history in the literature lymphedema remains a challenge that often leaves health care professionals and the medical community frustrated and searching for answers. This presentation will highlight and discuss the many treatments available for lymphedema. None can repair the damaged lymphatic system or return it to normal however it is possible to reduce and or control lymphedema with treatment or a combination of treatments. We will discuss lymphedema treatment regimes such as Complete Decongestive Therapy, Compression Therapy, Compression Pumps and other treatment modalities. Lymphedema affects cancer survivors’ quality of life. Some articles report increases in anxiety, depression, difficulty at work, home, in social situations and sexually. These challenges cause a disruption to a normal life. We will discuss the research regarding psychosocial issues and how we as health care providers approach this problem. It is our hope that nurses will spread the knowledge and incorporate lymphedema assessment into practice. By doing this we are offering our patients earlier intervention, which will mean fewer consequences. Knowledge is power and the key to empowering our practice.

**II-04**

**DIFFICULT PEOPLE & DIFFICULT SITUATIONS: TRANSFORMING TOUGH CONVERSATIONS INTO COLLABORATIVE DIALOGUE**

Corinne C. Walsh, MA, LLM (Cand.). Platinum Leadership Inc., London, ON, Canada.

Nursing professionals engage in tough conversations every day: the patient who feels powerless against their cancer and yells at their nurse; the chronically-late co-worker; the underperforming employee or micro-managing supervisor; the client or loved one who disagrees on a plan of care; the team member who doesn’t ‘pull their weight’; advocating for a client’s needs, an improved work environment, or system change; and, many, many more challenging situations. Difficult conversations can provoke anxiety, frustration, anger and stress. This workshop will assist participants to engage in difficult conversations in a productive, proactive manner and increase the likelihood of a tough conversation becoming a more collaborative dialogue. In this hands-on, interactive workshop, participants will: - explore the underlying structure of difficult conversations; - learn to create a collaborative environment for dialogue; - discover how to manage strong emotions - both yours and theirs; and, - practice their communication skills to maximize opportunities for collaborative dialogue.

Participants will be invited to engage in small group activities and role-plays during this workshop.

**II-03**

**CANCER EMERGENCIES: FROM NOVICE TO EXPERT**

Nanette Cox-Kennett, Cross Cancer Institute, Edmonton, AB, Canada.

Whether young or old, new to cancer management or an old hat, a good review is always beneficial. As a nurse practitioner with a mixed hematology oncology and lung cancer practice, 5 cancer emergencies have been experienced in this patient population. This 90 minute case based lecture will review these cancer emergencies including superior vena cava obstruction, spinal cord compression, hypercalcemia, brain metastases, and tumor lysis syndrome. As a nurse practitioner preparing for independent practice or a new staff nurse, there are often overwhelming learning needs and the list of questions seems endless. Which other tumor groups do these emergencies commonly present in? What types of symptoms should raise alarm signals for me? What might I notice in a physical exam? What investigations should be requested? How do I interpret the blood-work? What kind of treatment should I expect for the patient? Are there any specific nursing recommendations I should plan to implement? This review will address these questions in an effort to prepare the novice and reinforce for the expert their understanding of presentation, diagnosis, and management of oncologic emergencies.

**II-05**

**THE ABC’S OF INTERDISCIPLINARY TEAMWORK: THE EXTRAORDINARY ROLE OF NURSES...**

Anne Plante, M.Sc.inf., CSIO, CSIP, Inara H. Karrei, RN, BScN, M.ED, CON(C)1, RoyaLe Cancer Center, Hôpital Charles LeMoyne, Greenfield Park, QC, Canada, 2The Ottawa Hospital Cancer Center, Ottawa, ON, Canada.

Over the past decade, studies have shown that quality interprofessional teamwork results in quality care delivery to complex oncology patients and their families throughout the care continuum. Nurses play an extraordinary role and possess a unique form of power that can foster such teamwork. In Quebec, a specific framework to enhance teamwork has been in place since 2005 and is inclusive of all health care professionals, including administrators. Evaluation of this innovation has confirmed that improvements have been realized in both quality of patient care and in quality of life for the health care professionals. Topics that the facilitators will discuss include foundational concepts of collaborative practice, the “basic ingredients” required for effective teamwork, and how to involve all stakeholders. Participants will leave the workshop with concrete strategies to enhance their skills in dealing with organizational and interpersonal problems. These will be highlighted through the use of case studies. A complete bibliography will also be shared.
III-01-A

Finding Meaning: When There is No Cure: A Hermeneutic Exploration of Life with Incurable But Treatable Cancer

Linda C. Watson, RN BScN MN CON(C). Tom Baker Cancer Center, Calgary, AB, Canada.

Due to the development of a new class of cancer medications known as “cytostatic drugs” a shift in cancer care is occurring. The current paradigm of attempting to cure cancer by obliterating the diseased cells is being displaced by an alternative paradigm where the goal is biological control of the cancer cells themselves, limiting their proliferation. This leaves cancer patients in unfamiliar territory, as what they expect cancer treatment to offer (cure), and the reality of what cancer treatments are being designed to offer (maintenance, control, and suppression) are not in alignment. A research study was conducted focusing on this emerging population of cancer patients, which begins to articulate what living with cancer as a chronic disease is like for the individual. Six participants with a variety of chronic cancers were interviewed. Participants articulated isolation as a central experience. The findings indicate that our patient’s appreciate and value the conventional aspects of cancer treatments, but feel that the emotional support provided by both society and cancer care professionals are lacking. Indications for further research include how system change can be facilitated to create healthcare systems where time to listen is valued and honored as essential to excellent patient care, and the development of educational tools to augment healthcare professionals listening skills, specific to this population.

III-01-B

Finding Meaning: Help! I Need Somebody Help! Not Just Anybody... Building Relationships in Cancer Care

Kate Butler, RN, Cheryl Howe, RN, BN, CON(C). Tom Baker Cancer Centre, Calgary, AB, Canada

This opening line from a popular Beatles song resonates with truth when we think about the patients we meet everyday in our role as oncology nurses. Patients require a holistic approach to their care, encompassing not only the biomedical side of their diagnosis and treatment, but also the psychosocial aspects. We enter patients lives at the most difficult and scary times, when their “lives have changed in oh, so many ways.” Nurses have a unique opportunity to form strong helping relationships with their patients. These relationships are instrumental in helping patients deal with the hurdles that they face at each stage of the cancer continuum. The challenge for the nurse is to identify these needs in the moments we have together. Listening to their stories is the first step, and by having the moral courage to ask patients to “Teach me about your illness” many insights into the patient’s world will be gained. By establishing open lines of communication we can help patients identify the issues which are most important to them, thereby honoring their individuality. This presentation will concentrate on efficient ways to assess patient’s needs, and to foster relationships which can result in increased satisfaction for both the oncology patient and nurse. Help me if you can, I’m feeling down... And I do appreciate you being round Help me get my feet back on the ground Won’t you please, please help me.”

III-01-C

Facilitating Respect: A Demonstration of the Use of the Participatory, Patient-Centered, Evidence-Based Framework (PEPPA) in a Northern Ontario Cancer Program

Terry M. MacKenzie1, Barbara Ballantine RN, BNSc1, Tracie Parks, RN, BSc, BScN1, Bertha Paule, MHA1, Esther Green, RN, Msc (T)2. 1Regional Cancer Program, Sudbury, ON, Canada, 2Cancer Care Ontario, Toronto, ON, Canada.

Advanced Practice Nurses (APNs) working collaboratively have the potential to significantly impact patient care and clinical outcomes. The under-developed palliative care services within one Northern Ontario Oncology Program presented an excellent opportunity to explore the possibility of implementing APN roles. Cancer System Quality Index data (2005-2006) confirmed that palliative care services were fragmented, under-serviced, and that expertise was required to improve upon performance measures. Over the years, we recognized the need for an APN, however we were unsuccessful in securing the role. In 2007, The Change Foundation funded a study that applies the PEPPA Framework1, a participatory, patient-centered, evidence-based process and engages stakeholders in developing and evaluating APN roles. In June 2007, we began the journey with key in-house professionals, as well as community partners focusing on the needs of our palliative patient population and identifying a care model that would best meet those needs. This process included a systematic approach utilizing a skilled facilitator, gap analysis, process mapping, involvement of stakeholders and development of the role utilizing the logic model. The APN role was being defined in parallel with the establishment of an outpatient palliative care clinic. This presentation will identify our strengths, challenges and successes with the process, framework and will highlight the product to date. Footnotes
1 Bryant-Lukosius et al.

III-02-A

Advanced Practice Terrain / Range: Collaborating for Comprehensive Patient-Centred Care Closer to Home: an Advanced Practice Nurse Outreach Model of Care

Barbara Godfrey, RN, MScN1, Lia Kutzscher, RN(EC), MScN, CINAC1, CON(C), AOCNP, PhD(in progr)2. 1Prince Margaret Hospital, Toronto, ON, Canada, 2Royal Victoria Hospital, Barrie, ON, Canada.

The supportive care needs required by leukemia patients following induction and consolidation or during maintenance therapy are complex and require vigilant monitoring for any complications related to treatment. Access to health care professionals closer to home with the knowledge and skills to assess, monitor and treat symptoms and complications related to treatment for
these patients is limited and a challenge to providing comprehensive patient-centred care close to their home. This presentation will outline the collaboration between Princess Margaret Hospital and Royal Victoria Hospital to address these challenges and provide safe, patient-centred care close to home. An advanced practice nurse (APN) collaborative outreach model for care delivery was developed to address these challenges. Through this APN collaboration, referral of leukemia patients post treatment closer to home has been successful. To facilitate communication between staff at both facilities, and between staff and patients, an outpatient pathway is being developed as a tool to help outline the plan of care for acute myelogenous leukemia (AML) and acute lymphocytic leukemia (ALL) that addresses the supportive care and monitoring requirements for these patient populations. The APN collaborative outreach model for care delivery has improved coordination of care. AML and ALL pathway development will serve to standardize patient care, and increase capacity for local management of side effects of therapy in this population.

III-02-B

ADVANCED PRACTICE TERRAIN / RANGE: COLLABORATIVE NURSING ROLES ACROSS A REGIONAL CANCER SURGERY PROGRAM: ACADEMIC AND COMMUNITY HOSPITAL PERSPECTIVES

Beth Brownlee, BScN1, Robin Morash, BNSc., MHS2, Susan Freed, BScN3.
1Pembroke Regional Hospital, Pembroke, ON, Canada, 2The Ottawa Hospital, Ottawa, ON, Canada, 3Queensway Carleton Hospital, Ottawa, ON, Canada.

Improving access to quality cancer surgery is a priority for our provincial ministry of health and provincial cancer agency. In attempting to standardize regional cancer surgery care, it became evident that a new model of improving access to quality cancer surgery was essential. A model was designed to address inequity in regional access to a common standard of high quality cancer surgery, lengthy wait times, and unused regional surgical capacity. This "hub and spoke" model, with a central assessment clinic as its ‘hub’, serves to improve access to quality cancer surgery by: developing communities of practice; implementing regional standards; utilizing multidisciplinary cancer conferences; and, by aligning resources and appropriately redistributing regional cancer surgery using real time performance data. Nurses holding unique roles within regional hospitals have been pivotal in the planning, implementation and evaluation of the new model. Four distinct nursing roles have been utilized representing the consultative, administrative, educational and clinical domains of practice. These specific roles support strategic planning, program leadership, knowledge dissemination, quality improvement methodology and direct patient care. This presentation will describe the distinct responsibilities of each nursing role including a discussion of successes and barriers along with lessons learned. More specifically, the collaborative relationships developed between an academic centre and community hospital partners will be described. Knowledge and sharing amongst regional nurses is the key!

III-02-C

ADVANCED PRACTICE TERRAIN / RANGE: ROLE CLARITY FOR ADVANCED PRACTICE NURSES IN ONCOLOGY: MAKING THE EXTRAORDINARY A LITTLE MORE ORDINARY

J. Colleen Johnson1, Cindy Murray, RN, MNA/ACNP2.
1Trillium Health Centre, Mississauga, ON, Canada, 2Princess Margaret Hospital, Toronto, ON, Canada.

So what do you do? If you are an advanced practice nurse working as an oncology acute care nurse practitioner or a clinical nurse specialist you are probably asked this quite often. Hopefully you are able to answer this question clearly and with confidence. However, it can be disconcerting when healthcare professionals and administrators you have worked with for years are asking you this question.

The Role Clarity Working Group evolved from the Oncology Advanced Practice Nurse Community of Practice (APN COP). The APN COP is a group sponsored by Cancer Care Ontario. The APN COP identified, through discussions and surveys that a lack of role clarity leads to inconsistent titling as well as confusion among health professionals and employers on the role responsibilities. The objective of this working group is to develop a position statement for oncology advanced practice nursing in Ontario for the purpose of providing clarity to roles. This presentation will review the work that has been done in collaboration with the membership of the Ontario APN COP group to date. Several drafts of the position statement have been presented as well as a group brainstorming afternoon. Progress to date as well as the next steps in the process will be presented.

III-03-A

QUALITY RADIATION THERAPY: PERFEXIONTM GAMMA KNIFE RADIATION TREATMENT: WHEN THE EXTRAORDINARY BECOMES THE ORDINARY

Anne Bradwell, RN1, Sandra Chapman, RN2, Barb Willson, RN, MS, CON(C)3, Leela Kesavan, RN4.
1Toronto Western Hospital/University Health Network, Toronto, ON, Canada, 2Princess Margaret Hospital/University Health Network, Toronto, ON, Canada.

Any ordinary day is characterized by change. The change nurses faced at our institution was the discovery that a new radiation therapy treatment unit was going live. The planning team did not anticipate an increase in nursing care as stereotactic radiation treatment for brain tumour patients had been delivered via linear accelerator for many years. The new treatment unit, the Leksell Perfexion™ designed specifically to treat a patient’s brain, presented new challenges. The heavy metal head frame restricted the patient’s ability to see, eat and perform other activities of daily living. Two hospitals were involved in the treatment planning and delivery process, thus adding complexity. Nurses quickly recognized the impact of this change. This presentation will share how complex healthcare environments implement technology, sometimes not knowing the full impact on patient care. The treatment, the processes of care, including nursing care provided during the day
of treatment and the patient experience will be presented. Nurses worked together with the team, patients and educator, drawing on the expertise of a nurse with expertise in gamma knife radiosurgery to put in place the training and education for nurses to provide quality patient care. What continues to be extraordinary is how oncology nurses meet patient care needs each and every ordinary day.

III-03-B
QUALITY RADIATION THERAPY: ORDINARY TREATMENT WITH EXTRAORDINARY POTENTIAL: MammoSite Brachytherapy for Breast Cancer
Kathy Fitzgerald, Eastern Health, St John’s, NL, Canada.

Breast conservation treatment has been recognized as an effective treatment alternative to mastectomy for early stage breast cancer. Standard breast conservation treatment includes lumpectomy followed by 3 to 6 weeks of external radiation to the whole breast. Women who receive radiation after lumpectomy have a 3% to 8% rate of cancer reoccurrence in the breast compared to a 20% to 40% risk for women who do not receive radiation. Research indicates that if the cancer reoccurs in the treated breast, the majority (80% to 90%) do so within centimetres of the original tumour site. This has given rise to the idea that perhaps it may only be necessary to treat the area of the breast where the tumour originated. Unfortunately, research also shows that some women choose not to accept breast conservation treatment because of the time commitment required for external radiation. Both of these issues give credence to the question of treating patients with accelerated partial breast radiation. Introduction of the MammoSite catheter for high dose rate brachytherapy in early stage breast cancer addresses both of these issues. A collaborative and coordinated approach, by a multidisciplinary team, across sites has seen the development of a high dose rate brachytherapy program for women with early stage breast cancer. This session will highlight appropriate patients for MammoSite catheter, the process involved, advantages of treatment and experience to date.

III-03-C
QUALITY RADIATION THERAPY: USING PATIENT SATISFACTION RESULTS TO IMPROVE PATIENT OUTCOME: MEDICAL RADIATION ONCOLOGY UNIT
Eleanor Miller, PCM, RN, BScN, Gerry Beaudoin, MSW, Audrey Moore-Garcia, RN, BScN, Nancy Siddiq, RN, BScN, Elsa McKie, RN, Barbara Jackson, B.Sc.O.T, William Ford, B.A., M.Div., Dr. Anita Chakraborty, MC. CCFP, Nadine Walters, BCom, Philiz Goh, BSc, BScN(C), Margaret Fitzch, RN, Phld, Kate Hamner, Family member, Sunnybrook Health Sciences Centre – Odette Cancer Centre, Toronto, Ontario, Canada

Patient satisfaction and improved quality outcomes are highly valued by staff on a busy Medical/Radiation Oncology unit. The use of patient satisfaction questionnaire is commonly used to evaluate care across the organization. The team felt that having a tool that accurately reflects the unique needs of our diverse oncology patient population would definitely assist in improving patient care outcome.

The purpose of this study is twofold: (I) to develop a patient satisfaction questionnaire that would clearly define and capture the patients’ perspective pertaining to their care experience and (II) to use the feedback to improve patient quality outcomes.

The method used includes designing a patient satisfaction questionnaire with input from patients, nurses, allied staff and family members. The questionnaire was piloted prior to the study. It was then administered at the time of discharge. The results will be compared to the current Picker Survey scores, a tool currently used to measure patient satisfaction nation wide. The overall goal of this project was to assess patients’ perceptions of care, with the intent of acknowledging and improving quality outcome.

III-04-A
OUTCOMES IN PRACTICE: MALODOROUS FUNGATING MALIGNANT WOUNDS. A PATIENT QUALITY OF LIFE ISSUE.
Pamela Savage, MAEd, CON (C). University Health Network, Princess Margaret Hospital, Toronto, ON, Canada.

Cancer patients may experience alterations in skin integrity ranging from surgical incisions, drug reactions, infectious lesions related to immunosuppression, pressure ulcers, radiation skin reactions etc. One of the most disturbing skin conditions to the patient’s quality of life is the presence of a malodourous, possibly bleeding malignant wound. The presence of a malodourous malignant wound can be the cause of psychological and physical distress. Such types of wounds can be a constant reminder of the patient’s disease, result in an altered self-image, and be the cause of social isolation. This presentation will discuss the role of the Oncology nurse in the assessment and management of malignant malodorous wounds using a patient-centered care approach.

III-04-B
OUTCOMES IN PRACTICE: ORDINARY PROBLEM... EXTRAORDINARY RESULTS: DEVELOPMENT OF A LYMPHEDEMA PROGRAM
Martina A. Reddick, RN, Dr. H. Bliss Murphy Cancer Centre, St. John’s, NL, Canada.

The development of new programs and services for patients with cancer can be challenging. In Newfoundland and Labrador, no comprehensive Lymphedema Program existed until May 2005. This presentation will demonstrate the benefits of partnership in the development of patient programs. It will specifically highlight the nurse led process used to develop a Lymphedema Prevention and Education Program in Cancer Care. This Program was developed in partnership with the Canadian Breast Cancer Foundation, Atlantic Chapter, and included the creation of a pilot project. The goals of this project focused on prevention, education, early detection and diagnosis of lymphedema as well as an education strat-

Karen Janes, MSN\(^1\), Patti Taschuk, BS\(\rm{N}\) RN\(^1\), Janice L. Chobanuk, MN CON(C) CHPCN(C)\(^2\), Sandra Cook, BA MN\(^3\), BC Cancer Agency, BC, BC, Canada; \(^2\)MACO, ACB, Edmonton, AB, Canada; \(^3\)Cancer Care Nova Scotia, Halifax, NS, Canada.

Development of an integrated, coordinated system that insures optimum access and continuity is a serious challenge for cancer control across Canada. The term “cancer patient navigation” (CPN) is an emergent term used to characterize a system or professional role to accelerate access to services and supportive care, and to improve continuity and co-ordination of care throughout the cancer journey. Although navigation is becoming an integrated role in cancer settings across the country, thus far there is no educational curriculum based on cancer standards or competencies for training navigators in Canada. A comprehensive provincial cancer needs assessment, the Canadian Association of Nurses in Oncology (CANO) standards and competencies, and an extensive literature review was used to design a case based CPN educational curriculum. Three provinces involved in CPN programs have partnered to implement and complete the testing of this innovative competency based curriculum for training in cancer patient navigation. The aim of this presentation is to provide an overview of the curriculum and development process, the methodology and results of testing with both novice and experienced in CPN, and lessons learned.

Innovation and Evidence Based Practice: Reaching New Heights in Patient Safety

Kim Chapman, Brenda Grant.
River Valley Health, Fredericton, NB, Canada.

The concept of patient safety is fundamental to health care today. Although seen as a priority, it has often been seen as a priority that could be rearranged or shifted to meet needs or competing concerns (Institute for Safe Medication Practice, 2004). In order to overcome this tendency, safety has to be a value associated with every activity and priority (ISMP, 2006). Making safety a part of our value system began with recognizing aspects of our own work environment which were unsafe and patterns of behaviour which contributed to the unsafe environment. A literature review of safe practice was conducted. The necessity of an integrated service plan and integrated population level care plans (disease site specific pathways) became really clear if we truly wanted to streamline service and standardize care, ultimately enhancing a culture of safe practice. Several quality initiatives (clearly defining the referral process to the Oncology Service, review of safe handling and enhancing compliance in the work environment, identifying guidelines to safely administer oral systemic cancer therapy in the in-patient environment with limited resources) were undertaken as part of developing the integrated care plan and outcomes from them are now an integral part of practice. This presentation will focus on the strategies used to further enhance the movement of the Oncology Service on patient safety as a priority, to a culture where safety is a value that is an integral part of everyday activities. The tools and evidence based guidelines developed via our quality initiatives will be shared.

Abstracts - Oral Presentations

Innovation and Evidence Based Practice: Ordinary Surgical Site Infections? - An Extraordinary Interprofessional Quality Improvement Initiative Benefiting Surgical Oncology Patients

Shari L. Moura, RN, MN, CON(C), CHPCN(C).
Odette Cancer Centre - Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

Surgical site infections (SSIs) are a common type of adverse event of patients undergoing surgery. SSIs can increase mortality, length of stay, readmission rates, inpatient and community care costs but most importantly can delay adjuvant cancer treatments following surgical interventions. In a large tertiary hospital’s cancer centre, a dynamic cross-programs initiative to reduce the rates of surgical site infections in patients undergoing surgery for colon, rectal, hepatic, pancreatic, and biliary procedures was initiated in 2006 co-lead by an Advanced Practice Nurse in cancer care. Utilizing Safer Healthcare Now’s patient safety campaign as a guideline and a model of quality improvement several evidence-based interventions have been systematically implemented and measured including the optimal use of prophylactic antibiotics, maintaining normothermia for colorectal and open abdominal surgical patients and appropriate methods for hair removal. The overall aim of the project is to reduce the rate and severity of SSIs and ensure patient safety through interprofessional collaboration. The objectives of this presentation are to describe the initiative, the intricacy of working with several key stakeholders from various programs and departments, share key findings, ongoing successes and continued project implementation.

Innovation and Evidence Based Practice: Women’s Experiences with Breast Prosthesis

Margaret I. Fitch, RN PhD, Alison McAndrew, BA RAP, Andrea Harris, James D. Anderson, BSc DDS MS\(\rm{D}\).
Odette Cancer Centre, Toronto, ON, Canada.

The use of a breast prosthesis appears to improve body image in women who have undergone surgical intervention due to cancer. However, women who opt to wear a conventional breast...
prosthesis are often dissatisfied with various aspects about it. Women report dissatisfaction with incorrect fit, restrictive choice of clothing and difficulty dressing, discomfort, weight and cost. A new type of prosthesis, an artistic custom prosthesis, has been developed at our cancer centre. It was designed to offset the types of issues women have been dissatisfied with about conventional breast prostheses. This new type of prosthesis offers the opportunity to simulate the missing tissue more realistically. The prosthesis is individually designed to conform to the surface of the skin of patients and is held in place through various methods. This new type of prosthesis has been made available to women with breast cancer at the cancer centre on a pilot trial basis. In-depth pre and post interviews have been conducted with women who have selected a custom artistic prosthesis. Their experiences have been contrasted with those using a conventional prosthesis. In addition to documenting the experiences of these women, quality of life and satisfaction with care data have also been gathered using standardized scales. This presentation will highlight these results and focus on the implications for cancer nursing practice.

III-06-A
MENTORING, COACHING AND CERTIFICATION: HEALTHY WORKPLACE:
COACHING AND CANCER CARE - A SUCCESS STORY IN SYSTEMIC THERAPY PROGRAM EFFICIENCY

Cindy A. McLennan, RN, BScN, CON(C) CPN(C), Greg Doiron, MHA, Leslie Cameron, RN, Joanne Ready, RN, Maura Eleuterio, RN, BScN, Angela Blasutti, RN, BScN.
The Ottawa Hospital, Ottawa, ON, Canada.

Historically, cancer program development or redevelopment has been a top-down approach to achieving organizational goals and objectives initiated by senior nurse managers or program directors. So saying, successful achievement of these imposed program changes are sporadic at best and most often are unsustainable. Precious time and resources, both human and fiscal are frequently wasted as we attempt to improve our current systems and processes. That said, when a coaching approach to change is undertaken by the team the projected successes are almost always attained and the results are overwhelmingly sustainable. The approach is a collegial, collaborative, non-threatening approach and entails: determining the issue; discovering possibilities; action planning; barrier identification; and, the recap. The coaching approach recognizes the four primary styles of communication and the interaction between each type impacts upon our abilities to effectively interact, coach, and consult with others. Coaching skills discussed will include contextual listening, discovery questioning, messaging and acknowledging. Moreover, the various personal coaching styles will also be reviewed. From inception to execution, the use of coaching in cancer care has resulted in team ownership of profound operational changes in a regional cancer program that has a zero sum financial outlay but a future full of benefit for patients, their families and the oncology team as a whole.

III-06-B
MENTORING, COACHING AND CERTIFICATION: HEALTHY WORKPLACE:

CAREER DEVELOPMENT PERSPECTIVES AMONG NURSES IN OBTAINING SPECIALTY CERTIFICATION IN ONCOLOGY

Jayesh Patel, RN, BScN, MN1, Maureen McQuestion, RN, APN, BA, BScN, MSc, CON(C)c, Doris Howell, RN, BScN, MScN, PhDc, Karen Gayman, RN, BScN, MN(c)c, Janice Stewart, RN, BScN, ONC(c)c, Kelly McGuigan, RN, BScNc, Catriona Buick, RN, BScN, MN(c)c, CON(C)c.
'Systemic Therapy Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 2Radiation Medicine Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 3Chair, RBC Oncology Nursing Research, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 4Systemic Therapy, Apheresis, & Photopheresis Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 5Systemic Therapy, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada. 6Community Interlink, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada.

Literature in career planning and development show nurses will often approach their careers in the following stages: explore an area of practice, develop professional skills for best outcomes, develop professional commitment through continuing education, and then engage in succession planning. The literature also shows nurses will strategically seek employment by evaluating their career goals, seeking mentors, and continuing their education to find the “right fit”. The role of organizations in career development is to shift focus of employment to employability of nurses to maintain organizational vitality.

A recent survey involving oncology nurses in an urban regional cancer center accounts for employment variables such as sub-specialization within oncology, age, years of practice in nursing, years of practice in oncology, educational preparation, and current certification and memberships. Nurses were given the opportunity to report factors in obtaining certification such as family demands, personal interest, professional recognition, and recognition of courses toward a degree program. Nurses also have the option to provide the organization with preferences for educational support in obtaining their oncology certification from e-learning, in-services, self-learning packages, and journal clubs.

This presentation will convey key statistical findings and key opinions from current oncology nurses about obtaining national credentials in their career planning and development strategies.

III-06-C
MENTORING, COACHING AND CERTIFICATION: HEALTHY WORKPLACE:
RECRUITING AND MENTORING NOVICE ONCOLOGY NURSES - SUPPORTING THE PROFESSIONAL DEVELOPMENT OF NOVICE ONCOLOGY NURSES THROUGH A MENTORSHIP PROGRAM.

Carole Beals, RN, BScN, CON(C), Shelley Debison, RN CHPCN(C), Dana Naylor, RN, BScN, MN.
Royal Victoria Hospital, Barrie, ON, Canada.

Acting as a mentor and a resource person to fellow nursing colleagues and students in the specialty of oncology nursing is considered one of the expectations of the specialized oncology professional. The Ottawa Hospital, Ottawa, ON, Canada.
CanCer ScreeNiNg: BaRrIeRs, aTTItuDeS aNd BehavIorS In oNeThIC GrouPs.

The nursing graduate initiative was introduced in the spring of 2007 by the Government of Ontario. This initiative was open to all Ontario nursing graduates and employers in all sectors. The goal of the initiative was to provide full-time employment, as well as the benefit of an extended orientation and support through mentorship, to new graduates as they transition into independent practice. Another goal of the program was to support the experienced bedside nurse to enhance their professional development and retention by acting as mentors to the graduate nurses. As well, employers are able to use the balance of funds for other nursing initiatives such as: intraprofessional mentorship and/or preceptorship programs; 80/20 for staff nurses; or internships for experienced nurses in specialty areas (Nursing Secretariat, Ministry of Health and Long Term Care, 2007).

A 44 bed Oncology and Palliative Unit, received funding for four graduate nurses through this initiative. A program was developed to support their professional development, provide education specific to the unit, encourage reflective practice, teach clinical skills, and evaluate the outcomes of the program in terms of knowledge transfer and confidence to practice independently. This presentation will outline the planning, implementation and evaluation of the program for integrating new graduates into an acute oncology and palliative unit.

III-07-A

Novel PrescriptiveS: CaNCer ScreeNiNg: BaRrIeRs, aTTItuDeS aNd BehavIorS In a SuBpOpUlAtIoN oF aFrO-CaRiBbeAN aDultS LiViNg In ToRonto.

Mary Glavassevich, Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

Screening for cancer is recommended for better overall outcomes yet some ethnic groups may not be taking full advantage of the screening regimen. Immigrant minorities in USA continue to experience disproportionately higher cancer incidence and mortality rates although there is a decline in the overall cancer death rates (Gany et al., 2006). The Canadian experience is not well explored. A recent literature review has shown limited research in Canada regarding screening for cancer among ethnic groups including Afro-Caribbean. Hence a group of (Afro-Caribbean) nurses within the Oncology Program decided to examine screening for four types of cancers among the Afro-Caribbean living in Toronto. Key questions focused on the individual’s knowledge of screening, whether they had screening done and the family physician’s role in cancer screening. The presentation will describe knowledge about and extent of cancer screening in the cross-sectional community sample, as well as barriers to screening and possible solutions. Understanding the perspective of the Afro-Caribbean community members provides insight into the attitudes and behaviors regarding cancer screening. Knowledge gained will contribute to professional development of oncology nurses and support the need for development of screening programs and further research focused on ethnic groups.

III-07-B

Novel PrescriptiveS: ReCRUITING tHe NOVICE, RETAINING tHE EXPERIENCED: A Pi-LOt EDUCATIONAL PROGRAM TO SUPPORT oNCoLo GY NURSiNg PrACtICE.

Susan King, RN, BScN, CON(C), Cynthia Cummings-Winfield, RN, BScN, CON(C). Cross Cancer Institute, Edmonton, AB, Canada.

The international shortage of nurses mandates that organizations be creative to ensure ongoing recruitment and retention. This presentation will describe an innovative educational strategy developed to facilitate the transition of graduate nurses to the oncology nursing role. New graduates participated in the traditional hospital orientation and completed three months of clinical practice. Thereafter, the nurses were released from clinical responsibilities one day per week to attend the 14 week on site instructor-led educational program. The program of studies addressed essential oncology nursing knowledge from carcinogenesis to early detection and diagnosis, to recovery or death. Student enthusiasm piqued the interest of experienced staff nurses. To support the ongoing professional development of existing staff and to encourage staff retention the original pilot program was modified for delivery to experienced oncology nurses. As with the new graduates, organizational support was extended to ensure that the nurses were able to attend weekly sessions. This presentation will include an overview of the course content, teaching and learning strategies, assessment of student learning and course evaluations of the pilot programs. Data collected supports our hypothesis that this educational initiative is an important contributor to the transition of a new graduate, a support to the experienced nurse and a creative recruitment and retention strategy. Narrative comments convey that the nurses experienced heightened job satisfaction, increased confidence in their practice and an enhanced ability to critically assess and proactively address patient care issues.

III-07-C

Novel PrescriptiveS: SuRVIvORS DeBATe: tHE PaST dECA DE IN oVARIAN CANCeR.

Pamela J. West, RN(EC), NP-Adult, MSc, CON(C), CHPCCN(C); Sandi Pniauskas; Carolyn Benivenga. 1Rouge Valley Health System, Toronto, ON, Canada, 2No Institution - patient, Whitby, ON, Canada, 3No Institution - patient, Novi., MI, USA.

Two fascinating and novel cancer survivor-led conferences point the way to the future. As healthcare providers, we may have missed an exceptional opportunity. We need to get ‘on board’ and truly ‘walk-the-walk’ rather than merely espousing a concept of innovation. In the U.S. and Canada during 2007, four ovarian cancer survivors coordinated and self-funded the first ever cancer debates. Oncology nursing professionals were asked to participate in supportive roles and to document the debate proceedings. The debates were planned, co-ordinated and delivered by ovarian cancer survivors who took them on the road, presenting both in Michigan and Ontario. Research data from the past decade were presented from a pro and
con perspective and included awareness and communication; early detection; survival; access to care and genetics. Marketing the programs garnered significant controversy, but successful results were proof positive that the vision of these cancer patient survivors was brought to fruition. In preparation for the debates, the survivors conducted a survey, in part to highlight the value patients place on relationships with their physicians. If, as healthcare providers we feared criticism or exclusion, there was little cause for concern. This presentation features the results of the e-survey (n = 303), the essence of the debates (including video footage) and evaluations of the process. Health care professionals were impressed by the patients’ knowledge, expertise and wonderful ability to ‘relay the message.’ Survivors were anxious to learn more about the role of advocacy and information sharing. Future debates are planned.

**IV-01-A**

**BEYOND THE OVERPASS: WHAT’S OUTSIDE CITY CENTRES: COMMUNITY CANCER SUPPORT NETWORKS**

Janice L. Chobanuk, MN CON(C)CHPN(C), Miriam Dobson, BScN CHPCN(C). ACB, Edmonton, AB, Canada.

The cancer journey is complicated for individuals and families living with cancer. At the time of diagnosis, these individuals are expected to make difficult decisions regarding their cancer treatment and care while dealing with the psychosocial, physical and practical aspects of a potentially life threatening illness. In 2006, a comprehensive provincial needs assessment and patient experience survey identified timely access to supportive care and integration of services as areas requiring improvement in the current cancer system. Consequently, to improve care for individuals living with cancer in rural and remote regions, Community Cancer Support Networks are being developed to increase access to services and improve quality of care closer to home. The networks include: psychosocial and palliative care, cancer rehabilitation, community cancer treatment centers, and cancer patient navigation. Community Cancer Support Networks provide partnering opportunities, interprofessional collaboration, and conduits for sharing and disseminating information. The integration of services through these virtual networks and communities of practice improves timely access and coordination of services by capitalizing on partnerships. This type of collaboration between the Provincial Cancer Program, the Rural Health Regions, health facilities, and other key stakeholders has led to enhanced communication flow, opportunities for knowledge transfer, dissemination, uptake, and improved coordination of patient care. The aim of this presentation is to demonstrate how networks increase access to services and improve quality of care closer to home.

**IV-01-B**

**BEYOND THE OVERPASS: WHAT’S OUTSIDE CITY CENTRES: EXPLORING THE UNIQUENESS OF SPECIALIZED ONCOLOGY NURSING PRACTICE IN THE SMALL RURAL COMMUNITY: THE CHALLENGES, TRIALS, AND DYNAMICS OF CARING FOR THOSE IN YOUR NEIGHBOURHOOD**

Wayne Enders, RN. Alberta Cancer Board, Edmonton, AB, Canada.

Until recently, most specialized cancer care has been delivered by tertiary facilities located in major urban centers. Increased demand on these centers, along with the public’s request for specialized care delivery closer to home, has been the catalyst to the development of cancer treatment and follow-up services in small rural communities throughout our province. The majority of the nurses recruited to manage and operate the “Community Cancer Centers” are long term residents of the community (in which they practice). Community Cancer Centre Nurses identify multiple and unique issues and situations which arise while caring for their neighbours, friends, relatives. The boundaries between professional and personal relationships can become blurred and the challenge of finding one’s place while continuing to meet the needs can be arduous and unsettling. This presentation will outline our provinces’ cancer care network and highlight the unique situations and relationships confronting rural oncology nurses. The author will share his personal experiences and observations and discuss coping strategies.

**IV-01-C**

**BEYOND THE OVERPASS: WHAT’S OUTSIDE CITY CENTRES: BRINGING EXTRAORDINARY PEOPLE TOGETHER: A PROVINCIAL NURSING ONCOLOGY NETWORK**


There are many challenges in meeting the mandate of a province-wide system of population based cancer control which addresses the spectrum of cancer care from prevention and screening, to diagnosis, treatment, rehabilitation or end of life care. Nurses are uniquely positioned within the health care system to provide evidence-based care to individuals, families, and communities across the entire cancer care continuum. This important work, however, takes place in a plethora of widespread geographically, culturally, and organizationally diverse settings. How might nursing’s strengths be effectively utilized and enhanced, and the barriers be overcome, for the benefit of cancer care? The development of a provincial nursing oncology network, a consistent formal structure to support oncology nursing practice throughout the cancer continuum, is key to effective provincial cancer control. The nursing oncology network provides opportunities for nurses throughout the province to “collaborate and ensure consistent standards of cancer care and treatment are provided to patients as close to home as possible” and for knowledge to “permeate all the environments in which cancer control is delivered”. This presentation will describe the history and formation of a provincial nursing oncology network, its purpose, goals, strategies, and outcomes to strengthen the contribution of nurses toward the provision of extraordinary cancer care to individuals, families, and communities throughout the province.

**IV-02-A**

**DIVERSE TECHNOLOGIES: DEVELOPMENT OF A SYSTEMIC THERAPY NURSING WORKLOAD TOOL**

Janice D. Stewart, RN BScN CON(C), Esther Green, RN, MSc(T), Colin Preyra,, MA. MSc, PhD, Kathy Be-
attie, RN, CON(C)\textsuperscript{4}, Marcia Langhorn, RN, CON(C)\textsuperscript{5}, Rosemary Bland, RN, BScN, CON(C)\textsuperscript{6}, Cindy McLennan, RN, BScN\textsuperscript{7}, Tracy McQueen, RN\textsuperscript{8}, 1Princess Margaret Hospital, Toronto, ON, Canada, 2Cancer Care Ontario, Toronto, ON, Canada, 3Institute for Clinical Evaluative Sciences, Toronto, ON, Canada, 4Odette Cancer Centre, Toronto, ON, Canada, 5London Regional Cancer Program, London, ON, Canada, 6Juravinski Cancer Centre, Hamilton, ON, Canada, 7The Ottawa Hospital Regional Cancer Centre, Ottawa, ON, Canada, 8Cancer Centre of Southeastern Ontario, Kingston, ON, Canada.

During the past 12 months, a group of nursing leaders and clinicians working in collaboration with a health economist developed a workload tool based on over 250 actual chemotherapy regimens consistently delivered in 14 cancer programs. Excluded from this work were clinical trials, oral and in-patient chemotherapy and supportive care regimens. The group discovered that there were a number of provincial models independently developed but none were validated. A validated tool developed by Cusack et al., 2004 was used as a reference tool. The group initially met by phone to review the scope of the work and to identify nursing activities associated with the delivery of systemic therapy. The workload estimates were derived via a consensus panel, informed by discussions with front line clinical experts. Initially, 50 high volume regimens were scored and the data were validated using hospital specific estimates. Upon completion of the initial validation of the tool, the group continued with scoring the remaining 250 regimens. Concurrently our pharmacy partners scored their workload using the same regimens such that a comprehensive tool could be used for planning purposes such as human resources and funding. At this presentation, individuals from this group will present on the process that was developed, outline how we came to consensus and show examples of our data. We will discuss the policy implications of our work from the perspective of managing and funding the delivery of systemic therapy.

**IV-02-B**

**Diverse Technologies: Experiences with the Development, Implementation and Evaluation of a Web-Based Nursing Education Resource**

Joy Bunsch, RN, BSN, BC Cancer Agency, Fraser Valley, BC, Canada.

The Breast Cancer Nursing Education Resource (BCNER) is a web-based program that gives nurses ready access to current and evidence-based information about key issues related to breast cancer. The resource was primarily developed to enhance the knowledge and skills of experienced breast cancer nurses. It was designed to be used in the clinical setting so that a nurse could easily locate current information about a variety of issues, including breast cancer pathology, diagnosis, hereditary breast disease, current treatment recommendations, symptom management, and patient resources.

The information provided throughout BCNER is organized into twelve sections, each of which reflects patient needs identified throughout the phases of the cancer trajectory. The program was pilot-tested and the resulting feedback was incorporated into the program’s design. BCNER was then directly linked to the website of a large provincial cancer center. The program went “live” in May 2007.

This presentation will outline the steps in planning and developing the BCNER. Key features of the resource will be profiled. The results of pilot-testing, and evaluation after implementation will be shared. Other issues that will be addressed include the unique challenges of developing and maintaining web-based educational resources; recommendations for others planning to develop similar programs; and future plans for the BCNER.

**IV-02-C**

**Diverse Technologies: Questioning Practice: Finding Evidence to Support Best Practice in Skin Care for Patients Receiving Radiation Therapy**

Donna J. Gies, RN, CON(C), CHPCN(C). Tom Baker Cancer Centre, Calgary, AB, Canada.

It is well known that human skin is radiosensitive, and that 95% of patients endure skin reactions when receiving radiation therapy. As a result of these realities RT nurses must be knowledgeable about the assessment and management of radiation skin reactions. It is essential that they understand the dosing and type of energies used during radiation in order to guide skin care protocols. Nurses in Radiation Oncology at our centre have begun to question current skin care practices. We have initiated three projects in a quest to find evidence to support best practice. 1. A randomized study is underway to evaluate the relationships between the use of antiperspirants and skin reaction intensity and the reported quality of life in women receiving external beam radiation treatment for Stage 0, I, or II breast cancer. 2. A quasi-experimental comparison study has been conducted comparing the use of standard hydrophilic (water-based) cream and a hyaluronic acid-based cream to assess any difference between the onset and intensity of skin reactions and the comfort of the patient. 3. A quasi-experimental comparison study evaluating the standard dressing protocol for moist desquamation, which is gauze with hydrophilic cream, against the use of a silver leaf nylon dressing was done. This study measured the outcomes of comfort, symptom relief, ease of application and cost. These three novel studies will be synthesized and implementations of findings to practice will be explored.

**IV-03-A**

**Innovative Practice Opportunities: New Innovative Roles for Oncology Nurses; Participation in a Selection Process for a New Provincial Vendor**

Jayesh Patel, RN, BScN, MN\textsuperscript{1}, Barbara Godfrey, RN, BScN, MSc\textsuperscript{2}, Janice Stewart, RN, BScN, OCN\textsuperscript{3}(C), Diana Incenkol, RN, BScN, CON(C)\textsuperscript{4}, Raquel Lopez, BASc, MASC\textsuperscript{5}. 1Systemic Therapy Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 2Leukemia Outreach Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 3Systemic Therapy, Apheresis, & Photopheresis Program, Princess Margaret Hospital, University Health Network, Toronto, ON, Canada, 4Healthcare Human Factors Group, Centre for eHealth Innovation, University Health
Network, Toronto, ON, Canada.

Over the past year a group of multi disciplinary oncology practitioners were invited to participate in a unique process to select a vendor for a Chemotherapy Physician Order Entry (CPOE) system. Oncology nurses participated as a member of a multidisciplinary team who were given the opportunity to review and assess the vendors responses to the request for proposal, develop scenarios for the vendors to use in demonstrating their products and evaluate the products during live demonstrations. This process was successful in narrowing the field of potential vendors. The next phase of evaluation provided nurses, pharmacists and physicians with access to a human factors lab where they were given minimal training on the products and then requested to carry out ordering and medication reconciliation and administration process. This presentation will focus on the unique opportunity for oncology nurses to participate in this process and discuss some of the key learning’s that came out of the involvement, in particular the time spent in the human factors lab. Oncology nurses are often requested to participate in processes that are outside of standard nursing roles. These opportunities give us a unique voice and position us as key opinion leaders in our organizations, which is where we need to be in 2008.

IV-03-B

INNOVATIVE PRACTICE OPPORTUNITIES:
PYNK - YOUNG WOMEN WITH BREAST CANCER PROGRAM:
BUILDING A PROGRAM FOR EXTRAORDINARY WOMEN

Margaret I. Fitch, Stephanie Burlein-Hall, RN BScN MEd CONC(, Ellen Warner, MD MSc FRCP FACP.
Odette Cancer Centre, Toronto, ON, Canada.

Approximately 8% of breast cancers occur in women under the age of 40. Young women differ from post-menopausal women presenting with more aggressive disease, more recurrences and lower 5 year survival rates. They are also at a different point in their life and family cycles, often juggling young children and career demands. In 2001, the Canadian Breast Cancer Network in partnership with the Psychosocial and Behavioral Research Unity at the cancer centre held consultations across Canada with young women. The subsequent report, “Nothing Fit Me”, highlighted the issues associated with being young and living through the diagnosis and treatment of breast cancer. Specific concerns related to fertility, early menopause, sexuality, relationships, talking to children, post-treatment supports and financial issues. PYNK—Young Women with Breast Cancer Program was established as an integrated cancer program within a comprehensive cancer centre, to provide a structure to address the clinical, educational and research needs of this group. The role of the Advanced Practice Nurse in the PNYK is pivotal in linking all the pieces of the program together while helping these young women navigate through their personal breast cancer journey. This presentation will describe the development and implementation of the program, the role of the APN and initial response from participants to this innovative program. This program was designed to address the unique needs of this extraordinary group of breast cancer survivors and offer the tailored clinical and educational support they require.

IV-03-C

INNOVATIVE PRACTICE OPPORTUNITIES:
The Needs of Young Adults with Cancer

Jennifer Parkins, RN, BScN, CONC(, MN (Candidate Univ. of Victoria). Grand River Regional Cancer Centre, Kitchener, ON, Canada.

Canadian researchers formed a working group to examine cancer patterns in young adults and this group finalized a report entitled, “Cancer in Young Adults in Canada” and the highlights of this report reveal that approximately 10,000 Canadians aged 20 to 44 were expected to be diagnosed with cancer in 2005 and 2,000 of them were expected to die from it. Young adults with cancer will have improved survival and decreased mortality rates but there is a need to examine the described supportive care concerns of this population. Young adulthood is a time of personal growth when individuals are faced with many social challenges. This presentation will discuss an interpretive description research study conducted in 2008 to gain a deeper understanding of the described needs of young adults with cancer within the domains of quality of life. The purpose of the conducted study was to learn about the described needs of young adults aged 20 to 44 living with newly diagnosed cancer and currently undergoing chemotherapy and/or radiation treatment; to enhance oncology care providers understanding of the described needs of young adults aged 20 to 44 and their families living with cancer; and to identify the nursing interventions that support the needs of young adults aged 20 to 44 and their families living with cancer. The results of this study will be shared with oncology nurses to contribute to the future health care delivery for this unique population.

IV-04-A

WORKING TOGETHER IN NEW WAYs:
INTEGRATING RN and NP PRACTICE INTO OUTPATIENT ONCOLOGY CLINICS

Stephanie M. Hubbard, RN, MN, NP, CONC, Cheryl Howe, RN, BN, CONC. Tom Baker Cancer Center, Calgary, AB, Canada.

Innovative ways to deliver cost effective holistic care are being introduced all over Canada. One such endeavor is the introduction of Nurse Practitioners (NPs) into Cancer Care delivery. At the Tom Baker Cancer Center (TBCC) in Calgary, Alberta an initiative was made to introduce an NP into the Hematology Tumor Group. Research in the area of NP integration illustrates many barriers to role development. The addition of the NP into the work environment resulted in alterations in the work design which resulted in conflict and a need for team growth. Introduction of the role did not occur over night but required collaboration from all team members including management, physicians and RNs. There is a paucity of Canadian literature related to this topic. This presentation will address the challenges encountered and the solutions realized. We have created three overlying themes: (1) improving communication between the interdisciplinary team, which included ongoing assessment of boundary issues and examining concerns of perceived territory; (2) realizing the shared vision for improving patient care, and (3) appreciating advanced education and an environment of mentorship, learn-
**IV-04-B**

**Working Together in New Ways: Partners in Care: Improving Breast Cancer Care Together**

Angela Leahey, RN, BScN, MN, Sharon Lemon, RN, BScN, CON(c).
Sunnybrook Odette Cancer Centre, Toronto, ON, Canada.

Meeting the complex care needs of breast cancer patients in an ambulatory oncology setting requires an innovative approach to quality nursing care. At this outpatient cancer centre, an Advanced Practice Nurse (APN) provides leadership and support to primary oncology nurses and specialized oncology nurses in various nursing roles. The goal of this model is to provide comprehensive quality care to all breast cancer patients at the center and through effective communication and collaboration. Within this model, the APN is not responsible for providing direct care to breast cancer patients. However, the APN influences patient care by offering leadership, education, research support, and clinical support to the specialized oncology nurses caring for these patients. The success of this model is contingent on effective collaboration and communication between the APN, the primary oncology nurses, and the specialized oncology nurses within the site. Monthly meetings, weekly communication, and daily clinical support are just a few of the methods used to ensure that the APN and nurses are working together to provide excellence in patient care. The benefits, challenges, and ongoing developments of this model of care will be discussed throughout the presentation.

**IV-04-C**

**Working Together in New Ways: Two Nurses are Better than One! The Collaborative Practice of a Primary Nurse and an Advanced Practice Nurse**

Rosemary Davidson, RN, Wendy A. Gillis, MScn.
London Health Sciences Centre, London, ON, Canada.

Current cancer care includes complex treatment plans, management of treatment-related side effects, symptom control, patient and family education, quality of life issues and community care. All are essential aspects of care as we help our patients navigate their cancer journey. Oncology nurses working together in a collaborative nursing model are able to provide expert knowledge, advanced skills, and personalized individualized care focused on the common goal of excellent patient care. When the Specialized Oncology Nurse and the Advanced Practice Nurse combine their considerable knowledge and expertise in cancer care, they are able to deliver patient-focused, individualized and holistic quality care. The seamless meshing of their individual skill sets benefits both the patient and their significant others. A skill set unique to each nurse’s practice, recognition of the other’s strengths, and the autonomy to develop collaborative practice has provided a rewarding nursing experience for both. It has resulted in positive patient outcomes as well as patient and family satisfaction. Coordinated continuous care encompasses both the outpatient clinic and inpatient setting. Our patient population experiences repeated hospital admissions for radioisotope therapy and long-term follow-up in the cancer centre. They have a multitude of information needs. Our collaborative practice is aimed at providing seamless care for this unique and challenging group of cancer patients. Two case studies will demonstrate our collaborative practice in action.

**IV-05-A**

**Symptoms and Side Effects: Controlling Complex Oncology Pain: A Retrospective Review of Patients Managed on Combined Opioids / Ketamine Infusions**

Sylvie Bruyere, RN, BScN, CON(c), CHPCN(C), Lynn Kachiuk, RN, BA, MS, CON(C), CHPCN(C). Ottawa Hospital, Ottawa, ON, Canada.

The specter of uncontrolled pain is one of the greatest fears for patients with advanced cancer, causing physical, psychosocial, and emotional distress. Recent advances in our understanding of the pathophysiology of cancer pain have led to new approaches to managing these often complex pain syndromes. Ketamine is an effective analgesic agent for treating a variety of neuropathic and cancer pain syndromes, particularly in patients with suspected opioid resistant pain. Our palliative care team has been successfully using Ketamine infusions in addition to opioids for approximately 7 years. This experience has led to the introduction of combined Ketamine and opioid infusions. This presentation will focus on the results of a retrospective chart audit of 95 patients managed with combined infusions of Ketamine and opioids. Our objective is to describe our experience of using combined Ketamine and opioid infusions in terms of patient demographics, pain syndromes involved, effectiveness as an analgesic, duration and outcome of infusions, patient disposition, side effects as well as patient and staff experience with the infusions. The study results provide important clinical information that will facilitate development of guidelines for the use of combined infusions of Ketamine and opioids to enhance the management of complex cancer pain syndromes with minimal toxicities and side effects in a variety of patient settings.
However, as disease burden grows and symptoms intensify, conventional laxatives may be rendered ineffective or become burdensome because of polypharmacy or side effects. A recent systematic review of peripheral opioid receptor antagonists supports that MNTX acts on the gut’s myenteric plexus by blocking opioids from occupying mu receptors. Analgesia is preserved because MNTX is neither absorbed systemically, nor does it cross the blood brain barrier. MNTX has tremendous potential to preserve dignity and promote comfort for individuals living with refractory OIC. This presentation reviews the action of MNTX and its role in therapy for treating refractory OIC amongst conventional laxatives.


IV-05-C

Symptoms and Side Effects:
The Incidence of Taxane-Induced Myopathy (Arthralgia/Myalgia) in Patients Receiving Chemotherapy for Early Stage Breast Cancer

Barbara Fitzgerald, Julie Napoliskikh, Nadia Salvo, George Dranitsaris, Ali Val, Sophie Kim, Christine Simmons, Małgorzata Tyszka, Mark Clemons. Princess Margaret Hospital, Toronto, ON, Canada.

Background. There has been a rapid increase in the use of sequential anthracycline/taxane based therapies for breast cancer. It is clinically evident that a significant proportion of patients develop debilitating arthralgia/myalgia despite the low incidence of toxicities reported in the literature. We therefore decided to investigate the extent of this problem in the non-clinical trial setting.

Methods. Patients, who had received prior Adriamycin, Cyclophosphamide, Paclitaxel (AC-T), AC-Docetaxel (AC-D), or 5-Fluorouracil, Epirubicin, Cyclophosphamide and D (FEC-D) treatment, completed a retrospective survey using Functional Assessment of Cancer Therapy-Taxane Scale and Memorial Symptom Assessment Scale.

Results. 82 patients were interviewed (age: median 50; range 27-70). Participants had received AC-T (43%), FEC-D (43%), and AC-D (14%). Only 11 (13%) patients reported no pain. In those patients who did, the majority (65; 79%) indicated that their worse pain occurred during the taxane treatment. Worse pain was reported more often in patients receiving D (45%) rather than T (34%). 35 of 82 (43%) patients required narcotic management for pain treatment. Pain occurred most frequently in joints (46%), followed by lower back (28%), legs (26%), upper back (24%), and arms (18%). Interestingly, on the Global Distress Index there were no significant changes in distress with taxane treatment in FEC-D or AC-T regimens; however, with D in the AC-D regimen, distress worsened.

Conclusion. We found a significant number of patients in the non-trial setting experienced arthralgia/myalgia toxicity in addition to pain and peripheral neuropathy. Prospective patient-reported outcome assessments and subsequent intervention strategies will help individualize interventions, evaluate their potential effectiveness and improve symptom management in this population.

IV-06-A

Learning Is What Counts:
Continuing Education as a Strategy for Nursing Recruitment and Retention

Marika Swidzinski, Liz O’Hagan, RN., CON(C), Nancy Hutchison, MSc (AIN, CON(C). McGill University Health Center, Royal Victoria Hospital, Montreal, QC, Canada.

A large metropolitan teaching hospital was recently recognized by Macleans Magazine as one of the top 100 employers in Canada. Innovative approaches to promoting professional development are a goal towards which we strive regularly. Nursing shortages worldwide and at home are challenging the health care system to develop creative strategies to not only recruit new staff but also to maintain job satisfaction and a healthy work environment. In response to this, the in-patient hematology/oncology/stem cell transplant unit of the this institution has developed new approaches to professional development. Previously, the unit held weekly continuing education (CE) sessions as the traditional manner of disseminating new techniques and topics to increase nursing knowledge and support professional practice. Over several meetings with the nursing staff, the team shared their desire to find innovative ways to receive the CE so that they were not distracted by patient care needs while attending the sessions. After evaluating their concerns, the leadership and educational teams developed a plan to review and modify the way in which we structure our learning opportunities. It was important for the leadership to structure the new workshops in a way that permitted the permanent evening and night staff to be able to participate. In this presentation, we would like to describe our creative way of offering our CE in a series of one-day workshops for nursing staff.

IV-06-B

Learning Is What Counts:
Perceived Barriers to Pap Smear Screening among Women of Newfoundland and Labrador

Kathy Fitzgerald, Eastern Health, St John’s, NL, Canada.

It is estimated that over 90% of cervical cancers are preventable. Since introduction of the Papanicolaou smear (Pap smear), which is known to be effective in reducing morbidity and mortality, the Canadian incidence of cervical cancer has declined dramatically. The past decade has seen a steady rise in incidence for Newfoundland and Labrador (NL), where mortality rates are twice the national average and screening rates are among the poorest in the country. Research has identified potential barriers to cervical screening such as fear, embarrassment, misunderstanding of its importance and lack of encouragement by phy-
LEARNING IS WHAT COUNTS: Creating a Culture of Continuous Learning: A Shared Responsibility

Linda C. Watson, RN, BScN, MN, CON(C). Tom Baker Cancer Center, Calgary, AB, Canada.

Current healthcare workplaces are complex, multi-faceted, and rapidly changing (Porter O’Grady & Malloch, 2003). Adapting to this changing workplace is a shared responsibility between the nurse and institution. This presentation will provide an overview of the concerted efforts undertaken at our institution to shift workplace culture towards continuous learning; supporting high levels of competencies among all nurses while simultaneously creating a quality practice environment (CNA, 2007). A needs assessment based on CANO Practice Standards and Competencies for the Specialized Oncology Nurse identified the nurses’ priority education needs. This survey has resulted in a reflexive approach to ongoing staff education including; a more comprehensive new staff orientation, and ongoing in-services. At the institutional level numerous exciting initiatives are underway. In order to support evidence based practice, access to current digital databases has been secured, with staff education regarding accessing the e-library, how to do literature searches, and retrieval of relevant evidence is underway. Money has been secured, with staff education regarding accessing the e-library, how to do literature searches, and retrieval of relevant evidence is underway. Money has been secured, with staff education regarding accessing the e-library, how to do literature searches, and retrieval of relevant evidence is underway.

There is substantial evidence to support continuous infusion therapy versus bolus infusion in the management of metastatic colorectal cancer. As well, reported supportive care advantages for home infusion chemotherapy include reduced travel and treatment associated anxiety, reduction in the burden on careers and family, and the ability to continue other duties. In order to ensure standardized, safe and evidence-based care for patients on the Chemotherapy Home Infusion Pump Program (CHIPP), a multidisciplinary, inter-agency team was formed and developed: a clinical pathway; educational materials and sessions for health professionals; and an infrastructure and processes to ensure access to medical oncologists for medical direction. Objectives included determining the accessibility and safety of CHIPP, providing health care education and training, and to evaluate overall patient and health care provider satisfaction. Resulting from this project, regional access has improved without significant incidents reported. Patient satisfaction is high, with strong recommendation to continue the program. Health providers are satisfied with their knowledge level gained and have confidence in the program infrastructure. Quality improvement initiatives such as incidence tracking, education and training are ongoing. A standing committee will co-ordinate ongoing program refinements, ensure continued regional collaboration and manage increasing demand. This presentation will share the evaluative results and lessons learned, and will discuss the ongoing leadership and education required to sustain the program.

EXPLORING QUALITY CARE: There’s Always Room for Improvement: Delivering Nursing Care within Radiation Oncology

Frankie Goodwin, RN, BN, BCCA, Vancouver Centre, Vancouver, BC, Canada.

The clinical nursing role in radiation oncology is extensive, involving patient assessment and education, planned nursing interventions, collaboration and evaluation. In January 2002, a change was made in the model of nursing care delivery within the Radiation Program at a large regional Cancer Care Centre. This change was made to better align nursing care to patient needs, affording nurses the potential to practice to their full scope, rather than concentrate on clinic flow and clerical support. Currently, nursing care occurs in several areas within the Radiation Department and with the delivery of multi-modality treatment regimens increasing the complexity of patient care, careful planning is required to ensure that the necessary nursing resources are in place to meet patient needs at the most appropriate points in the care continuum. In 2007, a review of nursing activities in radiation oncology over the previous 2 years was conducted within this regional Cancer Care Centre. The retrospective review assessed workload indicators and determined classification of workload by complexity factors. A significant growth in both workload and complexity occurred from 2005 - 2007. This presentation will demonstrate how nursing practice has changed over time in a complex radiation oncology environment and also how the data collected can be best used to improve patient outcomes through the provision of timely, efficient nursing care.
IV-07-C

**EXPLORING QUALITY CARE: HEAD AND NECK ONCOLOGY CASE MANAGER: ADDRESSING THE GAPS IN CARE**

Karen H. M. Woodworth, RN, BN, CON (c), Victoria L. Sullivan, BN, RN, MHS, CON(c). Capital District Health Authority Cancer Care Program, Halifax, NS, Canada.

Patients with head and neck cancers have complex needs requiring the coordination of multiple disciplines and services across the care continuum. In 2005, the Head and Neck Cancer Site Team (CST) recognized that the current systems and processes for the care and management of patients with head and neck cancer needed to be improved. Focus groups conducted with healthcare professionals and patients and their families revealed several gaps in care. Patients and families reported concerns about having access to adequate information and support in all stages of the cancer journey. They identified a need for a consistent health care professional to provide information and support and to coordinate care across the continuum. In response, a Head and Neck Oncology Case Manager position was created to improve the delivery of care to this patient population. The case manager position is a nursing role designed to address the identified gaps in care and to better meet the needs of patients and families throughout their cancer journey. The goal is to provide patients with a resource person who they can contact throughout their journey. This oral presentation will report on the development, implementation, and proposed evaluation of this patient focused role.

V-01-A

**FINDING MEANING: MOVING FORWARD AFTER SURVIVING CANCER: PICKING UP THE PIECES**

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The “Picking Up the Pieces” Workshop was designed as an aid for cancer survivors to move forward in the journey of recovery. The objectives of the workshop include: to facilitate a process that assists participants to move through the transition from survivor to living well; to assist in integrating the pre-cancer and post-cancer self; to support the participant in regaining a sense of control; to assist the participant in rebuilding confidence in their choices and hope in the future; to assist the participant in identifying newfound insights and strengths; to encourage the participant to ignite or renew their own healing spirit. Workshops have been offered across Canada. At each workshop, participants were asked to evaluate the sessions. The evaluation involved a two-step process: 1) participants completed a post-workshop survey; and 2) participants were contacted for an interview six months post-workshop. Data have been analyzed from the post-workshop surveys and post-workshop interviews for eight workshops. A total of 183 surveys and 15 interviews with survivors have been completed to date. Participants found the workshop provided valuable tools and information for survivors about healing and growth. The participants plan to encourage others to take the workshop; to use the information in moving forward in their own lives; and to share the information with others including family, friends and other survivors. The workshop is an excellent model for a survivorship program.

V-01-B

**FINDING MEANING: 10 YEARS OF REFLECTIVE PRACTICE: WHAT HAVE WE LEARNED?**

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Community Interlink consists of a team of community-based specialized oncology nurses who enable adults and children with cancer and their families to access the care and support they require at all stages of illness in their home. For the past ten years, Community Interlink has been using reflective practice to share knowledge and experience among peers as part of their professional development. Each nurse feels that reflective practice has advanced the quality of her caregiving (Howell & Pelton, 2001) but there has never been a systematic analysis of this. Reflection is a process of knowing how we know. It can deepen our own sense of identity and integrity and it can deepen our understanding of the nursing self (Livsey & Palmer, 1999). A qualitative descriptive study involving nine Community Interlink nurses, four adult and five pediatric nurses, was undertaken to understand their process of reflection and uncover the effects of reflection on their nursing practice. Data from pediatric and adult team focus groups and individual interviews was analyzed using Giorgi’s analytical technique. This presentation will highlight the process and key elements of reflective practice used by these nurses and how reflective practice has contributed to improving the quality of their nursing care to patients and families.

V-01-C

**FINDING MEANING: SURVIVE ‘N’ THRIVE**

Pamela J. West, RN(EC), NP-Adult, MSc, CON(C), CHPCN(C), Heather L. Cameron, BSW, MSW, RSW, Lorna Moore. Rouge Valley Health System, Toronto, ON, Canada.

Oncology nurses cheerfully say “good-bye and goodluck” to their patients as they complete treatment: either radiotherapy or systemic care. However patients/families may be less enthusiastic about finishing therapy as they venture forward to a new ‘normal,’ often filled with fear and trepidation. In order to support patients facing completion of cancer care, our community hospital offers a 4 week ‘survive ‘n’ thrive’ course, every 3 months. Each week of the course, a Nurse Practitioner, Social Worker and volunteer focus on topics such as physical concerns, psychosocial health and the pragmatic/practical aspects of life after cancer. On the last session, seasoned survivors return to share their stories and suggest strat-
Mentorship: Intergenerational Workplaces: A Collision Course for Canadian Cancer Care

Cindy A. McLenann, RN BScN CON(C) CPN(C), Kelly Anne Baines, RN, Mychelle Rheumne, RN BScN, Joanne Ready, RN, Leslie Cameron, RN, Greg Doiron, MHA. The Ottawa Hospital, Ottawa, ON, Canada.

Recruitment into the nursing profession is difficult at the best of times and retaining new graduates as well as seasoned nurses is becoming increasingly difficult. In addition to significant fiscal constraints affecting our ability to provide quality care, inter-generational issues are wreaking havoc from within our nursing ranks. Underreported and frequently unrecognized, the generation diversity in nursing needs to celebrate the differing characteristics of the nurses in Generation Y, Generation X, Baby Boomers and Retiree categories instead of letting issues between the groups negatively impact upon our ability to provide quality cancer care. Being proactive and learning to recognize the various drivers and characteristics of the differing groups will improve communication between staff, defuse conflict and let us celebrate our differing perspectives in not only life as a whole, but nursing in particular and cancer nursing most specifically.

Implementing a Clinical Expert Oncology Nursing Model Across the Continuum

Lana Bols, Shelley McIntyre. The Ottawa Hospital, Ottawa, ON, Canada.

Nursing has evolved from a predominantly task oriented focus where care is delivered discontinuously and intermittently to a profession focused on providing holistic specialized nursing care by the same nurse, thereby ensuring continuity (Hryniuk et al, 2007). Primary nursing models are increasingly being used throughout the ambulatory care setting for cancer patients, to ensure a patient / family focus as patients travel across the cancer care illness trajectory. This presentation will focus on our model of clinical nursing practice, based on guiding principles with a core concept of continuity of care for patients and families. The model, when put into practice, provides enhanced satisfaction for the patient and family, the nurse and the interdisciplinary team. This enhanced role promotes autonomy, development of specialized knowledge and increased job satisfaction amongst nurses at a time when retention is of utmost importance. Patients who have received care by a nurse practicing according to this model also report increased levels of satisfaction.

Care provided ensures the patient receives a comprehensive assessment from time of diagnosis across the illness continuum, identifying any gaps and establishing a collaborative care plan that includes the patient and health care team. In addition, this nursing model provides timely access to a health care professional, resolution of issues, as well as enhanced communication and co-ordination of care.

Mentorship: Transforming Ordinary Nurses to Extraordinary Oncology Nurses: A Mentorship / Preceptorship Strategy

Katherine Winters, RN CON(C), Lorna McBride, RN, Mario Da-Ponte, RN BScN. The Ottawa Hospital, Ottawa, ON, Canada.

Oncology nurses provide specialized care for patients and families across the trajectory of illness in a variety of settings. This care is guided by the Canadian Oncology Nursing Standards of Practice. In our complex acute care setting, it is often difficult to recruit and retain nurses to oncology nursing. Multiple strategies have been successfully used to attract and keep nurses in this specialized oncology setting. We have developed mentorship and preceptorship programs focused on students, new graduates and experienced non-oncology nurses to facilitate this process. This presentation will focus on the key factors needed to ensure success in recruitment and retention of oncology nurses on our unit. Positive outcomes result when this mentoring / preceptorship model, based on the oncology nursing standards, is implemented by a core group of competent oncology nurses skilled in sharing clinical expertise, critical thinking, decision-making and knowledge transfer. Mentoring also requires teamwork and collaboration, a critical component of patient / family focused oncology care. This model of supportive learning provides a safe, open and accepting environment in which to foster development of technical, communication and holistic oncology / palliative care skills. We will discuss the challenges, barriers, and enablers inherent in these programs and share mentee outcomes including recruitment and retention rates, level of skill, confidence and professional development.

Quality Improvement: Nursing Practice: Building an Environment of Safety when Using Ambulatory Infusion Pumps

Patricia Murphy-Kane, BSc, BA, MA, Laura L. Rashleigh, BScN, CON(C). PMH, UHN, Toronto, ON, Canada.

Over the decade, a clear shift in health care priorities has occurred, with safety and Patient-Centered Care taking precedence; our large, urban cancer center has embraced this challenge through our Safe Medication Practice (SMP) Committee. This committee is guided by evidence from the Canadian Institute for Safe Medication Practice (ISMP) and review of our medication incidents and near misses. After thorough analysis of multiple documented near misses and errors with Ambulatory Infusion Pumps (AIP), our Committee identified the need for a detailed examination of the medication delivery system. An interdisciplinary Task Force
was formed for the purpose of developing recommendations that will increase safety and reduce the possibility of errors with AIPs. A rigorous, systematic process has begun, that includes an in-depth literature search, an analysis of errors reported via ISMP and our internal hospital system, which is guided by a modified Root Cause Analysis process, human factors and safety theory. This process is challenging us to consider new ways of providing care, for now and the future. Our presentation will highlight key steps in this systemic process, including our committee’s recommendations with consideration given to the challenges of implementation and accountability. As treatments for cancer and palliative care continue to progress, it is imperative that a commitment be made to ensure the safest and most patient centred approach to its delivery; this is one organization’s story of individuals embracing that journey and its challenges as a team.

V-03-B
QUALITY IMPROVEMENT: NURSING PRACTICE: EXTRAORDINARY ONCOLOGY NURSES/EXTRAORDINARY DOCUMENTATION: COMPETENCIES TO GUIDE PRACTICE
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Have you ever read “Tolerated treatment well”? Does your nursing documentation paint a clear picture of your nursing contribution to patient care? Did you know that missing nurses’ signatures is one of the common documentation errors according to the College of Nurses of Ontario (CNO)? Oncology nursing documentation serves as an integral part of safe and effective nursing practice that reflects knowledge, judgment, critical thinking and meaningful patient focused interactions regardless of the oncology practice setting (i.e. inpatient, outpatient or community). The essence of oncology nursing practice should be reflected in the documentation for the purposes of communication, accountability, legislative requirements and quality improvement. The “Oncology Nursing Documentation Competencies” were developed to align with the CANO Practice Standards and Competencies for the Specialized Oncology as well as principles based on standards set by the CNO, Registered Nurses Association of Ontario (RNAO) Best Practice Guidelines and established Cancer Care Ontario Telephone Practice Standards. In order to facilitate the implementation and consistency of the documentation competencies, we developed an audit tool and checklist as well as creative and practical strategies. This framework is designed to provide structured guidance, stimulate discussion and develop enthusiasm to live and breathe the oncology nursing documentation competencies. Oncology nurses provide extraordinary care to their patients and written documentation must reflect the essence and details of that interaction.

V-03-C
QUALITY IMPROVEMENT: NURSING PRACTICE: IS EXTRAORDINARY COMMUNICATION POSSIBLE? IMPLEMENTING CHANGE ON AN INPATIENT SURGICAL ONCOLOGY UNIT.
Shawne Gray, BScN, RN, Anne Li Ting Guan, BScN, RN, Miranda Lamb, BScN, RN, Shari Moura, RN, MN, CON(C), CHPCN(C), Elizabeth Yabbour, BScN, RN. Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

In a large tertiary care hospital’s cancer centre inpatient surgical unit, the Kardex is an important tool for communicating patient care needs and plan of care between surgical oncology nurses, the interprofessional team and acts as a shift handover tool. However, a Kardex is only valuable when the time is taken by nurses to update the changing patient’s care plan within each shift. Surgical oncology nurses within the unit’s Nursing Practice Council identified a need to revise the Kardex’s current format with the endeavor to make the updating process straightforward and time efficient. Following in-depth conversations during Council meetings, this quality improvement project was initiated and co-lead by the unit’s Nursing Practice Council Chair. The aim of this project is to improve patient care by encouraging nurses to maintain and embrace the process and practice of revising the patient care plan in a timely manner. The current Kardex’s layout was reformatted with the objective to utilize preprinted information and easy to check items. This presentation will describe in detail the opportunities and challenges of implementing a change in practice for frontline surgical oncology nurses, the process for how this change was achieved and evaluation results.

V-04
ADVANCED PRACTICE: MAKING THE ORDINARY AND EXTRAORDINARY WORK DONE BY ADVANCED PRACTICE NURSES MORE VISIBLE: WHAT DATA SHOULD BE COLLECTED AND WHO IN YOUR LEADERSHIP TEAM NEEDS TO KNOW
J. Colleen Johnson, RN, MN/ACNP CON(C)1, Cindy Murray, RN, MN/ACNP2. 1Trillium Health Centre, Mississauga, ON, Canada, 2Princess Margaret Hospital, Toronto, ON, Canada.

The ordinary and extraordinary activities performed by advanced practice nurses are often invisible to both the clinical and administrative members of the healthcare team. The expectations of this role are variable and communicating the work of advanced practice nurses remains a constant challenge. In an environment of continuous fiscal restraint advanced practice nurses must seek opportunities and develop strategies for communicating their activities and contributions to the administrative members of the healthcare team. Collecting data related to the clinical and non-clinical expectations of the role is one strategy that can be used. The complexities of data collection coupled with the broad role expectations of advanced practice nurses can make this an intimidating process.

This workshop will start by reviewing the literature regarding workload measurement and data collection for advanced practice nurses. The next step in the workshop will be to assist each advanced practice nurse to select data to collect which is meaningful and pertinent to their area of specialty and role responsibilities. Lastly there will be a discussion of how to present the data in a purposeful way to the administrative members of the healthcare team.
Symptom Management / Supportive Care: Cancer Rehabilitation Improves Sleep

Siobhan M. Carney, BScN, Margaret Eades, N. MSc (A) CON(C), Virginia Lee, N. PhD, Pasqualina Di Dio, PhD, Rajesh Sharma, MD. McGill University Health Centre, Montreal, QC, Canada.

Objective: Insomnia is a common symptom in persons with cancer and impacts on physical and psychological adjustment to treatment and overall quality of life (QOL). This study aims to examine the prevalence of insomnia, explore relationships between insomnia, other symptoms and (QOL) and review insomnia interventions in participants in an interdisciplinary ambulatory Cancer Nutrition Rehabilitation (CNR) Program. Method: A 12-item modified version of the Edmonton Symptom Assessment Scale (ESAS) was used to measure symptom severity at baseline and upon completion of an 8 week CNR program which included a physiotherapist-supervised exercise program and individualized follow-up by the CNR oncologist, psychologist, nurse, nutritionist, occupational therapist and social worker. This prospective study examined ESAS results of patients who reported moderate to severe (> 4 on 10) sleep disturbance at program outset. Chart reviews examining interventions potentially affecting insomnia were performed. Results: 65 patients completed pre and post program ESAS measures. 25 reported sleep disturbances >4 and showed significant improvement in sleep, depression, nervousness, strength, sleepiness and overall quality of life at program completion. There was a significant relationship (r=.30) (p=0.015) between sleep and quality of life in the baseline (n=65) group. Discussion: CNR emphasizes an interdisciplinary approach to patient needs with the nurse playing an integral role in symptom management and continuity of care. Our findings suggest that participation in CNR decreases sleep disturbance. Specific insomnia interventions identified in our chart review will be presented and need to be further tested in this population.

Symptom Management / Supportive Care: Experiences of Family Caregivers of Patients with Advanced Head and Neck Cancer Receiving Enteral Tube-feeding

Jamie L. Penner, RN, BN, BPE. Faculty of Nursing, University of Manitoba, Winnipeg, MB, Canada.

Background: Dysphagia is a common symptom experienced by people with advanced head and neck cancer, often necessitating tube-feedings to help meet nutritional needs. Family caregivers report feeling ill-prepared to manage tube-feeding related aspects of care. The ability of the health care team to support family caregivers is contingent upon a clear understanding of their caregiving experiences, and the information and support needs they identify as being helpful in the provision of care. To date these experiences have not been systematically examined and described. Method: Given the paucity of research in this area, a qualitative study using a descriptive phenomenological approach is currently being conducted with family caregivers of tube-feeding dependent advanced head and neck cancer patients (n=15). Verbatim transcribed face-to-face interviews are being conducted with family caregivers to obtain a rich description of their experiences. Data analysis will proceed using Spiegelberg’s three step process of inductive data analysis. Results: Resultant themes emerging from the data will help to explicate family members’ caregiving experiences. Study findings will provide an empirical foundation from which specific interventions aimed at providing psycho-educational support for family members can be developed and evaluated. Conclusions: The specific and considerable needs of patients with advanced head and neck cancer receiving tube-feeding place significant caregiving demands on family members. A clear understanding of family caregivers’ experiences is urgently required to enhance the ability of the healthcare team to provide meaningful support to these individuals.

Symptom Management / Supportive Care: Managing Sleep-Wake Disturbances in Oncology Patients: Putting Evidence into Daily Practice

Barbara D. Hues, RN MN CON(C), Erin E. Elphee, RN BN CON(C), Anne Katz, RN PhD, Rebecca Pritchard, RN BN. CancerCare Manitoba, Winnipeg, MB, Canada.

While statistics report that sleep-wake disturbances affect more than 50% of patients diagnosed with cancer, the true incidence and prevalence across disease sites remains unknown. Alterations in sleep patterns remain under-reported by patients and families and an under-assessed aspect of nursing care. However, when cancer patients are surveyed, sleep disturbance ranks as highly as pain for causing distress in their daily lives. The goal of this project was to integrate an evidence based approach to nursing care, patient education and interventions at an ambulatory oncology centre. The Best Practices and Nursing Research Committee at CancerCare Manitoba reviewed the literature on sleep-wake disturbances in the oncology population and developed three resources to improve nursing outcomes and assist nurses to better assess and manage this symptom in their patient care areas. The three outcomes included: a nursing resource guide, an assessment/intervention care pathway, and patient/family sleep hygiene handout. Two important aspects of this project were that interventions would fall within the scope of nursing practice and that the tools be practical and easy to use. This presentation will provide a review of literature on sleep-wake disturbances in oncology patients, and the resources developed to assist nurses everyday in their practice. Finally, we will show how nursing collaboration can produce effective nursing outcomes that improve quality of life for our patients.

Evidenced Based Practice: Comprehensive Psychosocial Care: An Innovative Nursing Approach


Psychosocial care is a crucial component of the therapeutic plan for cancer patients and their families. Presently in Quebec,
cancer teams and programs are undergoing a formal process of accreditation to obtain supraregional designation. A set of criteria to reach supraregional status focused on the provision of psychosocial aspects of care for specific cancer populations. Criteria requirements impelled our organization to revisit the vision and delivery of our Psychosocial Services. This presentation describes: 1) the model adopted to provide comprehensive psychosocial care; 2) the goals and expected outcomes of the program; and 3) the leadership from nursing in this initiative. A case study drawn from our clinical experiences will demonstrate how the Clinical Nurse Specialist, as part of a Psychosocial Oncology team, can assess and intervene with cancer patients and their families. While clinical work with patients and families is a major component of the role, the Clinical Nurse Specialist also plays a part in education and consultation as she works with other nurses and health care professionals. Ongoing research is a valuable component in our attempt to create services based on evidence drawn from our population. Finally, a collaborative effort and interdisciplinary team approach are considered crucial to ensure that patients and families referred to the program receive the psychosocial support most appropriate for them.

V-06-B
**EVIDENCED BASED PRACTICE:**
**EFFECTIVENESS OF KNOWLEDGE TRANSLATION INTERVENTIONS TO IMPROVE CANCER PAIN MANAGEMENT: A SYSTEMATIC REVIEW**

Greta G. Cummings¹, Neil Hagen², Robin Fainsinger¹, Carla Stiles², Susan Armijo-Olivo¹, Lesa Chizawsky, RN MN¹, Alison Connors, RN BNN¹, Patricia Blondo, PhD². ¹University of Alberta, Edmonton, AB, Canada, ²Alberta Cancer Board, Calgary, AB, Canada.

Research aim: The study purpose was to examine the research literature to determine the effectiveness of knowledge translation (KT) interventions for changing behavior, beliefs and knowledge in healthcare practitioners, patients and family, with the goal of improving clinical outcomes in cancer pain management. Methods: Extensive electronic database searches and manual and website searches, were performed. Studies that evaluated the effect of KT interventions on patient or health provider behavior change or knowledge uptake were considered. Findings were summarized according to the effect of KT strategies targeted at health providers and cancer patients or family. Results: The database and manual searches yielded 14486 titles and abstracts. Sixteen articles, reporting on thirteen studies, met the inclusion criteria. Four studies involved KT interventions targeting health professionals, and nine studies targeted patients or patients and families. Latter studies reported significant improvement in knowledge, beliefs and adherence with analgesic administration resulting in improved pain outcomes, evidenced by decreases in pain intensity, improved pain relief, improved quality of life or satisfaction with pain relief. Interventions targeting health professionals could be effective, but were less likely to result in such positive changes. Conclusions: KT interventions that target health professionals often fall short of intended effects, and similar interventions aimed at patients are more likely to work. These results inform planning for future KT programs in cancer pain control.

V-06-C
**EVIDENCED BASED PRACTICE:**
**“ORDINARY DAYS, EXTRAORDINARY PEOPLE”: LIVING THE CAREING**

Corsita T. Garraway, MSN - FNP, CON(C), CHPCN(C). Princess Margaret Hospital, Toronto, ON, Canada.

Caring, according to Florence Nightingale, is the most important work in nursing. Patients who are palliative and have a cancer diagnosis, suffer from psychological distress because they face a life-limiting disease. Nurses demonstrate caring when they actively listen, respect, are genuine, empathetic, trusting and respond to patient concerns. (RNAO, BPG Establishing Therapeutic Relationships). Patients often experience a psychological transformation after interaction with the nurses in the palliative radiation oncology clinic. Understanding the aspects of caring that induce patient transformation is of utmost importance. Numerous nurse researchers have examined the phenomenon of caring. Findings from an extensive review of the literature will be presented demonstrating why, on “ordinary days, we are extraordinary people”.

V-07-A
**PATIENT SAFETY AND QUALITY CARE:**
**ALGORITHMS FOR PREVENTION, TREATMENT AND FOLLOW-UP AFTER ANTIMETABOLITE AGENTS EXTRAVASATION IN CHILDREN AND ADOLESCENTS: A SIMPLE STRATEGY FOR A SAFER NURSING CARE**

Daniella Chanes, BSN, Maria Gaby Gutiérrez, BSN, MSN, PhD, Mavilde L. G. Pedroira, BSN, PhD. Federal University of Sao Paulo, Sao Paulo, Brazil.

The antineoplastic agents extravasation is one of the most severe acute reactions related to intravenous administration of this sort of treatment, resulting in significant tissue damage, pain and impact on the patient’s quality of life. However, this adverse event may be prevented, have earlier diagnosis, nursing intervention and follow-up better managed with established institutional protocols based on evidence associated to the nurses clinical and technical skills. Protocols are important to establish a standardized nursing care and are important measure to improve nursing care and assure patients’ safety. Understanding this fact, a literature review was performed and based on the results, two algorithms were developed concerning prevention, treatment and follow-up after antineoplastic agents extravasation in children and adolescents. Algorithms provide a picture of the entire process, providing a standardized “map” of care with a step-by-step guidance when making decisions. Moreover, to assure their validity, reliability and specificity, both algorithms were submitted to a content validation process with specialists in pediatric oncology nursing in Brazil and in United States. After the specialists’ assessment and a final review on the instruments based on their suggestions and another literature review, we are able to offer for other oncology nurses two algorithms that will help to provide a higher quality and safer nursing care for children and adolescents undergoing chemotherapy.
V-07-B
PATIENT SAFETY AND QUALITY CARE: DECREASING WAITING TIMES: A CHEMOTHERAPY UNIT MAKES AN EXTRAORDINARY CHANGE

Sherrol Palmer Wickham, RN BScN CON(c), Kathy Beattie, RN CON(c). Odette Cancer Centre, Toronto, ON, Canada.

Like most other cancer centres in the province, this Centre received feedback from patient surveys about time waiting for chemotherapy treatment. Patients said, “We like you, but we do not like the wait times.” Over the last 4 years, projects to respond to this feedback failed to significantly improve survey results. Increasing patient numbers and acuity, changing treatment regimens are compounding the problem. A review was conducted to implement high impact fresh solutions designed to improve chemo process efficiency and reduce in-Centre wait times for patients. Ultimately, this effort should enable the team to handle more patients and improve the patient satisfaction with their chemotherapy experience. A multifunctional steering committee was established to assess information, make timely decisions and drive implementation of the change. A unique applied creativity methodology - Simplex and experienced external facilitators supported the execution of the project. The Simplex facilitation, enabled participants to engage in highly interactive, efficient discussions and decision making throughout the project. The steering committee chartered solution sub teams to tackle each of the process improvement challenges. Process flow and identification of constraints was critical for sub teams to develop high impact and targeted solutions. This podium presentation will describe the bottlenecks and the success flow and identification of constraints was critical for tackling each of the process improvement challenges. The steering committee chartered solution sub teams to develop high impact and targeted solutions.

V-07-C
PATIENT SAFETY AND QUALITY CARE: IMPROVING THE DIAGNOSTIC PROCESS FOR PATIENTS WITH SUSPICIOUS BREAST ABNORMALITIES

Bridgette Lord, Naomi Miller, Karina Bukhanov, David McCready. Princess Margaret Hospital, Toronto, ON, Canada.

In 2007, an estimated 22,300 Canadian women were diagnosed with breast cancer (Canadian Cancer Society, 2007). Considerable variation exists for patients from the time a breast abnormality is detected to the time of diagnosis. Many patients wait several weeks to receive a diagnosis. This delay in diagnosis leads to prolonged patient anxiety and a delay in treatment (Olivotto, 2001). At a large Canadian cancer centre, both patients and health care providers recognized the need to improve the diagnostic process for patients with breast abnormalities. An Advanced Practice Nurse-led, same-day, rapid diagnostic breast clinic was created. The goals of this clinic were two-fold: to expedite the diagnostic process for patients with suspicious breast abnormalities, and to provide a caring and supportive environment for patients throughout the diagnostic process.

To date, the data shows that the current time to diagnosis has been decreased from several weeks to several hours, with 96% of patients receiving a same-day diagnosis. Patient satisfaction with the same-day, rapid diagnostic clinic has also been evaluated. Up-to-date results and statistics will be provided at the time of the presentation. Oncology nurses can play an important and unique role in developing and leading new clinics to ameliorate the diagnostic process for patients and improve overall patient care. Other departments and/or hospitals may adopt this clinic model to provide superior patient care and a more timely diagnosis for patients.

VI-01-A
PALLIATIVE CARE: EMPOWERING NURSES TO PRACTICE AT FULL SCOPE: THE PALLIATIVE CARE NURSE CONSULTANT MODEL

Wendy Petrie, RN, MScN, CON(C), CHPCN(C), Lynn Kachuik, RN, BA, MS, CON(C), CHPCN(C). The Ottawa Hospital, Ottawa, ON, Canada.

Dr. Balfour Mount was the first person to coin the term “palliative care” in describing the philosophy of care for those with a life-threatening illness. Palliative care focuses on quality of life and impeccable pain and symptom management. The past several decades have seen an increase in the provision of palliative care across all settings. In acute care institutions this is often done via Palliative Care consult teams, most of which are physician driven with minimal nursing involvement. On our Palliative Care consult team, palliative care nurses function as clinical experts, role models, educators and mentors for their peers. Nurses functioning at full scope of practice and working in close collaboration with the physician, have the capacity to independently assess palliative patients and families and make appropriate recommendations for their care. This enhanced role is based on the CNA Hospice Palliative Care competencies and is supported by our hospital’s model of clinical nursing practice. This presentation will describe the evolving model of palliative care nursing embraced by our interdisciplinary palliative care consult team. We will discuss the benefits of empowering nurses using this unique model. In addition, we will outline the challenges presented in implementation of the model as well as the positive outcomes realized for patients, families and the referring clinical teams.

VI-01-B
PALLIATIVE CARE: EXTRAORDINARY PEOPLE: ONCOLOGY NURSES REMOVING BARRIERS TO IMPROVE TRANSITION FROM CANCER CARE TO PALLIATIVE CARE

Deborah L. Gravelle, RN BScN MHSc, Frances Legault, RN BScN MN PhD, Lynn Kachuik, RN BA MSc, CON (c) CHPCN, Lilian Locke, RN BScN, MPA, 1. 1SCO Health Service, Ottawa, ON, Canada, 2University of Ottawa, Ottawa, ON, Canada, 3The Ottawa Hospital, Ottawa, ON, Canada.

Utilizing the Canadian national framework and standards and the Pan Canadian Gold standards for Palliative Home Care,
oncology nurses in an outpatient cancer care program, a teaching hospital, and a community-based palliative consultation service worked in partnership to conduct an intervention study to improve transitions in palliative care services. Working on removing barriers by reaching across programs, institutions and service boundaries will improve continuity and communication. Oncology nurses working together for the benefit of patients is nothing new and this partnership emphasizes the incredible dedication that nurses practice every day. This project will support a primary care model, assist in clinical decision making regarding the appropriate provider and setting of care to provide high quality palliative care. Transitions in palliative care services occur when there is a change or an addition in the service that is required by a patient and their family. A local research study has demonstrated that the management of transitions in palliative care across settings of care is challenged by the fragmentation of physician services and the lack of coordinated home care nursing services. Study findings and policy and practice recommendations will be presented demonstrating the benefits of a community-based partnership approach for managing transitions in palliative care services.

VI-01-C
Palliative Care: Facing Your Own Death: the Transition Experiences of Adult Patients in a Tertiary Care Hospital, Palliative Care Unit
Nancy Lee Brown, MSc(A) 1, 2. 1McGill University Health Centre, Montreal, QC, Canada; 2Inova Health System, Falls Church, VA, USA.

In the western industrialized social context, dying and death have been transformed from familiar, expected, and natural processes occurring predominantly at home with family present, to unfamiliar and frightening medical problems to be treated in hospital palliative care units (PCUs). This context of medicalized death is complicated by the lure of technological ‘miracles’, and negative perceptions of the meaning of palliative care. It is thus not surprising that the experience of transitioning from acute or chronic care to palliative care may be difficult for many patients and their families. Unfortunately, this transition-experience has been somewhat neglected in the literature. The purpose of this study was to explore how patients experienced their transition from active treatment to terminal care in a PCU. Using an interpretive descriptive design and convenience sampling, three terminally ill patients in a hospital setting were recruited. The data collection methodology was unique. There were no formal interviews; all data were derived from field notes, written directly after brief conversations at the participants’ bedside during routine nursing care activities, over many days. The data were analyzed using Meleis’ transition framework. The findings demonstrated that participants’ main concerns centered on ‘facing your own death’. Three main themes evolved from the data: battling demons, changing relationships and coping. Nurses were identified as being in a unique position to assist patients in this transition process, particularly in relation to those themes.

VI-02-A
Palliative Care / Supportive Care: End-of-Life Care in the Acute Care Setting
Katrina Longfield, Patricia Murphy-Kane. Princess Margaret Hospital, Toronto, ON, Canada.

As we move into the 21st century advances in medicine and technology have given great hope to patients that their life will be extended and the possibility of a cure is always within reach. However, there may come a time when the cancer journey focus changes from cure to palliation and end-of-life care. In the acute care setting, this shift can bring feelings of uncertainty, anger, confusion, sadness, fear and anxiety for the patient and family. These feelings may be echoed by members of the health care team and result in a hesitancy in continuing active treatment. This hesitancy may intensify the patient’s suffering as the focus remains on the medical interventions that are being done to the patient rather than supportive interventions that can be done with the patient and family. Research indicates that the nurse at the bedside is the primary resource for patients and families as they seek information, guidance, and support at the end of life. For many nurses working in the acute care setting it is extremely challenging to shift their focus from curative interventions to end-of-life care. Potential barriers to providing exceptional end-of-life care include; the setting, overuse of interventional technology, lack of knowledge and education in end-of-life symptom management and psychosocial support. This presentation will explore these potential barriers and provide information and specific interventions that may be used to support the patient, family and health care team during the final days and hours of living.

VI-02-B
Palliative Care / Supportive Care: Improving Access, Integration and Patient-Centered Care for Gynaecologic Oncology Patients Via Sustainable Process Re-Design Strategies at UHN
Sherida P. Chambers, MSN. University Health Network-Toronto General Hospital, Toronto, ON, Canada.

Objective: To develop, implement, and evaluate enhanced palliative care services in order to improve access, integration and patient-centered palliative care for patients on a gynaecologic oncology inpatient unit. Study Methods: Rigorous “Lean” process improvement methodologies were employed by an interdisciplinary team as the primary driver of change. To discover areas of potential improvement, the team mapped the inpatient process and identified opportunities to enhance care based on palliative needs. Rapid Cycle Change Events enabled the team to quickly diagnose issues within the current process, define metrics and agree upon targets, design strategies to achieve the vision for the future, and test solutions. Results: Solutions were developed via: 1) standardizing work; 2) tightening hand-off points between care providers; 3) enhancing transparency; and 4) pulling processes between departments. Examples of the process enhancements include: • An admission form to facilitate early identification of palliative
patients
• A whiteboard to facilitate timely discharge of palliative patients
• Transfer notes to ensure completeness of information from external partners
• Distress screening tools to assist in identification of palliative needs

Conclusions: The improvement initiatives led to significant enhancements in patient-centered care for gynaecologic oncology inpatients, including: 50% reduction in time to discharge home or to a palliative care unit, 95% increase in proportion of patients with documented goals of care upon admission, and 95% increase in proportion of patients with identified psychosocial needs upon admission.

VI-02-C  
Palliative Care / Supportive Care: Cancer Patient Navigation

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Development of a coordinated system that assures access and continuity has been identified as a significant challenge in cancer control. Continuity is especially salient in the cancer system, as care is often intense, distributed among a range of providers, and lengthy from diagnosis to treatment including survivorship or palliation. Continuity and support are integral aspects of care identified by patients and families. Cancer Patient Navigation is a term used to describe a system or professional role intended to expedite access to services and resources particularly supportive care needs, and to improve continuity and co-ordination of care throughout the cancer journey. CPNs provide information and support to the patient, link with other professionals in the treatment process, and act as a single contact in addition to accelerating access to services. CPNs in rural communities’ link people to formal and informal community resources facilitate and assist in decision-making, enable patients to develop effective coping strategies using psychosocial supports, home care, and other information. In short, this new role not only assists patients through the healthcare maze in a more timely fashion, but plays a vital role in improving patients’ psychosocial well-being, quality of life, and enabling patients to be active partners in their own care. The aim of this presentation is to provide the highlights of a CPN demonstration project involving three rural communities, the successes, and lessons learned.

VI-03-A  
Paediatrics and Quality Care: Linking it All Together: Practice and Patient Outcomes

Christine Gervais, BScN, Colleen Graham, BScN, Pat Bieron- ski, BScN, Jane Burns, BScN, Donna M. Holmes, BHSScN. Grand River Regional Cancer Centre, Kitchener, ON, Canada.

Patients require and seek care that is coordinated and flows in a seamless fashion along the trajectory of their cancer illness. Accurate recording of observed events, plan of care, teaching, and interventions are part of our professional practice and responsibility. In order for documentation to reflect these cornerstones of care it needs to be succinct and reliable. We felt that nursing practice standards for our LHIN needed to be embedded in our electronic and paper documentation. This would be accomplished by linking CANO standards, RNAO best practice guidelines, telephone triage guidelines and our provincial Oncology nursing documentation competencies into this project. Benner’s novice to expert principles guided the evolution of this work in collaboration with our nursing colleagues in the LHIN. Once these standards are finalized, knowledge transfer and exchange will occur systematically utilizing different venues throughout the region; CANO meetings; Community of Practice groups and workshops. An evaluation process will put in place using the audit tool designed by the documentation working group. Embedding practice standards into the documentation ensures that plan of care is documented and patient outcomes are realized.

VI-03-B  
Paediatrics and Quality Care: The Use of the ESAS Tool to Empower RN’s in the Oncology Ambulatory Care Setting

Cathy Comerford, BScN, CON(C), Anne Roberts, BScN, CON(C). The Ottawa Hospital, Ottawa, ON, Canada.

In the fast paced setting of the outpatient cancer clinic there are many challenges facing the nurses. In a limited amount of time, the nurse must effectively assess the oncology patient, provide patient and family support/education, and communicate their findings and recommendations to the treating oncologist. The use of the Edmonton Symptom Assessment System (ESAS) provides a succinct, comprehensive overview of the patient’s current symptoms. With the patient’s reporting of their symptoms on a numerical scale, the RN is then able to quickly identify problem areas requiring intervention. This, in turn, empowers the nurse to support and educate the patient/family and also work as a contributing member of the health care team. This presentation/poster will focus on the use of the ESAS tool in the Ottawa Hospital Cancer Centre outpatient clinics. Incorporating the ESAS tool into the ambulatory care setting empowers the nurses and enables them to be more influential in the ongoing care of the oncology patient.

VI-04-A  

Pamela Savage, RN, MAEd., CON(C), Kathy Trip, RN, MN, APN¹, Rachel White¹, Diana Incekol, RN, BScN, CON(C), ¹University Health Network, Princess Margaret Hospital, Toronto, ON, Canada; ²University Health Network, Centre for Global eHealth Innovation, Toronto, ON, Canada; ³Institute for Safe Medication Practices, Toronto, ON, Canada.
ADMINISTRATIONS - ORAL PRESENTATIONS

administered nurses is thought to decrease the risk of error. However reported lethal administrations of chemotherapy continue to occur despite a double check being performed. Some of the difficulties in implementing a double check include variation among clinicians regarding the knowledge of content required to facilitate an independent double check process and the document design to facilitate an accurate check. Based on research, performed by nurses, human factors specialists and medication safety experts, this team of researchers will present a number of fundamental principles that are believed to be useful in the design and implementation of an independent double checking method and document for high risk chemotherapy medications delivered via ambulatory infusion pump.

VI-04-B

PATIENT SAFETY: WHILE I AM AWAY: HAND OVER COMMUNICATION FOR PLANNED AND UNPLANNED NURSING ABSENCE IN AN AMBULATORY CANCER CENTRE

Mary Jamieson, RN, BScN, CON(c), Tracey Das Gupta, RN, MN, CON(c). Sunnybrook Odette Cancer Centre, Toronto, ON, Canada.

Hand over communication based on best practice is integral to patient care and safety. Explicit within the hand off is the transfer of responsibility and accountability. In a regional cancer centre, where care is provided within a primary nursing model, nurses have been challenged to find new ways to improve the handover and communication of their practices for planned and unplanned absences. In the absence of the primary nurse, float nurses provide coverage for the clinic setting and telephone practice. Covering nurses must be informed of the unique information required for the practice as well as patient specific concerns to ensure continuity of care for patients and families. This presentation will describe the planning, implementation, and evaluation of a standardized approach to ensure that covering nurses are provided with the necessary information to fulfill the role expectations and provide continuous quality care. The approach included the development of structured communication tools within a “While I Am Away Package”, revision of policy, and staff education. A summary of the evaluation from the perspective of the Primary Nurse, Covering Nurse, and patient will be provided.

VI-05-A

PERCEPTIONS IN CANCER NURSING: ONCOLOGY PATIENTS’ AND NURSES’ PERCEPTIONS OF CARING

Patricia A. Poirier, PhD, RN, Ann Sossong, PhD., RN. University of Maine, Orono, ME, USA.

Research Objective: Caring is a concept adopted in the early 1800s by Florence Nightingale. Since that time, it is generally acknowledged that the concept of caring is central to the practice of nursing. There are differing findings in the literature as to how patients and nurses actually perceive caring. The purpose of this study was to determine if there are differences in patient and nurses perceptions of caring. Method: The Caring Behaviors Inventory (CBI) was administered to 207 patients and 216 nurses on inpatient units. The CBI measures caring words and phrases on a 3-point scale: 1 = rarely; 2 = sometimes; and 3 = often. Mann-Whitney U test was used to compare responses. Results: Mean for all patients = 2.77; nurses = 2.86; Z = -1.907, p = .056 (max=3); mean for oncology patients = 2.70; nurses = 2.90; Z = -2.222, p = .026. There was a statistically significant difference between patients and nurses on several behaviors including knowing how to give treatments, responding quickly to call, checking on a patient, and managing pain. Conclusions: Both nurses and patients rated nurses fairly high on caring behaviors. The oncology unit had a statistically significant difference in patient and nurse perceptions. Nurses cited time and staffing constraints as impediments to their providing care. To truly meet the concept of patient-centered care it is necessary to adapt to the patient’s perception of caring.

VI-05-B

PERCEPTIONS IN CANCER NURSING: PSYCHOSOCIAL ISSUES IN SCREENING FOR HEREDITARY CANCERS: IMPLICATIONS FOR CANCER NURSE

Margaret I. Fitch, RN PhD. Odette Cancer Centre, Toronto, ON, Canada.

Genetic mutations for both hereditary breast/ovarian cancer and hereditary colorectal cancer have been identified within the past fifteen years and psychosocial research has begun to emerge related to this area. The psychosocial literature related to genetic testing for these cancers has focused primarily on the motivations and psychological impact for the individual during the trajectory of genetic testing (i.e. before, during, after receiving the test result). More recently work is beginning to emerge regarding the impact on the family. The genetic test reveals not only information about the individual, but also about the potential risks for relatives, as these particular mutations are inherited in an autosomal dominant fashion. There is a range of psychosocial issues inherent in screening for hereditary cancer. For example, access to relevant information, perception of risk, elevated anxiety and emotional distress, and disclosure of genetic test results have been identified as concerns. Cancer nurses need to be aware of the psychosocial issues and have the capacity to implement the appropriate interventions. This presentation will highlight the current knowledge available for practice regarding the psychosocial care of individuals undergoing screening for hereditary cancer and their family members.

VI-06-A

INFORMATION NEEDS AND PERCEPTIONS OF PATIENTS : IT’S NOT GOING TO RUIN OUR RELATIONSHIPS - OR WILL IT?: SMOKING, LUNG CANCER AND FAMILY DYNAMICS

The influence of the smoking behaviour of family members on LC patients has received little attention. The purpose of this qualitative study was to explore family interactions in relation to smoking after a LC diagnosis. LC patients and an immediate family member who smoked consented to participate in individual or conjoint semi-structured interviews. Thematic analysis of transcribed interviews revealed that following their diagnosis LC patients experienced considerable distress as they struggled to understand how family members could continue to smoke. Two themes described the ways that LC patients responded to family members who smoked: 1) preserving relationships was a dynamic where maintaining harmony and connection with family members took priority over stopping smoking among family members, and 2) demanding cessation was a dynamic where patients repeatedly confronted family members about continued smoking in an effort to influence their cessation. Neither pattern was particularly successful in terms of influencing smoking reduction or cessation among family members, and the latter dynamic resulted in conflicted relationships. This study brings attention to the distress that LC patients experience when family members smoke. In addition, it highlights the importance of encouraging tobacco reduction among family members as a supportive intervention for LC patients.

VI-06-B

INFORMATION NEEDS AND PERCEPTIONS OF PATIENTS : LES BESOINS INFORMATIONNELLS D’HOMMES ATTEINTS DE CANCER DE LA PROSTATE LOCALISÉ, CEUX DE LEURS PARTENAIRES DE VIE ET CEUX IDENTIFIÉS COMME ESSENTIELS PAR LES PROFESSIONNELLS DE LA SANTÉ

Nicole Tremblay, MSN, CHUM, ANIOU, QC, Canada.

Le cancer de la prostate constitue un problème de santé important pour les hommes et leurs familles comme en témoigne les statistiques. Un homme sur 8 fera face à cette expérience. Avec le dépistage plus systématique du cancer de la prostate, la proportion des cancers localisés s’accroît. Approximativement, deux cancers de la prostate sur trois sont localisés. En revanche, ces hommes ainsi que leurs partenaires sont confrontés à une décision difficile face au traitement, car peu d’études indiquent des différences significatives sur le plan de la survie entre les différentes modalités de traitement à ce stade : soit l’observation vigilante, la chirurgie ou la radiothérapie. Dans ce contexte, l’information est plus qu’essentielle. Or malgré la prise de conscience de ce besoin pour l’adaptation de la personne atteinte de cancer et l’évolution des pratiques de soins, il demeure fréquemment inadéquatement comblé. Diverses études mettent en évidence la lourde responsabilité des familles de choisir un traitement et d’en vivre les conséquences, et ce, sans se sentir adéquatement préparés à le faire. Une étude sera entreprise en 2008, dans un grand centre hospitalier universitaire, afin de mieux connaître les besoins informationnels jugés essentiels de la part d’hommes atteints de cancer de la prostate localisé (early-stage) et de ceux de leurs partenaires de vie et de mesurer dans quelle mesure les professionnels de la santé y répondent. La présentation portera sur la problématique et la méthodologie envisagée.

VI-06-C

INFORMATION NEEDS AND PERCEPTIONS OF PATIENTS : MAKING TREATMENT DECISIONS ABOUT ADJUVANT ENDOCRINE THERAPY FOR BREAST CANCER

Melissa TeBrake, RN, Yolanda Madarnas, MD, Deborah Feldman-Stewart, PhD, Marianne Lamb, RN, PhD, Joan Tranmer, RN, PhD. Queen’s University, Kingston, ON, Canada.

The decision about adjuvant endocrine therapy for early-stage breast cancer is particularly complex for patients when there are multiple treatment options with similar efficacy. Patient decision aids are tools designed to help patients participate in these complex decisions, and to help decrease possible decisional conflict. The initial step in the development of decision aids is to identify the information that is essential to the decision making process. The purpose of this study is to identify the informational needs of women making decisions about adjuvant endocrine therapy for early-stage breast cancer and the information priorities of the healthcare professionals involved in treating them. This descriptive exploratory study is being conducted at a regional cancer centre from January-April 2008. We are conducting one-on-one, semi-structured face-to-face or telephone interviews with breast cancer patients and with healthcare professionals to identify the questions that they recommend be addressed before treatment decisions are made. We will report on the background rationale, relevant research method, and results that will contribute to decision aid development for this group. Findings from this study will inform the development of a decision aid for adjuvant endocrine therapy potentially relevant to meeting the patient and healthcare professional’s informational needs and questions. A better understanding of the informational needs of women facing decisions about adjuvant endocrine therapy for breast cancer may enable healthcare professionals to enhance information delivery and alleviate some of the decisional conflict experienced by patients.

VI-07-A

CLINICAL APPROACHES TO QUALITY CARE AND SURVIVORSHIP : A NEW APPROACH TO MEETING THE NEEDS OF COLORECTAL CANCER PATIENTS

Karin Y. Runnalls, BSN, Marlene M. Mackey, BNSc, Michele A. Holwell, MSW. The Ottawa Hospital, Ottawa, ON, Canada.

Colorectal cancer is the second leading cause of cancer deaths and is curable ninety percent of the time if detected in the early stages. Nationally, approximately 20,000 people were diagnosed with colorectal cancer and nearly half died from the disease last year. The author’s province has one of the highest rates of colorectal cancer in the world. In the fall of 2006, funding was provided by the provincial government to plan, implement and evaluate an innovative regional cancer surgery model for colorectal cancers. It was launched to improve access, decrease wait times and to standardize cancer surgery across the region by maximizing regional capacity. The focus of this presentation is on the development and implementation of the surgical oncology colorectal program in a Cancer Assessment Clinic. Processes established and successes/ barriers to date will be discussed, including the establishment of an inter-professional team, medical directives, collaborative practice within and out of our facility and the commitment regionally with the model.
Using case illustrations this inter-professional presentation will show the benefit of a collaborative approach to patient care which includes information, education, nursing intervention, psychosocial support and counseling, and surgical consultation and follow-up. The emphasis of the program is on continuity of care throughout the patient’s cancer journey.

**VI-07-B**

**Clinical Approaches to Quality Care and Survivorship: Multidisciplinary Evidence Informed Practice Change for Assessing and Managing Dyspnea in Patients with Lung Cancer: a CANO/Eli Lilly Mentorship Award Summary**

Lorraine Martelli-Reid, RN, MN1, Denise Bryant-Lukosius, RN, MN, PhD1,2, 1Juravinski Cancer Centre, Hamilton, ON, Canada, 2McMaster University, Hamilton, ON, Canada.

Through the CANO/Eli Lilly Mentorship award new knowledge and research skills were applied to educate nurses about evidence-informed practice and an identified priority project within the Lung Disease Site Team was initiated. The overall purpose of the health service research project selected was to determine the need to augment current services provided to patients with dyspnea associated with their lung cancer. The systematic ‘model for change to evidence-based practice’ developed by Ross-wurm and Larabee (1999), was selected to guide the process of developing and integrating an evidence-informed practice change. The first 3 steps in the process have been completed. The presentation will highlight the work completed during the mentorship award including the completion of a chart audit to assess the problem, a literature review with the best practice report related to the assessment and management of dyspnea and a recommended program for implementation.

**VI-07-C**

**Clinical Approaches to Quality Care and Survivorship: Factors Influencing Men Undertaking Active Surveillance for the Management of Low Risk Prostate Cancer**

B. J. Davison, PhD, RN1, John Oliffe, PhD, RN1, Tom Pickles, MD1, Larry Mroz, PhD (c)1, 1UBC, Vancouver, BC, Canada, 2BC Cancer Agency, Vancouver, BC, Canada

OBJECTIVE: To identify and describe decision-making influences on men who decide to manage their low-risk prostate cancer with active surveillance (AS).

PATIENTS AND METHODS: Twenty-five patients diagnosed with low-risk prostate cancer and on AS participated in semi-structured interviews. An interpretative descriptive qualitative methodology was used to inductively derive and describe factors having an influence on men’s decision to take up AS.

RESULTS: The specialists’ description of the prostate cancer was the most influential factor on men choosing AS. Patients did not consider their prostate cancer to be life-threatening, and were relieved no treatment was required. Avoidance of treatment related suffering and physical dysfunction, and side-effects were cited as major reasons to avoid treatment. Few men actively sought treatment or health promotion interventions when and if they needed treatment. Being elderly and having co-morbidities did not preclude the desire for future active treatment. Patients carried on with their lives as usual and did not report having any major distress related to being on AS.

CONCLUSION: The study findings indicate that men are strongly influenced by the treating specialist in taking up AS. Men relied on their specialist’s recommendation and did not perceive the need for any adjunct therapy or support until the cancer required active treatment.

**Palliative Care: Extraordinary People: Oncology Nurses Working Together to Provide Advanced Palliative Care Education**

Deborah L. Gravelle, RN BScN MHS1, Leipe, Elaine, RN, BSN, CHPCN(c)2, Maryse Bouvette, RN BScN MEd, CHPCN, Lynn Kachuik, RN BA Msc, CON (c) CHPCN3, 1SCO Health Service, Ottawa, ON, Canada, 2Hospice May Court, Ottawa, ON, Canada, 3The Ottawa Hospital, Ottawa, ON, Canada.

Generally, when we talk about capacity building in the field of palliative care, we’re talking about enhancing the ability of an individual, organization or a community to address the palliative care needs in their own practice. The process of capacity building relies heavily on collaboration and partnerships. Providing access to advanced palliative education for oncology nurses continues to enhance the ability of those nurses to provide quality palliative care to their patients and families. A partnership was developed between a community hospice, a regional palliative care program, and a teaching hospital to develop and conduct an advanced palliative care course for nurses providing palliative care within different health care sectors and care settings. As palliative care experts within our community it is our responsibility to ensure that nurses working with palliative care patients have the knowledge and skills to provide high quality care. Registered nurses’ contribution to hospice palliative care is vital since they have the knowledge, education and skill and are positioned throughout the health care system, to provide hospice palliative care nursing to patients and their families when they require it.

This presentation will discuss the collaborative partnership developed between a residential hospice, an acute care consultation service, a community based consultation service and an inpatient palliative care unit to develop and implement an advanced palliative care education program for nurses. In addition, the presentation will highlight the purpose, objectives, criteria for selection and evaluation of this collaborative education project.

**Supporting Patients and Families: Treatment to Survivorship: The Patient Passport Initiative: a Tool for People with Cancer to Call their Own**

In 2007 a provincial working group of oncology nurses took the initiative to develop a standardized patient passport targeted for people with cancer. The passport has two goals: 1) to improve partnership between patient and health care provider, and 2) to encourage patients to be self-directed in their own care. While serving as a means for patients to keep track of treatment schedules, resource persons, and to quickly recognize symptoms that require immediate attention, it also serves as a tool to manage symptoms related to cancer and its treatment. The objective of this presentation is to describe the passport as a standardized tool that people with cancer can use independently. It includes a brief review of existing tools used across centres, a description of evaluations done jointly across various health centres, consultations with health care professionals, and the use of evidence based guidelines to develop the symptom management content of the passport. Implications for practice include improvement of communication and webserving with patients with cancer and those with complex needs along their cancer trajectory as well as support to standardize patient tools when collaborative efforts take place. A brief description of outcomes to date will also be discussed.

**VII-01-C**
**Supporting Patients and Families: Treatment to Surviv...**

Maureen A. McQuestion, RN, BScN, MSc, CON(C)², Doris Howell, RN, PhD ¹, ², Lucy Ruggiero, RDW, MSW ¹. ¹Princess Margaret Hospital, Toronto, ON, Canada, ²RBC Financial Group Chair in Oncology Nursing Research, University Health Network, University of Toronto, Toronto, ON, Canada.

Supportive care has been defined as “the provision of the necessary services as defined by those living with or affected by cancer to meet their physical, social, emotional information, psychological, spiritual and practical needs across the cancer experience” (Fitch, 1997). It is clinically well understood that patients with head and neck (H&N) cancer experience extraordinary changes through the phases of diagnosis, treatment, rehabilitation and survivorship. This includes both physical and psychosocial adjustments resulting from the effects of the disease and side effects of treatment, but little research has been conducted with this group of patients, particularly following treatment. A study was undertaken with patients with H&N cancer in the period from 3 to 6 months following treatment in order to better understand the early survivorship period and the losses and challenges patients experience as they attempt to regain health and wellness following treatment. 67 patients from one comprehensive cancer centre participated in a survey assessing their supportive care needs, the extent of unmet needs, the level of social supports available, and the degree of access to formalized and social support services. Data collection included demographic data, the Supportive Care Needs Survey Short Form (SCNS-SF 34), an investigator developed tool to assess H&N specific needs, the Medical Outcomes study (MOS) Social Support Survey, and an Access to Services Survey. Evaluations included the relationship between unmet needs, demographic characteristics and social supports.

This presentation will review the supportive care literature highlight the findings from the study, and make recommendations to better support patients in the community and at the treatment centre.

**VII-02-A**

Lynda G. Balneaves, RN, PhD ¹, Tracy L. O. Truant, RN, MSN ², Marja J. Verhoef, PhD ³, Alison S. A. Brazier, PhD ⁴. ¹UBC School of Nursing, Vancouver, BC, Canada, ²BC Cancer Agency, Vancouver, BC, Canada, ³Dept. of Community Health Sciences, University of Calgary, Calgary, AB, Canada.

Complementary medicine (CAM) use has become part of the care experience for Canadians living with cancer. Research suggests the majority of cancer patients use at least one form of CAM during their illness. It is thus timely that education programs specific to CAM be developed to serve the diverse information and decision support needs of both patients and health professionals. The purpose of this presentation is to describe the recent development of the nurse-led Complementary Medicine Education and Outcomes (CAMEO) Program at the BC Cancer Agency in Vancouver, BC. The objectives of CAMEO as well as the planned health services related to CAM information and decision support will be discussed. CAMEO is a 4-year program that aims to: 1) support people with cancer in making CAM decisions, 2) strengthen health professional’s knowledge and skills related to CAM, and 3) facilitate the development of CAM research knowledge. To achieve these goals, a variety of education and decision support services are under development, including education programs for patients and health professionals, one-on-one counselling for patients with complex needs related to CAM, and clinical tools and guidelines to assist the interprofessional health care team in supporting safe and informed decisions about CAM.

**VII-02-B**
**Information to Support Patient Decision Making: Human Papillomavirus Vaccine, Separating the Myths from the Facts**

Cathriona J. Buick, RN, BscN, CON(c), MN(C) ¹, ², ³. ¹Princess Margaret Hospital, Toronto, ON, Canada, ²University of Toronto, Toronto, ON, Canada.

"Stop: We have no epidemic, no crisis, no major problem on our hands," said epidemiologist Abby Lippman of McGill University (Ubelacker, 2007). However, every year approximately 510,000 women worldwide are diagnosed with cervical cancer (American Cancer Society, 2006). Of these women, 288,000 will die from this disease (American Can-
cer Society, 2006) and approximately 400 of these deaths will be Canadians (Canadian Cancer Society, 2007). With the recent release of the HPV vaccine, it is critical for oncology nurses to understand the research behind the vaccine to separate the myths from the facts and to determine exactly what it means for women in Canada and around the world. The recent release in Canada of the quadrivalent for high-risk HPV strains 18 and 16, as well as low-risk HPV strains 6 and 11 (Newall, Beutals, Wood, Edmunds, & MacIntyre, 2007), has caused controversy surrounding the age of vaccination and the promotion of sexual promiscuity. However, the effectiveness of the HPV vaccine has been well established in trials involving over 21,000 women (American Cancer Society, 2006). This quadrivalent has shown to be 100% effective in the prevention of CIN and cervical cancer from HPV 16, 18, 6 & 11 (Koutsky & Harper, 2006).

This presentation will examine the evidence surrounding the HPV vaccine. It will highlight Canada's provincial agendas for vaccination as well as international programs for the HPV vaccine and its proposed impact on women's health. American Cancer Society (2006). HPV Vaccine Fights Cervical Cancer. CA: A Journal For Clinicians, 56, p249-250.


VII-02-C
Does Your Heart Sing?: A Potentially Shocking Ethical Dilemma: End-of-Life Care of a Patient with an Implanted Cardiac Defibrillator (ICD)

Susan J. Collins, RN, MScN, ACNP, CON(C), Robin L. Moffatt, RN, BScN. London Health Sciences Centre, London, ON, Canada.

When caring for patients with cancer one often has to shift, sometimes rapidly, from a curative goal to one of palliation, the aims then becoming relief of pain, anxiety and other symptoms. Patients with implanted cardiac defibrillators (ICDs) pose unique problems for those attempting to provide end-of-life care. Indeed, the experience of being shocked by an ICD can be very distressing, inducing anxiety and fear, even in the well person (Beattie, 2007), quite the opposite of what we are trying to achieve. Nursing and other personnel in palliative care and/or oncology are likely to be unfamiliar with the device, how and when to deactivate it and who should do the deactivation. Guidelines for ICD deactivation in the terminally ill are minimal, if they exist at all (Kahn, 2006). An experience the authors had in providing end-of-life care for a patient with an ICD highlighted several issues: 1) the presence of a Do Not Resuscitate (DNR) order can be complicated by the presence of an ICD; 2) the need for collaboration and communication between those providing end-of-life care and those with knowledge and expertise of ICDs, and 3) the need to discuss potential future complications/issues at the time of implant. This presentation will explore the issues identified above via case study and a review of the relevant literature.

VII-03
See It, Perceive It, Feel It: Comprehending Illness: Exercise and Cancer: Let’s Get Moving!

Jan Park Dorsay, BAA(N), MN, ACNP(D), Oren Cheifetz, BScPT, MPT. Hamilton Health Sciences, Hamilton, ON, Canada.

A growing body of evidence demonstrates the importance of exercise in preventing the development and recurrence of certain cancers. Exercise can help patients manage treatment side effects and toxicities, maintain physical functioning, complete difficult treatment regimes, prevent muscle loss and fat gain, as well as improve mood and quality of life. Even during the end-of-life, exercise can slow functional decline. The knowledge about the potential benefits of exercise and cancer has not been translated into the everyday practice of oncology nurses. The authors surveyed 648 cancer patients about their knowledge and preferences regarding exercise. Over half of those surveyed reported both interest, and belief that they could participate in an exercise program. While research demonstrated that patients with cancer who received exercise counseling were more likely to be active than those who did not, approximately 70% of the patients surveyed could not recall receiving any exercise counseling throughout their cancer care continuum. This workshop will help oncology nurses broaden their knowledge about cancer and exercise. Research evidence and implications for nursing practice will be reviewed. Videotaped interviews will illustrate the importance of exercise from cancer survivors’ perspectives. This workshop will provide oncology nurses with practical information to knowledgeably help support cancer survivors safely experience the potential benefits of exercise.

VII-04-A
Partnerships and Linkages: The Comprehensive Breast Cancer: A Multidisciplinary and Multi-Jurisdictional Approach to Enhancing the Patient Care Path

Janet E. Bates, RN, MScN, Barb Rocchio, RN, BScN, MEd, Cathy Duong, BScPharm1, 1Alberta Cancer Board, Edmonton, AB, Canada, 2Innovative Health Care Consulting Inc., Edmonton, AB, Canada.

The Comprehensive Breast Cancer Program (CBCP) is a provincial cancer board and regional health authority partnership. This program is the first time these partners have collaborated in this way and is a multidisciplinary collaboration developing new roles, goals and care paths.
The presentation will look at the processes used in establishing a multidisciplinary program involving multiple jurisdictions and user groups and that is dependent on interdisciplinary cooperation. The presentation will also discuss how outcomes are being evaluated. The goal of the CBCP is to provide an integrated approach to diagnosing and treating breast cancer which is patient-centered, timely, consistent and high-quality. The demonstration project is working to establish a framework and infrastructure potentially transferable to other health regions and provide the basis for a provincial approach to breast health services. Crucial to this project is the development of a standard care path, new and enhanced business processes, change management and communication strategies. An electronic data monitoring system for case management and evaluation facilitates information flow amongst various health care disciplines. As well, new roles have been established such as nurse navigator, breast expert and clinical social worker. Evaluation of the project is fundamental to quality assurance and improvement. Multi-jurisdictional multidisciplinary teams can work effectively to enhance the quality of health care - it is really ordinary people trying to enhance patient outcomes in an extraordinary way.

VII-04-B

PARTNERSHIPS AND LINKAGES: TRANSITION SERVICES IN AMBULATORY CANCER CARE: NAVIGATING BETWEEN TWO SYSTEMS

Sonya Caruth, RN, BN1,2, Linda C. Watson, RN, BScN, MN, CONC1. Tom Baker Cancer Center, Calgary, AB, Canada, 2Calgary Health Region, Calgary, AB, Canada.

In Canada, an increasing trend exists to deliver cancer care, wherever possible, in the outpatient ambulatory setting (Henderson, Murphy, Doyle, Van-Cleif, Lowry, & Honeyford, 2005). Unfortunately, many Canadian cancer patients and their families have reported that this outpatient system often does not allow for seamless care between hospital, ambulatory, community, and home care settings (Canadian Strategy for Cancer Control, 2006). At some point in the cancer journey, each patient must navigate between these systems. With this increasingly fragmented care delivery system, it is imperative that strategic linkages be nurtured to facilitate continuity of care. As a result of this need, the Transition Services Coordinator position has been created in partnership with the regional health authority. This nursing coordinator position, funded equally by the region and the cancer agency, is located within our ambulatory cancer center. The mandate of this position include:

- facilitating communication between the health region, home care and the cancer center
- initiating new home care referrals to adult, seniors or palliative home care services
- providing information resources regarding home care and supporting living options
- completing home care referrals to other regions both within or out-of-province

In this presentation, a one year report card will guide the discussion through the implementation of this new role, including challenges, successes, evidence of its effectiveness, and its anticipated growth into the future.

VII-04-C

PARTNERSHIPS AND LINKAGES: THINKING OUTSIDE OF THE BOX: BRINGING RADIATION THERAPY TO NORTH SIMCOE MUSKOKA

Tracey A. Keighley-Clarke, Garth Matheson, B. Comm., M.B.A., The Royal Victoria Hospital of Barrie, Barrie, ON, Canada.

The residents of Ontario’s region of Simcoe, Muskoka, and East Parry Sound have been waiting nine years for a regional cancer centre to be constructed closer to their homes. Although construction of a centre is approved, residents will wait another three years until the building is open and operational. For an individual patient requiring radiation services, the wait means they will need to make upwards of 35 trips to Toronto for treatment. The psychological and social cost of this can detrimentally affect the patient’s outcome and at times, patients can’t accept the burden of travel and do not receive possible life saving treatment.

To respond to the regional need, a unique proposal was developed by Royal Victoria Hospital in collaboration with Cancer Care Ontario and Odette Cancer Centre. By “thinking outside the box” the partners collaborated to bring a new technology to the region to allow for temporary placement of a portable radiation facility at a hospital. This innovation brings radiation care close to home. The technology will be used for 3 years and then be relocated in the province where the patient need is the greatest.

This presentation will outline the process of bringing this “first in Canada” technology to the region. The value of partnerships focused on patient care will be highlighted when ordinary people with a patient focused mission accomplish the extraordinary by thinking outside of the box.

VII-05-A

SYMPTOM MANAGEMENT: TEACHING PATIENTS TO BREATHE OFFERS A BREATH OF FRESH AIR

Cathy A. Kiteley, RN, BScN, MSc, CONC, CHP-CNCC1, Jennifer Parksins, RN, BScN, MNC, CONC2. 1The Peel Regional Cancer Centre, Mississauga, ON, Canada, 2Grand River Regional Cancer Centre, Kitchener, ON, Canada.

Breathlessness is best understood as a symptom which has complex physical psychological emotional and functional influences. (O’Driscoll, Corner, Bailey, 1999) Breathlessness is frequently seen as a presenting symptom of lung cancer and a symptom of advancing disease in other cancers. Bredin and colleagues (1999) state between 10% and 65% will have the symptom at some point during their illness. Two randomized control studies by Corner and colleagues (1996) and Bredin and colleagues (1999) concluded a nurse led educational and supportive intervention for individuals with breathlessness was beneficial to their quality of life. We used this evidence to help build a breathlessness management intervention program in collaboration with the Provincial Palliative Care Integration Project dyspnea management care plan. The program was implemented in the homes of individuals with advanced cancer illness to provide a comfortable and secure setting for successful interactions between patients and community nurses. The clear and significant
benefit of reduced breathlessness based on best practice was the foundation of the proposed intervention program. This interactive workshop will move participants through the steps we undertook to move evidence into practice. We will also leave participants with useful resources and tools to take back to their practice setting.

**VII-05-B**

**SYMPTOM MANAGEMENT: CHEMOTHERAPY INDUCED CARDIOTOXICITY**

Valarie M. Ali, RN, BA, CON(C)1, Alison M. Nasu, RN, BN, OCN2.

1Princess Margaret Hospital, Toronto, ON, Canada, 2Credit Valley Hospital, Mississauga, ON, Canada.

Historically, anthracycline chemotherapy has been associated with cardiotoxicity. Research and experience have shown chronic toxicities that were not previously identified. Other chemotherapy agents used in treating cancer can induce acute and chronic cardiac complications. This has challenged us as oncology nurses to broaden our knowledge of cardiology. Our presentation will review the basics of heart failure and the impact of chemotherapy on cardiac function. Monitoring of cardiac function, nursing assessment and patient education will be reviewed.

**VII-06**

**PROFESSIONAL NURSING ISSUES: GROWING YOUR CANO CHAPTER... MEETING BY MEETING**

Carole Beals1, Lynne Penton, MN. 1Royal Victoria Hospital, Barrie, ON, Canada.

The Simcoe Muskoka Chapter of CANO was founded in 2001. Our goal is to support the advancement of oncology nursing in Simcoe / Muskoka. by promoting and developing excellence in oncology nursing practice, education, and research. Our events and meetings provide a forum for members, and other oncology nurses in the area, to communicate and share knowledge and expertise.

Our chapter provides a linkage between different health care providers and organizations where we can create solutions to local cancer issues. The events we host as a chapter serve to promote membership. In order to increase the membership, improve the coordination of educational events, and promote a sharing of knowledge and expertise our group developed a partnership with the palliative care group in Simcoe/Muskoka.

Our activities have ranged from poster presentations on Oncology Nursing Week to hosting a breakfast meeting. These events have been attended with interest from oncology nurses across the continuum of cancer care.

As a result of this partnership several regional initiatives have been undertaken, preprinted palliative care order sets and a review of central venous access practices across the region. This presentation will review the process of development of the chapter and our ongoing initiatives to increase our membership.

**VIII-01**

**WHAT IS MANUSCRIPT REVIEWING? WHAT IS THE ROLE OF THE CONJ REVIEWER?**

Heather B. Porter, CONJ, Waterloo, ON, Canada.

Discussion and demonstration of the art and science of reviewing will form the core of this learning session. Participants will gain an understanding of the activities involved in this essential role with the Canadian Oncology Nursing Journal (CONJ), a peer reviewed professional journal. The session will be conducted by CONJ editors (who have all been reviewers) and current CONJ reviewers. All aspects of the reviewer role with CONJ, from how to review and critique manuscripts and encourage their authors, to the time required for this work will be presented. Experiences and examples from current and past reviewers will be offered for discussion by the group. It is hoped that by learning more about the role of the reviewer and gaining further insight into the CONJ review process, participants of this session will feel encouraged to submit their manuscripts to CONJ.

**VIII-02-A**

**ONGOING NURSING EDUCATION: AN INNOVATIVE APPROACH TO PALLIATIVE CARE EDUCATION: AN E-LEARNING MODULE ON MANAGING PAIN TOGETHER**

Deborah L. Gravelle, RN BScN MHS1, Margaret Lerhe1, Emma Stodel1, Maryse Bouvette, RN BScN, Med, CHPCN (c)1. 1SCO Health Service, Ottawa, ON, Canada. 1Excellence4Learning, Ottawa, ON, Canada.

Canadians are living longer with major and complex illnesses. Those with chronic and life threatened illnesses require specialized care and treatment that can only be offered by providers with advanced knowledge and expertise in palliative care. As we know, this is not possible in many sectors due to many reasons. As the experts, we must provide education to health care providers in different sectors in order that they can provide care to their patients and families. A major challenge for health care educators is delivering programs to busy employees when patient workload is high and coverage for replacement employees is unavailable due to the dearth of health care professionals. The crisis in health care challenges clinicians and education experts to explore new and innovative ways to provide much needed education programs that will enhance knowledge and upgrade skills to ultimately meet the care and treatment demands of Canadians. Building on the success in the private sectors, academic institutions and hospitals are successfully implementing e-learning solutions to provide much needed education programming to health care professionals. A review of the literature emphasized that an e-learning solution to providing clinical education is an equally viable and effective option when compared to traditional methods. A team of palliative care experts, education specialists, and instructional designer, graphic designer and information systems experts worked collaboratively to develop this innovative project on Managing Pain Together. The presentation will discuss the steps in developing the module and the evaluation results from the pilot project.
VIII-02-B
ON GOING NURSING EDUCATION:
FROM WATSON & CRICK TO THE CLINIC - THE DEVELOPMENT OF A GENETICS TUTORIAL FOR ONCOLOGY NURSE

Kathryn R. Calder, BScN1,2, Brenda Cameron, RN, PhD2, Cindy Cummings Winfield, BScN, CONIC1,2, Karin Olson, RN, PhD1,2, 'Cross Cancer Institute, Edmonton, AB, Canada, 2Faculty of Nursing, University of Alberta, Edmonton, AB, Canada.

Despite the growing awareness and influence of genetics on every aspect of the human cancer experience, many nurses working in oncology evaluate their knowledge of genetics as insufficient. Certain exciting developments in cancer care, knowledge of predictors of disease susceptibility, individual physiological reactions to carcinogens, varied responses to treatment, and mechanisms of actions for targeted therapies can only be understood if one has a basic comprehension of genetics. Recognizing that a number of nurses have limited genetics content in their curriculum and that many nurses feel ill-prepared to fully integrate this science into their clinical practice, a Canadian oncology treatment centre's Department of Nursing Education and the affiliated Faculty of Nursing embarked on a project to develop a self-administered online genetics tutorial. The tutorial covers basic principles of genetics, some direct applications to oncology nursing practice, and selected legal, ethical, and social issues related to genetics in healthcare and research. Using the department's current educational framework, this tutorial was developed by a Master's of Nursing candidate with 17 years of cancer nursing experience. The tutorial was piloted and evaluated by practicing oncology nurses. This presentation will describe the development process, the integration of the educational framework, the evaluation data, and review key excerpts from the tutorial.

VIII-02-C
ON GOING NURSING EDUCATION:
PLANNING WITH THE END IN MIND: A NEW APPROACH TO ONCOLOGY NURSING CURRICULUM DESIGN

Cynthia Cummings-Winfield, RN, BScN, CONIC, Susan King, RN, BScN, CONIC, Anne-Marie Stacey, MMus, MEd. Cross Cancer Institute, Edmonton, AB, Canada.

Understanding by Design (UbD) (McTighe & Wiggins, 1999), provides a conceptual framework for instructional design for oncology nurse educators. This approach requires educators to think of curriculum in terms of desired performances of understanding and then plan backwards to identify needed concepts and skills. Design focus is on assessment first and relevant instructional activities last. This curriculum approach is designed to engage nurses' inquiry and 'uncover' ideas as an alternative to the more traditional 'coverage' of content. UbD was adapted for oncology curriculum development using the logic of “backward design”. This presentation will discuss the following stages of Understanding by Design lesson planning:
- Stage I: What is worthy and requiring of understanding?
- Stage II: What is evidence of understanding?
- Stage III: What learning experiences and teaching promote understanding, interest and excellence?
Participants will learn about the backward design process and be introduced to practical applications of this process to oncology nursing education. Questions used to facilitate backward design include:
- How do we know that nurses truly understand and can apply their understanding in a meaningful way?
- How can we unpack content standards to identify the important big ideas that nurses must understand?
- How can we design courses and units to emphasize understanding rather than coverage?
- What instructional practices are both engaging and effective for developing understanding?
The application of backward design offers oncology nursing educators a process to center their curriculum and assessments on big ideas, essential questions and authentic performances.

VIII-03-A
PROFESSIONAL NURSING ISSUES:
EXPLORING THE RELATIONSHIP BETWEEN ROTATING SHIFT WORK AND MELATONIN LEVELS: A TRANSDISCIPLINARY RESEARCH PROGRAM

Ann Grundy, Joan Tranmer, Harriet Richardson, Charles Graham, Kristan Aronson. Queen's University, Kingston, ON, Canada.

Epidemiologic studies suggest that night shift work is associated with increased cancer risk. One hypothesized pathway is through the hormone melatonin. The objective of this transdisciplinary research program is to increase our understanding of the important relationships between shift work, light exposure, melatonin production among rotating shift nurses, and to determine the influence of other variables such as light intensity, physical activity, diet and others on peak melatonin levels. We are in the process of implementing a multi-project research program based on the successful completion of a pilot project (Project 1). Project 1 involved 60 female, hospital, rotating shift nurses. Nurses who worked the day shift had longer sleep duration and experienced much lower intensity of light during sleep than nurses working at night and sleeping during the day. Light intensity during sleep was inversely associated with urinary melatonin levels among day workers. Among night workers, salivary melatonin metabolites indicated minimal shift in circadian rhythm. We will report on: (1) detailed findings from Project 1, (2) status of current projects and (3) future directions. Since it is necessary that some nurses work at night, we need a comprehensive understanding of the health risk associated with shiftwork to inform the development of occupational policies. [Support: Workplace Safety Insurance Bureau, CIHR Transdisciplinary Cancer Training Program; Breast Cancer Action Kingston; Programme de Research in Environmental Etiology of Cancer, NCIC]

VIII-04-A
SUPPORTING WOMEN WITH CANCER:
EXTRAORDINARY, MULTIDISCIPLINARY GROUP CLIENT INFORMATION SESSIONS: PREPARING BREAST CANCER CLIENTS FOR THEIR PRE AND POST OP JOURNEY

Lisa A. Albensi, MSN, Jo-Anne L. Marion, BN. WRHA-Breast Health Centre, Winnipeg, MB, Canada.
Receiving a breast cancer diagnosis is often overwhelming and devastating. To assist women and men through this journey, our multidisciplinary team developed pre and post-op group client information sessions, in partnership with outside agencies. These presentations support clients and their families through the cancer experience with the help of educational handouts, PowerPoint presentations, question and answer periods, and primary care nursing practice. The pre-op class is taught the first and third Friday of every month and includes the following lectures: 1) Types of Breast Surgeries and Preparation for Surgery (clinic nurse), 2) Arm Mobility and Exercises (physiotherapist/MLD therapist), and 3) Peer Support Program (breast cancer survivor and peer support program director). The post-op class is taught the second and fourth Friday of every month and includes the following lectures: 1) Diet and Healing during Chemotherapy (dietitian), 2) Arm Mobility and Exercises, Lymphedema Prevention and Treatment (physiotherapist/MLD therapist), and 3) Medical Oncology and Radiation Oncology Treatment Overview (external agency nurse). Clients receive separate bilingual pre and post-op teaching packets. In recognition of clients who cannot attend the sessions in person (due to weather or transportation issues), DVDs are available to be mailed to their homes. Copies of the DVDs are being sent to the province’s sixteen Community Cancer Program Network sites for quicker access. This presentation will provide a snapshot of how our client needs for breast cancer teaching are being met. These methods could easily be adapted for other cancer types.

VIII-04-B

Supporting Women with Cancer: Abnormal Breast Screening Results: the Psychological Consequences Experienced by Women and the Social Supports They Access

Patti Marchand, RN, MN, CON(C)¹, Manon Lemonde, RN, PhD². ¹RS McLaughlin Durham Regional Cancer Centre, Oshawa, ON, Canada, ²University of Ontario Institute of Technology, Oshawa, ON, Canada.

Breast cancer is the most common cancer among Canadian women. Approximately 400 women are newly diagnosed each year within the immediate region served by our large community hospital. The intent of regular breast screening is to find cancer when it is small. Breast screening and better treatments are helping to lower the death rate from cancer (Breast Cancer Canada, 2007). Despite the many clinical benefits of screening, acknowledgement of the anxiety this process brings is necessary. It has been reported that social support positively impacts emotional support, continuity of care, and patient education. This presentation will describe the organizational approach to facilitate change within a Supporting Families Collaborative framework was utilized to assess current practice, identify recommendations to address gaps in service, and systematically develop a plan to implement changes. Outcome measures included an evaluation of patient satisfaction scores in the domains of emotional support, continuity of care, and patient education. This presentation will describe the organizational approach to facilitate change within a Supporting Families Collaborative: Ovarian Cancer Canada, 2008. Ovarian Cancer and its treatment can significantly impact quality of life for women who are facing advancing disease (Fitch, 2003). An interprofessional team, within the Oncology Program at a teaching hospital in Toronto, partnered with a survivor of ovarian cancer, a family member, and Ovarian Cancer Canada, to explore, identify, and implement strategies to enhance care for patients and families. The aim of this quality improvement project is to ensure that women living with ovarian cancer and their families are satisfied with the support they receive along the continuum of care, including the ambulatory care centre, inpatient care unit, and during the transition from hospital to home. An evidence-based model was utilized to assess current practice, identify recommendations to address gaps in service, and systematically develop a plan to implement changes. Outcome measures include an evaluation of patient satisfaction scores in the domains of emotional support, continuity of care, and patient education. This presentation will describe the organizational approach to facilitate change within a Supporting Families Collaborative Cooperative Initiative using the rapid cycle change model. Successes, challenges, and plans to sustain change will also be discussed.

VIII-04-C

Supporting Women with Cancer: Changing the Way We Meet the Supportive Care Needs of Women Living with Ovarian Cancer and their Families

Shari Moura, RN, MN, CON(C)¹, Tracey Das-Gupta, RN, MN, CON (C)², Elaine Avila, RN, BScN³, Lynn Faltl, RN², Mary Giavassevich, RN, BA, MN⁴, Brenda Leung, RN, BScN⁵, Alison McAndrew, BA, RAP⁶, Cynthia Robinson, MSW, RSW, Terry Russell, Ph.D.⁷, Marilyn Sapsford, BA, MDiv⁸, Kalli Siilos, RN, MN, CHPCN(C)⁹, Sunnybrook Health Sciences Centre, Toronto, ON, Canada. Ovarian Cancer Canada, Toronto, ON, Canada.

Ovarian Cancer and its treatment can significantly impact quality of life for women who are facing advancing disease (Fitch, 2003). An interprofessional team, within the Oncology Program at a teaching hospital in Toronto, partnered with a survivor of ovarian cancer, a family member, and Ovarian Cancer Canada, to explore, identify, and implement strategies to enhance care for patients and families. The aim of this quality improvement project is to ensure that women living with ovarian cancer and their families are satisfied with the support they receive along the continuum of care, including the ambulatory care centre, inpatient care unit, and during the transition from hospital to home. An evidence-based framework was utilized to assess current practice, identify recommendations to address gaps in service, and systematically develop a plan to implement changes. Outcome measures included an evaluation of patient satisfaction scores in the domains of emotional support, continuity of care, and patient education. This presentation will describe the organizational approach to facilitate change within a Supporting Families Collaborative Cooperative Initiative using the rapid cycle change model. Successes, challenges, and plans to sustain change will also be discussed.

VIII-05-A

Communicating the E-Way: Pioneering eCommunication in Palliative Care

Lisa Streeter, RN, BN, Simone Steneke, RN, MN, CHPCN(C), Mike Harlos, MD, CCFP, FCFP. Canadian Virtual Hospice, Winnipeg, MB, Canada.

The Canadian Strategy for Cancer Control has identified supporting the cancer patient throughout the illness continuum and improving access to information as priority areas for investment. Health care providers are being challenged to seek innovative ways to overcome gaps in patient care and ensure access to credible information, support and services regardless of where one lives. Advances in communication technology provide an unprecedented opportunity to connect people affected by life-
thwarting illness and loss. Increasingly, cancer patients and family members are accessing the web to obtain information. With these new communication opportunities, it is imperative that health care providers appreciate the intricacies of providing care in this innovative environment. This interactive presentation will engage clinicians in discussion around web-based communication in palliative care. The experiences of the clinicians working with a national website that provides information and support to Canadians dealing with life-limiting illness will be shared. The ‘Ask a Professional’ area of the website is one of the bold steps that has been taken to address the palliative care concerns of Canadians. This area allows a website visitor to ask a question, and receive an individualized response, from a palliative care clinician. Those who attend this session will develop a better understanding of how to interact with palliative care patients, their family members and other health care providers through web-based modes of communication to enhance end-of-life care for cancer patients and their families.

**VIII-05-B**

**Communicating the E-Way:**

**Clinical Electronic Communication: Using E-mail to Share Patient Information Between Collaborating Advanced Practice Nurses**

Barbara Godfrey, RN, MSCh,1 Lia Kutzscher, RN(EC), MSch, CIN AD(C), CON(C), AOCNP, PhD in progress.2 Princess Margaret Hospital, Toronto, ON, Canada, 2 Royal Victoria Hospital, Barrie, ON, Canada.

Clinical Electronic Communication is quickly becoming acknowledged as a convenient and time saving means of sharing patient information for purposes of consultation, clarification and collaboration. The body of literature addressing e-mail communication amongst physicians and between physician and patient is growing, while very little exists regarding the use of clinical electronic communication in the form of e-mail for advanced practice nurses.

An advanced practice nurse (APN) collaborative outreach model for care delivery was developed between Royal Victoria Hospital in Barrie, Ontario and Princess Margaret Hospital in Toronto to facilitate leukemia patients’ access to skilled and knowledgeable assessment and monitoring closer to home. This partnership uses e-mail as a main form of communication to share patient plan of care, clarify supportive care needs and problem-solve issues that do not require immediate response.

This paper will review the literature on clinical electronic communication as it relates to e-mail use, explore legal and confidentiality issues, identify the benefits and challenges to using e-mail within an advanced practice nurse collaborative model and present a collaborative process to share clinical patient information safely and legally between two healthcare facilities clinical electronic collaboration.

**VIII-06-A**

**Leukemia: Treatment, Sexuality and Survivorship: Planning and Implementing an Ambulatory Management**

STRATEGY FOR ACUTE MYELOGENOUS LEUKEMIA (AML) PATIENTS UNDERGOING CONSOLIDATION CHEMOTHERAPY: EXPERIENCE OF AN INPATIENT ONCOLOGY UNIT

Jeanette Mallay, RN BScN, Jane Keown, RN. Regional Cancer Program, Sudbury, ON, Canada.

Acute myelogenous leukemia (AML) is traditionally treated in acute inpatient settings with aggressive myelosuppressive chemotherapy. Published studies indicate success treating patients during their consolidation phase as outpatients. Our unit commenced with an ambulatory management policy for AML patients by first assembling identified stakeholders. Preliminary meetings reviewed best practices, surveyed other cancer centres, and reviewed the literature. The team identified multiple benefits to an outpatient management strategy including increasing the patients’ quality of life, cost-savings and liberating hospital beds. Published literature supports these suppositions indicating no more frequent febrile episodes for ambulatory AML patients compared to their inpatient cohorts. We developed standardized febrile admission orders, teaching strategies, and worked with bed utilization to procure a bed on hold should admission become necessary for these patients. To date, obstacles included agreeing on a standardized protocol, developing pre-printed order sets for our emergency room and overcoming the logistical challenges of reporting blood work in a timely manner. The final hurdle was obtaining approval from bed utilization to secure an additional bed for patients on this protocol. The main messages in this presentation will be our experience in introducing this ambulatory management program for AML patients, obstacles encountered and strategies used to manage this complex population in a community hospital within a Northern Ontario setting.
ual function after hematopoietic stem cell transplantation
2) strategies for improving nursing practice in promoting sexual health

VIII-06-C
LEUKEMIA: TREATMENT, SEXUALITY AND SURVIVORSHIP:
BEYOND SURVIVAL: MANAGING LATE EFFECT COMPLICATIONS
OF ALLOGENIC STEM CELL TRANSPLANTATION

Janice A. Wright, MS, Nancy-Anne Pringle, RN.
Princess Margaret Hospital, Toronto, ON, Canada.

Bone Marrow Transplantation (BMT) is the standard of treat-
ment for a defined number of malignant hematology condi-
tions. Although the procedure is intense the advances in post
transplant supportive care ensure many patients are cured and
become long term survivors. Within the cohort of long term
survivors there are a significant number of people that experi-
ence lingering late complications. The late clinical effects of
Bone Marrow Transplantation are a major concern to clini-
cians as they significantly affect survivor’s functional staus, psy-
chosocial health and over all quality of life (Socie et al, 2003).
The Princess Margaret Hospital (PMH) BMT team has a well
established long term care follow up clinic designed to ad-
dress the on going health and wellness issues of long term
survivors. The clinic model utilizes a primary case manage-
ment approach and is staffed by four experienced BMT ambu-
latory nurses, an advanced practice RN and a BMT physician.
The purpose of the presentation is to: outline the clinic design;
identify the core elements of long term survivor care; high-
light our processes for surveillance and define early interven-
tion strategies used to address the late effect complications
as recommended by the Late Effects Working Party of the Eu-
ropean Study Group for Blood and Marrow Transplantation.
References: Socie, G., Salooja, N., Cohen, A., Rovelli, A., Car-
after allogeneic stem cell transplantation. Blood 101 (9) 3373-
3385
Group 1-A: Innovation and Evidence-based Practice

Authors will be present at their posters Monday, September 15 from 10:15-10:45 in the Ballroom Foyer.

P-03 **Thoracic Diagnostic Assessment Unit**

**Jennifer Parkins**, RN, BScN, CON(C), MN (Candidate Univ. of Victoria), Robinne Hauck, RN, Donna Holmes, RN, BHSc, CON(C), MN(c). Grand River Regional Cancer Centre, Kitchener, ON, Canada.

P-04 **Using the Multidisciplinary Tumor Board as a Springboard for Reflective Practice: Dialogal Phenomenology and Improved Patient Care in the Outpatient Chemo Clinic**

**Tracy Soloninka**, MS, Oncology, Caroline Alexander, Suzanna Bassier, Cathy Loureiro, Donna Parkhouse, Betty Matson. Humber River Regional Hospital, Weston, ON, Canada.

P-05 **Nursing Attitudes Towards an Electronic Health Record**

**Tracie L. Parks**, BScN, Jeannette Mallay, BScN. HRSRH-RCP, Sudbury, ON, Canada.

P-06 **Management of Breast Cancer in Newfoundland and Labrador**

**Cynthia M. Higdon**, Dr. H. Bliss Murphy Cancer Centre, St. John's, NL, Canada.

P-07 **The Development and Pilot Test of an Iatrogenic Menopause Education Program for Premenopausal Hematopoietic Stem Cell Transplant (HSCT) Recipients**

**Linda Hamelin**, RN, MN1, Donna Moralejo, PhD, RN2, Donna Bulman, PhD, RN2, Sheryl McDiarmid, RN, BScN, MED, MBA, AOCN, ACNP1. The Ottawa Hospital - General Campus, Ottawa, ON, Canada, 1Memorial University School of Nursing, St. John's, NL, Canada.

P-08 **Enhancing Professional Competencies by Bridging the Research Practice Gap**

**Lorraine Martelli-Reid**, RN, MN1, Sally Hapke, RN1, Nancy Knox, RN1, Marilyn Miscione, RN1, Janet Poirier, RN1, Christine Zywine, RN, MN1-2, Denise Bryant-Lukosius, RN, MN, PhD1-2. Juravinski Cancer Centre, Hamilton, ON, Canada, 1McMaster University, Hamilton, ON, Canada.

P-09 **The Nurse Navigators' Telepractice, an Evidence-Based Research.**

**Anne Plante**, M.Sc.inf, CSIO, CSIP. Regional Cancer Care Center, Hôpital Charles LeMoyne, Longueuil, QC, Canada.

P-10 **Transfusion Protocol: Saving More than Blood!**

**Pamela J. West**, RN(EC), NP-Adult, MSC, CON(C), CHPC(N)(C), Cheryl Owen, RN, BScN, Karen Mayne, RN, BA, MA. Rouge Valley Health System, Toronto, ON, Canada.

P-11 **Pivot Nurse for Northern Quebec: a Shared Project Targeting a Special Clientele**

**Eileen A. C. Curran**, RN, ME1, Mary Lou Kelly, RN, BA1, Andréanne Saucier, MSCInf1, Jacques Poliquin, DSP1. McGill University Health Centre, Montreal, QC, Canada, 1Centre de Santé Télattavik de l'Ungava, Télattavik, QC, Canada.

P-12 **Lung Cancer, Smoking Cessation, and the Concept of “Fasting”: an Innovative Nursing Approach**

**Stephanie Hooper**, BScN, Christine Blais, BScN, Chantal Bornais, BScN, Jennifer Smylie, BN, Dr. Andrew Pipe, Dr. Robert Reid, Debbie Aitken, Kerri-Anne Mullen. The Ottawa Hospital, Ottawa, ON, Canada.

P-13 **An Inter-Professional Approach to Rapid Assessment of Lung Cancer Patients**

**Stephanie Hooper**, BScN, Christine Blais, BScN, Chantal Bornais, BScN, Jennifer Smylie, BN. The Ottawa Hospital, Ottawa, ON, Canada.

P-14 **Update of the Bone Metastases Patient Information Booklet**

**Philiz Goh**, BSc, BScN(C), Margaret Fitch, RN, PhD, Carlo DeAngelis, PhD, Edward Chow, MBBS. Odette Cancer Centre, Toronto, ON, Canada.

Group 2-A: Workforce and Healthy Workplace Issues

Authors will be present at their posters Monday, September 15 from 15:30-16:00 in the Ballroom Foyer.

P-01 **Why Exemplary Oncology Nurses Seem to Avoid Compassion Fatigue?**

**Beth Perry**, Athabasca University, Edmonton, AB, Canada.
P-02 Strategies for the Recruitment and Retention of Foreign-Trained Nurses into Oncology Practice
Ahmadreza Baki-Jafarzadeh, RN, BScN, Jayesh Patel, RN, BScN, MN, Diana Incekol, RN, BScN, ONC(c). Princess Margaret Hospital, Toronto, ON, Canada.

Group 2-B: Quality Care
Authors will be present at their posters Monday, September 15 from 15:30-16:00 in the Ballroom Foyer.

P-15 Oncology Nurses’ Practice and Educational Needs Around Sexual Health
Catherine Doyle, BScN, CON(C), Kalli Stilos, MScn, CHPC(C), Pat Daines, MN, CHPCN(C). Sunnybrook Health Science Centre, Toronto, ON, Canada.

P-16 Providing Oncology Care in Rural and Northern Manitoba
Michelle Rosentreter, RN CON(C), Connie Randell, RN, Evelyn DeGrave, RN CON(C). CancerCare Manitoba, Pinawa, MB, Canada.

P-17 Self-Discontinuation of Baxter Infusors from an IVAD: Enabling Patients to Regain Control and Independence in the Treatment of Their Cancer
Shelley A. Dick, R.N. ConC., Seana E. Hutchison, RN, BScN. BC Cancer Agency/Fraser Valley Cancer Center, Surrey, BC, Canada.

P-18 A New Outlook at our Cancer Center
Maura D. Eleuterio, RN, BScN, CON(c). The Ottawa Hospital Regional Cancer Center, Ottawa, ON, Canada.

P-19 Changing Practice to Meet the Needs of the Population at Risk
Julie Wilson, RN, BSc.N.; CON(C), Carmen Gosselin, RN, Elaine Walker, RN, CON(C), Christine G loin, RN, B.A., CON(C); Angela Bourdreau, RN, MN, CON(C). Odette Cancer Centre, Sunnybrook Health Sciences Centre, North York, ON, Canada.

P-20 Cancer and its Treatment: Impact in the Patients’ Life
Maria Gaby R. Gutierrez, Professor, Tais C. Arthur, nurse, Maria Clara C. Matheus, Professor, Selma M. Fonseca, Professor. UNIFESP, Sao Paulo, Brazil.

P-21 Improving Nurse-Patient Communication Related to Symptom Assessment and Management for Gynecologic Oncology Patients
Joanne Power, RN, MScN. McGill University Health Centre, Montreal, QC, Canada.

P-22 Improving Nursing Practice: A Review of Side Effects Associated with Radiation Therapy in the Head and Neck Cancer Patient
Lisa M. Hussey, Master of Nursing, Nurse Practitioner Specialist. St.Clare’s Mercy Hospital, St.John’s, NL, Canada.

Group 3-A: Expanded and Advanced Nursing
Authors will be present at their posters Tuesday, September 16 from 09:30-10:00 in the Ballroom Foyer.

P-23 Charting in the 21st Century- Electronic Charting of Treatment Toxicity in Ambulatory Oncology Care
Karen D. Hough, RN, Yvonne Finnegan-Smith, BScPsych, RN, Alan Beseker, BScPsych, RN, Susan Horsman, RN, BScN, MN(Registrar). Cross Cancer Institute, Edmonton, AB, Canada.

P-24 Advanced Practice Nursing in Action: Shaping Nursing Practice for Women Dealing with Breast Cancer

P-25 Evaluating the Nurse Practitioner (NP) Role in an Ambulatory Tertiary Cancer Centre
Marie-Josée Paquin, Jill Bateman, Reanne Booker, Stephanie Hubbard, Linda Watson. Alberta Cancer Board/Tom Baker Cancer Centre, Calgary, AB, Canada.

Group 3-B: Other
Authors will be present at their posters Tuesday, September 16 from 09:30-10:00 in the Ballroom Foyer.
**P-26**  
*The Establishment of a Comprehensive Patient Education Program*  
**Cathy L. Bennett**, BScN, MEd. Juravinski Cancer Centre of Hamilton Health Sciences, Hamilton, ON, Canada.

**P-27**  
*Tissons des Liens*  
**Johane Pelletier¹**, Nicole Plante¹, Francine Köenig¹, Dany Fortin¹, Léo Cantin¹². ¹Cha-Hôpital de l’Enfant-Jésus, Québec, QC, Canada, ²Fondation québécoise du cancer, Québec, QC, Canada.

**P-28**  
*Evaluation of the Psychometric Properties of a French Assessment Tool for Stomatitis Severity (WCCNR)*  
**Nicolle Allard**, Pamphile Nkogno Mengue. Université Du Québec À Rimouski, Lévis, QC, Canada.

**P-29**  
*The Role of the Nurse and the Impact on Patients’ Experience with Hind Quarter Amputation*  
**JoAnne Pacione**, RN, Christina Fabbruzzo-Cota, RN, BScN, MN, CON(C). Mount Sinai Hospital, Toronto, ON, Canada.

**P-30**  
*The Establishment of a Comprehensive Patient Education Program*  
**Cathy L. Bennett**, BScN, MEd. Juravinski Cancer Centre of Hamilton Health Sciences, Hamilton, ON, Canada.

**Group 3-C: Cancer in the Elderly**  
Authors will be present at their posters Tuesday, September 16 from 09:30-10:00 in the Ballroom Foyer.

**P-31**  
*Age, Gender and Function in Older Adults with Cancer*  
**Joan Tranmer**, RN, PhD¹, Dianne Groll, RN, PhD¹, Linda Robb-Blenderman, RN, MSc⁵, Esther Green, RN, BScN, MSc². ¹Kington General Hospital, Kingston, ON, Canada, ²Queen’s University, Kingston, ON, Canada, ³Cancer Care Ontario, Toronto, ON, Canada, ⁴Kingston General Hospital, Kingston, ON, Canada.

**P-32**  
*The Relationship between Symptoms and Function in Older Adults with Cancer*  
**Marian F. Luctkar-Flude¹**, Dianne Groll, RN, PhD¹, Linda Robb-Blenderman, RN, MSc², Esther Green, RN, BScN, MSc². ¹Kington General Hospital, Kingston, ON, Canada, ²Queen’s University, Kingston, ON, Canada, ³Cancer Care Ontario, Toronto, ON, Canada, ⁴Kingston General Hospital, Kingston, ON, Canada.

**Group 4-A: Cancer in Children**  
Authors will be present at their posters Tuesday, September 16 from 15:00-15:30 in the Ballroom Foyer.

**P-33**  
*Neutropenia in Children with Cancer: Meaning and Needs at Home by Caregivers*  
**Maria Gaby R. Gutierrez**, Professor, Débora D. Gelesson, student, Liliiane Y. Hiraishi, student, Leticia A. Pereira, student, Sonia Regina Pereira, professor, Edvane B. L. De Domenico, professor. UNIFESP, São Paulo, Brazil.

**P-34**  
*POLI: Pediatric Oncology Learning Initiative*  
**Jennifer A. Brinklow**, BScN, Brennah Holley, BScN, Cindy Cook, RN, Rosemary Horlin, BScN, M.Ed CON (C). Children’s Hospital of Eastern Ontario, Ottawa, ON, Canada.

**Group 4-B: Survivorship**  
Authors will be present at their posters Tuesday, September 16 from 15:00-15:30 in the Ballroom Foyer.

**P-35**  
*Lymph Listens - a Community Based Report on Living with Lymphedema in Ontario*  
**Susan Bowles**, BScN, RN¹, Anna Kennedy². ¹Odette Cancer Centre, Toronto, ON, Canada, ²The Lymphovenous Association of Ontario, Toronto, ON, Canada.

**P-36**  
*In Men Receiving ADT for Prostate Cancer, What is the Effect of Cognitive Objective Information (COI) and Exercise, in Comparison to Usual Care, on Fatigue?*  
**Lia Kutzschzer**, RN(EC), MScN, CON(C), AOCNP, PhD (student). University of Toronto, Toronto, ON, Canada.

**Group 4-C: Treatment Developments**  
Authors will be present at their posters Tuesday, September 16 from 15:00-15:30 in the Ballroom Foyer.
P-37 Prophylactic Treatment of Radiation Induced Dermatitis: a Feasibility Study
G. Anne Hughes, RN, BSN, MN(C), CON(C)¹, Frankie Goodwin, RN, BN², June Bianchini, RN, CON(C)³.

P-38 The Infusion of Autologous Stem Cells by Registered Nurses
Kristen L. Brazel, Bachelor of Science in Nursing¹, Erin E. Mutterback, Bachelor of Science in Nursing².
¹Ottawa General Hospital, Ashton, ON, Canada, ²Ottawa General Hospital, Ottawa, ON, Canada.

P-39 Contact Dermatitis and Peripherally Inserted Central Catheters: A Conundrum
Lia I. T. Kutzscher, RN(EC), MScN, CON(C), AOCNP, PhD (student)¹, Pamela Savage, RN, MAEd., CON(C)². ¹Royal Victoria Hospital, Simcoe Muskoka Regional Cancer Program, Barrie, ON, Canada, ²University Health Network, Princess Margaret Hospital, Toronto, ON, Canada.

Group 4-D: Palliative Care
Authors will be present at their posters Tuesday, September 16 from 15:00-15:30 in the Ballroom Foyer.

P-40 Les Soins de Fin de Vie: l’Expérience Vécue par des Infirmières dans un Contexte de Soins Curatifs
Marie-Laurence Fortin¹, Marie-Laurence Fortin². ¹Hôpital général Juif Sir Mortimer B.Davis, Montréal, QC, Canada, ²Hôpital Général Juif Sir Mortimer B.Davis, Montréal, QC, Canada.

P-41 Bringing it Home, a Palliative Care Education Workshop for the Frontline Worker
Eleanor Getson. Saint John Regional Hospital AHSC, Saint John, NB, Canada.

P-42 Bibliometric Review: the Edmonton Symptom Assessment Scale (ESAS)
Greta G. Cummings¹, Neil Hagen², Robin Fainsinger¹, Carla Stiles², Patricia Biondo, PhD². ¹University of Alberta, Edmonton, AB, Canada, ²Alberta Cancer Board, Calgary, AB, Canada.

Group 5-A: Supportive Care
Authors will be present at their postersWednesday, September 17 from 09:30-10:00 in the Ballroom Foyer.

P-43: The Scoop on Poop. Teaching a Nation about a Novel Therapy in Treating Refractory Opioid-Induced Constipation
Cindy Shobbrook. Princess Margaret Hospital, Toronto, ON, Canada.

P-44: TLS: What Nurses Need to Know
Lorilee Pitcher, RN, BN, CON(c), Charlene Downey, RN, MN-ACNP, CON(c). Eastern Health, St. John’s, NL, Canada.

P-45: Febrile Neutropenia - A Guideline and Clinical Algorithm
Charlene Downey, RN, MN-ACNP, CON(c). Eastern Health, St. John’s, NL, Canada.

P-46: In Their Own Words: Helping Children Understand Their Parent’s Cancer

Group 5-B: Patient Safety
Authors will be present at their postersWednesday, September 17 from 09:30-10:00 in the Ballroom Foyer.

P-47: Development of a Paper-Based Hemoglobin Monitoring Program: Promoting Safety & Improving Quality of Life of Patients on Erythropoietin Stimulating Agents (ESA)
Rufina Hess, RN, BSN, CON(C), Paul Klimo, MD, Medical Oncologist. Lions Gate Hospital, N. Vancouver, BC, Canada.

P-48: Implementing a Patient Hand Over Tool in a Regional Ambulatory Oncology Cancer Centre
Tanis I. Watkins, RN, BScN, CON(c)¹, Tracey L. Das Gupta, RN, MN, CON(c)¹, Elaine Avila, RN, BScN², Angela Boudreau, RN, MN, CON(c)², Arlene Court, RN, BScN, CON(C)², Lynn Faitl, RN³, Shari Moura, RN, MN, CON(C), CHPCN(C)², Sharon Ramagnano, RN, BScN (E), MN/MHA (c), ENC (c)³. ¹Sunnybrook Odette Cancer Centre, Toronto, ON, Canada, ²Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

P-49: Moving Patient Assessment to the Next Level
Angela Boudreau, RN, MN, CON(C), Kathy Beattie, RN, CON(C). Odette Cancer Centre, North York, ON, Canada
P-01
WHY EXEMPLARY ONCOLOGY NURSES SEEM TO AVOID COMPASSION FATIGUE?

Beth Perry. Athabasca University, Edmonton, AB, Canada.

The topic of compassion fatigue (CF) is increasingly common in nursing literature. LaRowe describes CF as “a heavy heart, a debilitating weariness brought about by repetitive, empathic responses to pain and suffering others” (2005, p. 21). Potentially, CF brings with it many negative personal and professional consequences ranging from apathy and depression to hypertension and errors in judgement (Jackson, 2003, p. 22). Although the literature suggests that CF is a reality for many nurses there are some exemplary oncology nurses who seem avoid CF. The goal of this phenomenological study was to explore what within the lived experiences of these exemplary oncology nurses facilitated the avoidance of CF. A purposive sample of 7 oncology nurses (RNs) who were identified by their colleagues as exemplary caregivers was recruited. Data were collected through semi-structured conversations which were subsequently transcribed. Transcripts were analyzed for reoccurring themes using three points of reference; recurrence of ideas, repetition of ideas, and forcefulness with which ideas were expressed (Owen, 1984). Findings focus on three themes; moments of connection, making moments matter, and energizing moments. This presentation would be of interest to clinical nurses, nurse educators, and health care administrators.

P-02
STRATEGIES FOR THE RECRUITMENT AND RETENTION OF FOREIGN-TRAINED NURSES INTO ONCOLOGY PRACTICE

Ahmadreza Baki-Jafarzadeh, RN, BScN, Jayesh Patel, RN, BScN, MN, Diana Incekol, RN, BScN, ONc(c). Princess Margaret Hospital, Toronto, ON, Canada.

Canada will need to recruit from sources like foreign trained nurses to meet shortages facing the nursing workforce. Core professional values shared among nurses globally are autonomy, control over practice environment, and relationships with physicians (Bieski, 2007). Some areas to address for foreign nurses are the development of settlement services within the community and support services within the organization like language training, technology related training, understanding professional boundaries, and formal and informal differences in the nursing culture. This poster presentation will follow the journey of a new foreign-trained nurse recruit across five countries and highlight challenges while pursuing a nursing career in a leading national cancer centre.

P-03
THORACIC DIAGNOSTIC ASSESSMENT UNIT

Jennifer Parkins, RN, BScN, CON(C), MN (Candidate Univ. of Victoria), Robinne Hauck, RN, Donna Holmes, RN, BHSc, CON(C), MN(c).

Grand River Regional Cancer Centre, Kitchener, ON, Canada.

Patients with lung cancer have many unmet, complex needs in relation to their physical and psychosocial well-being (Krishnasamy, Wilkie, & Haviland, 2001). The incidence of lung cancer in Canada is not expected to decrease in the near future and former smokers continue to be at greater risk of having lung cancer even decades after stopping smoking (Roberts, Patisos, Paul et al., 2007; Ebbert, Yang, Vachon et al., 2003). Lung cancer remains the leading cause of death for both Canadian men and women (Canadian Cancer Society, 2007). Improving access to a timely, more efficient cancer diagnosis is a priority concern for oncology care providers and policy makers. Recognizing lung cancer as a serious health concern, a Thoracic Diagnostic Assessment Unit to evaluate individuals with highly suspicious lung cancer based on clinical features and diagnostic imaging was established at a regional cancer centre. A specialized team of a surgical oncology coordinator, a specialized oncology nurse, dedicated clerical secretary, two thoracic surgeons, surgical nurse practitioner, and seven respirologists participated in the implementation of this collaborative project. With the goal of improving time to diagnosis, a weekly clinic with a nurse, surgeon and respirologist was set up to provide consultation to patients with highly suspicious lung cancer. Post clinic conferencing with an inter-disciplinary oncology care team occurs to develop the best diagnostic approach for each new consult. Evaluation of this clinic will occur annually to review improvements in wait times and patient satisfaction for future developments.

P-04
USING THE MULTIDISCIPLINARY TUMOR BOARD AS A SPRINGBOARD FOR REFLECTIVE PRACTICE: DIALOGAL PHENOMENOLOGY AND IMPROVED PATIENT CARE IN THE OUTPATIENT CHEMOTHERAPY CLINIC

Tracy Soloninka, MS, Oncology, Caroline Alexander, Suzanna Bassier, Cathy Loureiro, Donna Parkhouse, Betty Matson. Humber River Regional Hospital, Weston, ON, Canada.

Specialized cancer nurses need to consistently grow their skills to ensure cancer patients receive care that is individualized and holistic, basing their nursing assessments and interactions on a solid foundation of cancer pathophysiology, disease progression, treatment modalities and treatment side effects. Reflective practice within this complex, changing environment is a challenge as practice scope is easily lost in the laser focus of the daily interaction. Having staff attend the multidisciplinary cancer conferences (MCC) was an opportunity to reframe reflective thinking to capture the full continuum of the patient experience, from early symptoms to differential diagnosis, frequently including psychosocial and family concerns, and showcasing all of the evidence-based multidisciplinary thinking behind the treatment options process. Using Steen Hallings active research methodology, dialogal phenomenology, as a framework the clinical nurse specialist organized nursing presence at the multidisciplinary cancer care rounds and then followed up with monthly presentations from diagnostic and other multidisciplinary experts on specific aspects of cases presented. Diagnostic imaging, staging, differentiation, pathology nuances, radiation oncology,
surgery options, and the specifics surrounding patient and family considerations regarding how treatment decisions are identified, prioritized and presented to patients and families became a dynamic tapestry for discussion and critical thinking. After the expert presentation the nursing staff are asked to reflect on the content and prepare to discuss how the information would impact their approach to patient care, including assessment and patient education.

P-05

NURSING ATTITUDES TOWARDS AN ELECTRONIC HEALTH RECORD

Tracie L. Parks, BScN, Jeannette Mallay, BScN. HRSRH-RCP, Sudbury, ON, Canada.

Information technology has allowed a number of changes in health care, including the transition from paper records to electronic formats.11 Changing processes can be problematic.3,7,9 Change theory2,4,9 has been used to evaluate employee willingness to adopt new processes6, survey attitudes concerning computer documentation5,8,10,12,13,14 and develop and evaluate educational interventions. The Technology Acceptance Model developed by Davis, suggests that acceptance is influenced by the perceived usefulness of a system. 1 Further theory development by Dixon led to the Information Technology Adoption Model. It proposes that there must be a fit between the technology and the user.1 These theories create a framework to examine attitudes related to electronic documentation and EHRs. Literature is available in regards to managing change associated with EHR implementation but there is little information regarding the attitudes of nurses. For this reason, it was decided to examine the concerns of nurses related to the implementation of an EHR at a Regional Cancer Program. It was proposed that using a strategy based on change management theory would facilitate the adoption of an EHR for nursing staff. The researchers administered a survey used by McLane (2005) 11 to collect information about nursing attitudes about EHRs. A focus group will be conducted to collect further information about nurses’ educational needs and concerns regarding EHRs. The data will be used to develop interventions with a post-survey in fall 2008. The poster will provide an overview of the project with the results to date.

P-06

MANAGEMENT OF BREAST CANCER IN NEWFOUNDLAND AND LABRADOR

Cynthia M. Higdon. Dr. H. Bliss Murphy Cancer Centre, St. John’s, NL, Canada.

Breast cancer remains the leading cause of cancer death in women in Canada. Following the identification of issues related to a breast cancer diagnosis, a coalition of health care professionals from the total continuum of care was formed to develop treatment guidelines. Representatives from the Provincial Breast Screening Program, radiology, pathology, radiation and medical oncology, palliative care, genetics, surgery, nursing, pharmacy, and administration came together to form the Eastern Health Breast Disease Site Group. The mandate of the group is to develop clinical practice guidelines for the management of breast disease in the province of Newfoundland and Labrador. In order to support the work, the provincial government provided the funding for a nurse coordinator to oversee this task. While some provinces in Canada already have well established CPG’s (clinical practice guidelines), this is a new and exciting initiative. The goal is to identify the best evidence-based practices from screening, diagnosis, treatment and supportive care and to standardize them for the benefit of all our patients. In this age of variations in clinical practice, dwindling resources for care, and the challenge of translating new research evidence into clinical practice, the development of CPG’s becomes crucial. This presentation will provide details regarding the processes followed by the group, identify some of the challenges, and share information regarding the strengths and opportunities regarding the process.

P-07

THE DEVELOPMENT AND PILOT TEST OF AN IATROGENIC MENOPAUSE EDUCATION PROGRAM FOR PREMENOPAUSAL HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) RECIPIENTS

Linda Hamelin, RN, MN1, Donna Moralejo, PhD, RN2, Donna Bulman, PhD, RN3, Sheryl McDiamid, RN, BScN, MEd., MBA, AOCN, ACNP3. The Ottawa Hospital - General Campus, Ottawa, ON, Canada, 1Memorial University School of Nursing, St. John’s, NL, Canada.

Women undergoing HSCT experience ovarian damage from the high-doses of treatment used to treat their disease. Iatrogenic menopause is not consistently discussed before or after HSCT. An education program has therefore been developed to address learning needs in a more formal manner. The education program has two components: a printed comprehensive information booklet and a post-HSCT education session. The booklet guides discussions and provides a good reference for patients. Prior to the transplant, patients are informed of the probability of iatrogenic menopause occurring post-HSCT. The education session, a comprehensive one-on-one discussion, occurs after patients are discharged and stable. The program was pilot tested with 6 patients. Feedback about processes, perceived benefits and stressors was obtained immediately following the education session and during one follow-up visit. The processes of the education session were reported as appropriate, the booklet was regarded as a valuable resource, and the program was perceived as important to post-HSCT care. Limitations to the pilot test related to the small number of patients, short timeframe for evaluation and limited feedback. Future recommendations include further process, outcome and impact evaluation, and evaluating patient understanding of the information. The program provides a systematic approach that is comprehensive and research-based. It increases awareness and emphasizes the need to discuss symptoms and concerns related to menopausal changes. Further evaluation of this program will lead to a more refined program and possible widespread implementation.
P-08  Enhancing Professional Competencies by Bridging the Research Practice Gap

Lorraine Martelli-Reid, RN, MN1, Sally Hapke, RN1, Nancy Knox, RN1, Marilyn Miscione, RN1, Janet Poirier, RN1, Christine Zywine, RN, MN1, Denise Bryant-Lukosius, RN, MN, PhD1,2
1Juravinski Cancer Centre, Hamilton, ON, Canada, 2McMaster University, Hamilton, ON, Canada.

A group of nurses within a Lung Disease Site Team (DST) identified learning needs within the Professional Practice and Leadership Domain of the Canadian Association of Nurses in Oncology's (CANO) standards of care after completing the self-assessment tool. By collaborating with the Lung Advanced Practice Nurse (APN) the nurses had identified a gap in the assessment and management of dyspnea in patients with lung cancer and wanted to work with the health care team to incorporate new findings related to nursing interventions for dyspnea into practice. The systematic ‘model for change to evidence-based practice’ developed by Rosswurm and Larrabee (1999), was selected to guide the process of developing and integrating an evidence-informed practice change. The first step in the process has been completed. Assessment of the need for a change in practice was accomplished through a chart audit to determine the extent of the problem for our patient’s experience with dyspnea. The poster will present findings related to the prevalence of dyspnea, risk factors, associated factors and the common etiologies found. The next stages of the project will also be highlighted.

P-09  The Nurse Navigators’ Telepractice, an Evidence-Based Research.

Anne Plante, M.Sc.inf, CSIO, CSIP. Regional Cancer Care Center, Hôpital Charles LeMoyne, Longueuil, QC, Canada.

The goal of the symposium is to share the results of a study on nurse navigators’ (n=11) telepractice in nine oncology centers. Over a week, 1500 phone calls were reported and analysis of these phone calls provides us with many clues on how to recognize and restructure care settings. The nurse navigators’ role is in place in the province since 2001, and this role is well established in most of the cancer care programs in Quebec. This role was developed in order to better address patient’s/families’ desires to receive care that was responsible their needs. In spite of patient’s/families’ identified needs and the nurses’ abilities to respond adequately to these, their capacity to fulfill their professional responsibilities was limited by the volume of telephone calls. The objective of the research was to document the source and reason for telephone calls to nurse navigators from a variety of sources. This session aims to reveal the results analysed of this research. Findings were discussed amongst all nurses and administrators of the nine oncology centers. Implications for practice will be explored with the participants.

P-10  Transfusion Protocol: Saving More than Blood!

Pamela J. West, RN(EC), NP-Adult, MSc, CON(C), CHPCN(C), Cheryl Owen, RN, BScN, Karen Mayne, RN, BA, MA. Rouge Valley Health System, Toronto, ON, Canada.

Giving packed red cells to patients with transfusion-dependent anemias is not always easy, nor is it always safe. There are risks to the patient and to the system at large. Risks include transfusion reactions and the development of antibodies that parallel the frequency of transfusions. Blood transfusions are also costly, averaging about $1500 for every unit of blood collected, transported and delivered. Transfusions are time consuming, averaging 2.5 hours for each unit of packed red blood cells infused in addition to cross-matching and accessing patients’ intravenous sites. As well, transfusions are often given in ambulatory care settings such as chemotherapy clinics, utilizing valuable chair time. Therefore, to provide safe and standardized care, our hospital developed an evidence-based protocol which is now implemented with all transfusion-dependent patients. Nurses call patients whose haemoglobin is less than or equal to 90g/L and based on objective criteria determine if and when he/she will receive blood. After 15 months of using this protocol, the number of transfusions has decreased significantly. Patients seem to value participating in the decision about when to have their blood, and are more aware of symptoms that need to be monitored. Staff have been able to bring patients in at mutually convenient times by having discussions with each potential transfusion patient. Savings have been achieved in many ways: savings in time, talent and treasure! Satisfaction has been achieved in that patients are receiving quality care based on evidence and practitioners have successfully implemented a change.

P-11  Pivot Nurse for Northern Quebec: A Shared Project Targeting a Special Clientele

Eileen A. C. Curran, RN, MEd1, Mary Lou Kelly, RN, BA1, Andréanne Saucier, MSc.Inf1, Jacques Poliquin, DSP1
1McGill University Health Centre, Montreal, QC, Canada, 2Centre de Santé Tulattavik de l’Ungava, Tulattavik, QC, Canada.

For many years, our hospital center has been formally responsible for providing clinical services, education and teaching to far Northern regions of Quebec. Recently, cancer care has become a priority for the government of Quebec, who has committed to improving accessibility to patients in their communities. To provide oncology care to such a clientele poses special challenges. We believed a pivot nurse in oncology situated in the hospital center but working closely with the north would help. Working with our partners, we developed a job description for such a position. We planned for an interview process using tele-conferencing. Experience was particularly important for this role, as the nurse will work with many disease sites, and will work on all sites of the hospital centre and travel to the north to plan for some transition of care there. An orientation specific to her needs was developed by the team. She needed to make a
wide basis of contacts here in order to recruit patients and follow them through their individual trajectories of the disease process. This also necessitated building a bridge to the Northern Module which is the organization that oversees the patient stays in the Montreal community. It involved travel to the north to make those links. This nurse reports to both Nurse managers: local and northern, who share the administrative support role. It is a new and exciting initiative in cancer care.

P-12
LUNG CANCER, SMOKING CESSATION, AND THE CONCEPT OF “FASTING”: AN INNOVATIVE NURSING APPROACH

Stephanie Hooper, BScN, Christine Blais, BScN, Chantal Bornais, BScN, Jennifer Smylie, BN, Dr. Andrew Pipe, Dr. Robert Reid, Debbie Atiken, Kerri-Anne Mullen. The Ottawa Hospital, Ottawa, ON, Canada.

There is a well established link between cigarette smoking and lung cancer. Many smokers are aware of the health risks associated with tobacco and have considered cessation at some point. The benefits of smoking cessation are documented for cancer patients undergoing all forms of treatment; surgical complications occur less often, radiation side effects are less severe, and chemotherapy is more effective. Even though the time of diagnosis is a ‘teachable moment’ for smoking cessation and there are many available resources, it continues to be an enormous challenge for individuals. In a diagnostic assessment unit focusing on patients with lung cancer there is a vital role for a systematic smoking cessation intervention. In accordance with best practice guidelines from the provincial nursing association and assistance from the local cardiac center, a smoking cessation program was implemented at the clinic. Prior to program implementation baseline data demonstrated a natural six month cessation rate of 35%. This increased to 40% with an individualized nursing intervention. Through their experiences with the cessation program the clinic nurses have identified ‘fasting’ from smoking as an approach which is hypothesized to increase the cessation rate for individuals who are not ready to quit smoking. The adapted cessation program, the ‘fasting’ approach and a planned research project will be presented.

P-13
AN INTER-PROFESSIONAL APPROACH TO RAPID ASSESSMENT OF LUNG CANCER PATIENTS

Stephanie Hooper, BScN, Christine Blais, BScN, Chantal Bornais, BScN, Jennifer Smylie, BN. The Ottawa Hospital, Ottawa, ON, Canada.

In 2007, an estimated 23,300 Canadians will be diagnosed with lung cancer and another 19,900 will die from it. Only 10-15% of patients diagnosed with lung cancer are expected to survive the next five years. Timely and effective care in the diagnosis, assessment, and treatment of lung cancer patients is crucial to improving prognosis. The provincial government has recognized this in their mandate to reduce wait times and improve access to quality cancer care. In early 2007, the cancer assessment clinic for thoracic oncology was opened. The focus of this innovative unit is the coordination of care from referral to diagnosis through treatment planning and implementation, with the goal of streamlining cancer care services. The clinic has a patient centred inter-professional approach in which nurses play a pivotal role as coordinators of assessment and care planning. This often takes the form of facilitating communication between care providers, coordinating the delivery of information, improving communication of the treatment plan to all members of the team, individualizing the care pathway, and advocating for the patient and family needs. The nursing role in the clinic creates a strong basis for timely, effective, and high quality care for people newly diagnosed with lung cancer. The innovative model of care at the cancer assessment clinic, along with highlighted successes, barriers, and future directions will be discussed.

P-14
UPDATE OF THE BONE METASTASES PATIENT INFORMATION BOOKLET

Philiz Goh, BSc, BScN(C), Margaret Fitch, RN, PhD, Carlo DeAngelis, PhD, Edward Chow, MBBS. Odette Cancer Centre, Toronto, ON, Canada.

Purpose: To update an existing publication, Bone Metastases Patient Information Booklet (2004) so as to better meet the information and support needs of patients diagnosed with bone metastases (BM). Methods & Materials: An on-line survey was created and distributed to health care professionals (HCPs) who treat patients with BM at hospitals and cancer centres throughout Canada. Patients were asked for their feedback about the content and format of the publication as well as the use of the book. Additionally, ideas were taken from reviewing other cancer patient information booklets currently being distributed to patients. Each chapter was revised and reviewed by an expert in the particular topics. Standards of patient education were followed in preparing the final version. Results: Input from HCPs, patients, and other information sources were summarized and sorted to update and create the new BM Patient Information Booklet. The content includes facts about BM and the complications that may stem from metastatic spread. It also includes information on means of investigation; possible systemic treatments such as bisphosphonates, radiation, chemotherapy, surgery; and medications with their side effects and tips on how to control them. Complementary therapies, coping strategies, and community resources are just some of the other topics that have been updated in this booklet. Conclusion: Through patients’ and health care professional input, we were able to update, publish and distribute the new updated BM Patient Information Booklet to centres across Canada that treat patients with BM. This new booklet will assist patients by helping them understand and better cope with their diagnosis.

P-15
ONCOLOGY NURSES’ PRACTICE AND EDUCATIONAL NEEDS AROUND SEXUAL HEALTH
Catherine Doyle, BScN, CON(C), Kalli Stilos, MScN, CHPC(C), Pat Daines, MN, CHPCN(C). Sunnybrook Health Science Centre, Toronto, ON, Canada.

Sexual dysfunction is a common long-term consequence of cancer treatment, affecting half of survivors of breast and gynecological cancer as well as women treated for other cancers. It is important for health care professionals to understand how cancer patients live with the debilitating outcomes of treatments and how quality of life is subsequently affected. Health care professionals, including those utilizing a holistic approach to patient care, are hesitant about discussing sexual health issues with patients. Reasons for this include: the taboo nature of the topic; personal attitudes about sexuality; and lack of educational preparation, knowledge, and assessment skills needed for personal discussions about sexual health issues. Nurses play a pivotal role in assisting and influencing patients in regaining a sense of normalcy after a cancer diagnosis. Patients benefit from receiving information about the effects of their diagnosis/treatment on sexual function and nurses need to be equipped with the knowledge and skill to provide it. In a recent on-line survey, oncology nurses were asked about their clinical practice and educational needs around addressing sexual health with patients. This poster will: present the results of this survey; highlight barriers in addressing sexual health issues; discuss the role of oncology nurses in addressing patients’ sexual health; and present tools that help nurses initiate discussion and assist in conducting a sexual assessment.

P-16
PROVIDING ONCOLOGY CARE IN RURAL AND NORTHERN MANITOBA

Michelle Rosentreter, RN CON(C), Connie Randell, RN, Evelyn DeGrave, RN CON(C). CancerCare Manitoba, Pinawa, MB, Canada.

A diagnosis of cancer creates feelings of uncertainty and fear in the lives of those affected by the disease. For patients living in rural and northern Manitoba, a cancer diagnosis may mean leaving family, friends and community supports to receive the necessary care. CancerCare Manitoba (CCMB) is dedicated to enhancing the quality of life for those individuals living with cancer. The Community Cancer Programs Network (CCPN) is a CCMB program which facilitates the delivery of out-patient oncology care within the local community, which is as safe and comprehensive as the care received at acute care facilities in Winnipeg. Initiated in 1978 as a pilot project involving five communities, the CCPN program has grown to 16 rural and northern sites where patients can receive chemotherapy treatment and follow up medical and nursing care while remaining under the care of their primary oncologists. Nurses are prepared through specialized oncology education and training, with access to ongoing support, direction, and communication from the clinic and chemotherapy staff at CCMB. This presentation will highlight the orientation process of nurses new to the oncology specialty and discuss the advantages and disadvantages of rural oncology nursing as experienced by nursing staff at a CCPN centre in Pinawa, Manitoba. Special attention will be given to the positive effects this program has on the everyday lives of the population it is designed to serve.

P-17
SELF-DISCONTINUATION OF BAXTER INFUSORS FROM AN IVAD: ENABLING PATIENTS TO REGAIN CONTROL AND INDEPENDENCE IN THE TREATMENT OF THEIR CANCER

Shelley A. Dick, R.N. ConC., Seana E. Hutchison, RN, BsN. BC Cancer Agency/Fraser Valley Cancer Center, Surrey, BC, Canada.

The BC Cancer Agency Fraser Valley Center is open 0800 until 1800 Monday through Friday. The Fraser Valley Center covers an approximate geographic boundary of 1600 square kilometers. Currently, the center offers twenty five protocols involving continuous infusional chemotherapy which requires the patient to have a central line. At present, there is a policy in place that allows patients to self-discontinue from a PICC line. However, there is no policy in place or research to support the safety of self-discontinuation from an IVAD. The majority of patients receiving continuous infusional chemotherapy are colorectal patients. These chemotherapy regimens include a 46 hour, 5-FU infusion, via Baxter infusor. Currently, the center can book these patients Monday through Wednesday. Thursday or Friday bookings would result in a weekend completion and due to increased workload in the community, they are unable to accommodate this patient population. Allowing self-discontinuation of Baxter infusors from an IVAD will benefit the patient’s quality of life. Patients and families have voiced great satisfaction when participating in their care. They have expressed some potential benefits in terms of improvement in quality of life related to fatigue, increased independence and control over their lives. Patients on either UGIFOLFOX or GOLFIRI based regimens are eligible. Twenty to thirty patients will participate for 3 months (6 cycles). Criteria have been developed for the selection of suitable patients and to explore quality of life issues and safety related potential complications and maintenance of the lines. This research will attempt to show an increased satisfaction in care resulting in improved quality of life, with no increased incidence in regards to complications with the IVAD.

P-18
A NEW OUTLOOK AT OUR CANCER CENTER

Maura D. Eleuterio, RN, BScN, CON(c). The Ottawa Hospital Regional Cancer Center, Ottawa, ON, Canada.

When in the process of revising our Cancer Center expansion for the purposes of providing patient care, there were many aspects to consider. For example, the architectural framework, the facilities that will be incorporated, the necessary staffing, but most importantly was, “how can we improve our Cancer Center for our patients to better provide optimal quality care?” We
decided to distribute a questionnaire to our oncology patients, and especially for those who are newly diagnosed entering the cancer center for the first time. Questions that were included were, what were/are their expectations, what would they like to see or expect from the Cancer Center, or how can we help them feel more comfortable and at ease when facing this potentially traumatic and frightening situation? We were amazed at the feedback received, what patients considered as essential items in a day-to-day life were often overlooked by the Cancer Center staff. By obtaining and compiling this data we now have the potential to achieve our goal; to construct an environment for our patients that closely mimics their basic home atmosphere, which in turn provides them with a small amount of comfort and ease.

P-19
CHANGING PRACTICE TO MEET THE NEEDS OF THE POPULATION AT RISK

Julie Wilson, RN, BSc.N.; CON(C), Carmen Gosselin, RN, Elaine Walker, RN, CON(C), Christine Gloin, RN, B.A., CON(C), Angela Boudreau, RN, MN, CON(C). Odette Cancer Centre, Sunnybrook Health Sciences Centre, North York, ON, Canada.

Vascular status is integral to the safe delivery of chemotherapy. The use of Peripherally Inserted Central Catheters (PICC) has become increasingly more common, considering variables such as ease of insertion, cost, and complications (Moreau, N., 2006). With the increased use of PICCs, challenges in caring for the line have become more apparent, specifically the use of antiseptic cleansers and their impact on skin integrity. In the home infusion department of our ambulatory cancer centre, there was an observed increase in skin reactions in our patient population receiving continuous Fluorouracil. The skin reactions were initially managed by changing the dressing type and applying topical cortisone cream. This met with minimal success. Changing the cleansing solution from Chlorhexadine to sterile Normal Saline, and maintaining sterile technique with the dressing change had positive results. This change in practice has resulted in a decrease in skin reactions and no noted increase in the rate of infection. This poster will illustrate the care path designed to maintain the skin integrity of patients with PICC lines.

P-20
CANCER AND ITS TREATMENT: IMPACT IN THE PATIENTS’ LIFE

Maria Gaby R. Gutierrez, Professor, Tais C. Arthur, nurse, Maria Clara C. Matheus, Professor, Selma M. Fonseca, Professor UNIFESP, São Paulo, Brazil.

Cancer and its treatment: impact in the patients’ life
Introduction: Studies shows that both the diagnosis and treatment affect significantly the patients’ life. Objective: To understand the meanings attributed by patients to receiving a cancer diagnosis and its treatment and identify the influence of age, gender and the localization of the tumor in that life experience. Method: Descriptive study with a predominantly quantitative approach. After the Ethics Committee approval, data was collected from June 2006 to March 2007 by interviewing 22 outpatients treating breast, lung and bowel cancers at a hospital in São Paulo city - Brazil. The data from the interviews was analyzed according to the Bardin technique and the categories that emerged were submitted to a quantitative descriptive analysis. Results: The categories related to receiving the diagnosis were: trying to rationalize the impact and living the unexpected. As for the disease process and treatment, the main categories were: suffering with the physiological and psycho-social changes, finding strength to cope with the disease, having the support of significant people and turning to God. Women and younger patients answered more positively to receiving the diagnosis of cancer and functional repercussions were more frequently mentioned by women, patients aged from 50 to 64 years old and with lung cancer. Conclusion: The repercussions of cancer and its treatment are multidimensional and can be influenced by gender and age.

P-21
IMPROVING NURSE-PATIENT COMMUNICATION RELATED TO SYMPTOM ASSESSMENT AND MANAGEMENT FOR GYNECOLOGIC ONCOLOGY PATIENTS

Joanne Power, RN, MScN. McGill University Health Centre, Montreal, QC, Canada.

Cancer patients’ quality of life is affected by symptoms they experience related to their disease and/or its treatment(s). Communication between nurses and patients is key to helping patients manage their symptoms. If nurses are not confident in assessing symptoms and providing symptom management strategies to patients. In addition, there was no consistent method for symptom assessment and documentation on the unit. A project was developed to provide nurses with information and the appropriate tools to address symptom assessment and management. The goal of project was to improve nurse-patient communication related to symptom assessment and management. The objectives for the project were: 1) to provide nursing staff with information about chemotherapy-related symptoms and symptom management strategies in order to increase their confidence with providing symptom management strategies to patients and their families and: 2) to support staff in the selection and implementation of a symptom assessment tool to be used with patients undergoing chemotherapy treatment. A chart audit two months after implementation of the symptom assessment tool showed it was used for 100% of patients receiving chemotherapy. Focus groups with nurses found they are satisfied with using the tool, and they feel more confident in providing symptom management strategies to patients.
P-22

DEVELOPING CLINICAL PRACTICE: A REVIEW OF SIDE EFFECTS ASSOCIATED WITH RADIATION THERAPY IN THE HEAD AND NECK CANCER PATIENT

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Carcinomas of the head and neck affect thousands of Canadians every year. Common sites for these cancers are the throat, oral cavity, face and neck. Radiation therapy is very important in the management of head and neck cancer. It can be used as primary treatment, adjuvant treatment, or as a palliative measure depending on tumor type, location, and stage of the cancer at time of diagnosis. Radiation treatment for any cancer can cause painful side effects, however in the patient with a cancer of the head and neck, these side effects can often be debilitating. Given the site of these cancers, high doses of radiation are delivered directly to vital areas such as the face, mouth and throat. Patients often report dysphagia, stomatitis, xerostomia, and painful burns to the treated area. More severe side effects of laryngeal edema and stenosis have also been documented. Because of these side effects, patient's nutritional status suffers, their body image is impaired, and their overall health can rapidly decline. During this time patients and their families require extensive education, preparation, support, and guidance. The nurse is often the first point of contact for patients receiving radiation therapy and therefore should be well equipped to help manage side effects. The purpose of this presentation is to help nurses understand the impact that radiation therapy can have on this specific group of individuals, discuss common side effects experienced in the head and neck patient, and also discuss management and treatment options for these side effects.

P-23

CHARTING IN THE 21ST CENTURY: ELECTRONIC CHARTING OF TREATMENT TOXICITY IN AMBULATORY ONCOLOGY CARE

Karen D. Hough, RN, Yvonne Finnegan-Smith, BScPsych, RN, Alan Besecker, BScPsych, RN, Susan Horsman, RN,BScN,MN(Student). Cross Cancer Institute, Edmonton, AB, Canada.

Assessing toxicities thoroughly is an essential component in the delivery of safe nursing care to patients in an oncology setting. Documentation of the assessment, intervention and outcome should also be complete and timely. Share with us our journey into the 21st century as electronic charting meets toxicity and intervention assessments. We’ll review the route we have taken at our tertiary care centre, from our teamwork with information management in developing a common toxicity list for our pilot group, to the practicality of using online assessments in real-time, and the use of this data in multidisciplinary case management. We’ll talk about some of the challenges we have overcome, and look to the future of expanding this method of toxicity and intervention documentation throughout outpatient oncology clinics at our facility.

P-24

ADVANCED PRACTICE NURSING IN ACTION: SHAPING NURSING PRACTICE FOR WOMEN DEALING WITH BREAST CANCER


Advanced practice nurses have the ability to influence the care of patients and impact positively on outcomes in varied ways. A quality improvement initiative undertaken in River Valley Health (RVH) exemplifies the varied ways that one Clinical Nurse Specialist (CNS) has enhanced patient care and supported colleagues in practice. The RVH Surgical Program raised concern that gaps in care existed for women having out-patient breast surgery instead of the traditional approach of admission for surgery plus several days of hospitalization. The RVH Surgical Program invited the CNS, Oncology to collaborate with them to identify gaps and address them as appropriate. The ability of advanced practice nurses to critically examine issues such as gaps in care and then use the obtained information to influence care delivery became evident. The in-depth knowledge that the CNS, Oncology contributed about breast cancer and its impact on women dealing with it fostered a broader discussion beyond just the surgical time period. Furthermore, the CNS stimulated interest in receiving direct feedback from women about their perceived gaps. The CNS spearheaded the development of a patient satisfaction questionnaire, and provided the needed knowledge to implement the questionnaire, analyze the data, and interpret the findings based on the literature and best practice. Goals of the project were measured based on change in physician practice, consensus about best practice for post-op physiotherapy, and timely access to appropriate physiotherapy assessment and intervention. Clinical practice outcomes promoted discussion about the role of the CNS in the care of women dealing with cancer during the surgical time period. The CNS, Oncology uniquely contributes to the surgical care of women dealing with breast cancer through unique contributions such as fostering coordinated care from one phase of the cancer experience to another, across settings and from a systems level perspective, and providing leadership in translating research into practice. This presentation will describe how the CNS through her in-depth knowledge, understanding of the research process, and awareness of the broader issues involved in care of women dealing with breast cancer positively impacted on the care delivered to these women dealing with breast cancer.

P-25

EVALUATING THE NURSE PRACTITIONER (NP) ROLE IN AN AMBULATORY TERTIARY CANCER CENTRE

Marie-Josée Paquin, Jill Bateman, Reanne Booker, Stephanie Hubbard, Linda Watson. Alberta Cancer Board/Tom Baker Cancer Centre, Calgary, AB, Canada.

Successful introduction of NP roles is a complex and challenging process (Bryant-Lukosius et al., 2004). Also, there is a paucity of research investigating oncology NP outcomes (Lynch, Cope &
Murphy-Ende, 2001; Lynch 2004; Cunningham, 2004). In order to design an evaluation framework, initial measures related to the implementation of the role of the NPs involved within the hematology and blood & marrow transplant (BMT) program was conducted.

Purpose
- To describe the clinical work of the Hematology and BMT NPs
- To gain insights into the views of staff regarding the role implementation.

Patient Attendance and NP Interventions
Methodology (quantitative data): Retrospective dictate notes reviewed with a validated data extraction form retrieving the following data:
- Number of patients seen
- Number of visits per patient
- Type of interventions (e.g., procedural, investigational, therapeutic, counseling & education)
- Referral pattern

Staff Satisfaction
Methodology (quantitative and qualitative data): Surveys of colleagues requesting their views related to the role implementation and its impact on patients, families, and the team (convenience sample).

Results will provide helpful directions in designing an evaluation framework specific to NP practice at an ambulatory tertiary cancer centre.

P-26
THE ESTABLISHMENT OF A COMPREHENSIVE PATIENT EDUCATION PROGRAM
Cathy L. Bennett, BScN, MEd. Juravinski Cancer Centre of Hamilton Health Sciences, Hamilton, ON, Canada.

Education is vital to help oncology patients manage their health needs and enable them and their family members to participate in service delivery and decision-making. This presentation outlines the development of a comprehensive patient education program within a regional cancer program designed to meet the complex information needs of cancer patients and their families. Recommendations for development of the program are based on the Cancer Care Ontario (CCO) evidence-based report Establishing Comprehensive Cancer Patient Education Services: A Framework to Guide Ontario Education Services released in 2006.

Our regional cancer program began the process of developing a patient education program by conducting an environmental scan from March to June 2007 to examine the present status of patient education services and determine future needs. Recommendations designed to enhance our present education services, by building the necessary organizational structure and processes of a comprehensive patient education program, will be discussed. Our new patient education program model will also be introduced. It is an exciting time for the specialty of patient education. With the establishment of the CCO provincial framework, CCO’s leadership in patient education, and an increasing demand of patient involvement in decision-making, one would expect more enhanced cancer patient education programs to develop across Ontario in years to come. This is a timely opportunity for our regional cancer program to participate in a comprehensive provincial program and to build on its own historical commitment to excellence in patient education.

P-27
TISSONS DES LIENS
Johane Pelletier1, Nicole Plante1, Francine Koëng1, Dany Fortin1, Léo Cantin1,2. 1Cha-Hôpital de l’Enfant-Jésus, Québec, QC, Canada, 2Fondation québécoise du cancer, Québec, QC, Canada.

Les tumeurs cérébrales ne totalisent qu’environ 3 % de l’ensemble des cancers. Son taux élevé de morbidité et mortalité représente un défi pour le personnel soignant. Les patients, leurs familles, et le personnel soignant ont besoin de soutien et d’information lors de la prise de décision et du retour à domicile. En phase aiguë, répondre aux besoins spécifiques de ces patients, n’est-ce pas la principale force des infirmières ouvrant en milieu hospitalier universitaire ? Par contre, lors du retour à domicile, comment poursuivre cette aide « spécialisée » pour une maladie plutôt rare ? Pour combler ce vide, une équipe interdisciplinaire en oncologie neurologique, a planifié la création d’un groupe de soutien et d’information pour les personnes atteintes d’une tumeur cérébrale et leurs proches. Consciente qu’elle ne pouvait y arriver seule, un partenariat s’est alors créé avec un organisme communautaire en oncologie. La création de ce groupe de soutien, issu de ce partenariat, permet maintenant aux infirmières soignantes, aux infirmières-pivots et aux infirmières de l’organisme communautaire de référer leurs patients à ce nouveau service. En effet, depuis septembre 2007, la clientèle bénéficie d’une rencontre mensuelle couvrant les volets - information - soutien et partage avec les pairs.

Agréablement surpris par les résultats obtenus, nous ne pouvons qu’espérer partager un tel projet où la complémentarité entre un milieu « scientifique » et un milieu « communautaire » engendre de réelles retombées positives pour l’ensemble de la clientèle et leurs proches.

P-28
EVALUATION OF THE PSYCHOMETRIC PROPERTIES OF A FRENCH ASSESSMENT TOOL FOR STOMATITIS SEVERITY (WCCNR)
Nicolle Allard, Pamphile Nkogno Mengue. Université Du Québec À Rimouski, Lévis, QC, Canada.

Stomatitis, is a common and devastating complication of cancer therapy. Incidence levels range from 10% to 90%. Risk factors for this symptom include the treatment regimen, schedule, and the use of radiation therapy. It can involve treatment delays or reduction, severe pain, infections, emotional distress, and altered morbidity and mortality. Currently, the WHO scale is widely used by clinicians but there is no evidence of its validity or reliability. The Western Consortium for Cancer Nursing Research (WCCNR) developed of a new tool, the WCCNR Stomatitis Staging System. The 3-item (English AND French) instrument was found to be a reliable and valid. Then, a fourth item, humidity, was
added to increase its psychometric properties. The purpose of this new study is to address the validity and reliability of the 4 items French version of this tool to be used Canada-wise. Factor analysis was done to assess the validity of the 4 factors scale. Item total correlation evaluation was used to establish the internal consistency of both the instrument. Weighted Kappa or intra-class correlation coefficients were also used to test the instruments’ inter-rater reliability to take into account chance agreement. The concurrent validity of the instruments was tested by correlating the scores of the WCCNR with the WHO scales. Patients were tested at different times in their scheduled treatment to obtain various degree of stomatitis. These preliminary findings will be used to assess the 4 items English version of this scale and seek funding to develop a complete systematic program to detect and treat stomatitis early into treatment and into the illness trajectory.

**P-29**
**The Role of the Nurse and the Impact on Patients’ Experience with Hind Quarter Amputation**

JoAnne Pacione, RN, Christina Fabbruzzo-Cota, RN, BScN, MN, CON(C). Mount Sinai Hospital, Toronto, ON, Canada.

The Sarcoma program, located in Toronto, is the largest multidisciplinary program of its type in Canada. The Sarcoma team uses a holistic patient and family centered approach to meet the challenging needs of their cancer population. Nurses play an integral role in the challenging journey that takes a Sarcoma patient from initial diagnosis and staging, through the aggressive treatment regimen of radiation/chemotherapy, often followed by limb-salvage surgery and rehabilitation. When limb-salvage surgery is not a possibility, a hind-quarter amputation may be one of the options for the treatment of sarcoma. This is a rare option. The severe impact of the loss of the limb is often not realized by the patient until the post-operative phase. These extraordinary people are faced with exception challenges. Patients must cope with grief and changes to self-esteem, body-image, independence and mobility, and role function. Further, pain and post-operative complications are often experienced. Clinical staff nurses physically and psychologically support the patient and family through these difficult life changes. A literature review results in a clearer understanding of the nurse’s knowledge and understanding of the unique role they play in their patients’ cancer journey. Further discussion and transfer of this knowledge with nursing and the interdisciplinary team will aid in the ongoing development of best practice initiatives, consistency and enhanced patient care specific to the cancer patient requiring hind quarter surgery. Finally, a case study reviewing a post-operative patient requiring hind quarter surgery for treatment of sarcoma will be reviewed using Roy’s Model of Adaptation.

**P-30**
**The Establishment of a Comprehensive Patient Education Program**

Cathy L. Bennett, BScN, MEd. Juravinski Cancer Centre of Hamilton Health Sciences, Hamilton, ON, Canada.

Education is vital to help oncology patients manage their health needs and enable them and their family members to participate in service delivery and decision-making. This presentation outlines the development of a comprehensive patient education program within a regional cancer program designed to meet the complex information needs of cancer patients and their family members. Recommendations for development of the program are based on the Cancer Care Ontario (CCO) evidence-based report Establishing Comprehensive Cancer Patient Education Services: A Framework to Guide Ontario Education Services released in 2006. Our regional cancer program began the process of developing a patient education program by conducting an environmental scan from March to June 2007 to examine the present status of patient education services and determine future needs. Recommendations designed to enhance our present education services, by building the necessary organizational structure and processes of a comprehensive patient education program, will be discussed. Our new patient education program model will also be introduced. It is an exciting time for the specialty of patient education. With the establishment of the CCO provincial framework, CCO’s leadership in patient education, and an increasing demand of patient involvement in decision-making, one would expect more enhanced cancer patient education programs to develop across Ontario in years to come. This is a timely opportunity for our regional cancer program to participate in a comprehensive provincial program and to build on its own historical commitment to excellence in patient education.
and overall function. Increasing age was associated with lower levels of physical, role, social and overall function at both 6 and 12 month followup. Findings suggest that most older adults with cancer maintain function levels during and following cancer treatment; however, older women and subjects with advanced age are more likely to have functional deficits that may indicate need for increased health care support.

P-32
THE RELATIONSHIP BETWEEN SYMPTOMS AND FUNCTION IN OLDER ADULTS WITH CANCER

Marian F. Luctkar-Flude1, Dianne Groll, RN, PhD2, Linda Robb-Blenderman, RN, MSc1, Esther Green, RN, BScN, MSc(T)3, Joan Tranmer, RN, PhD4.
1Kington General Hospital, Kingston, ON, Canada, 2Queen's University, Kingston, ON, Canada, 3Providence Care, Kingston, ON, Canada, 4Cancer Care Ontario, Toronto, ON, Canada.

This prospective, longitudinal study describes the relationship between symptoms and functional well-being in a cohort of older cancer patients. 440 subjects aged 65 years and older were recruited following consultation for treatment at a regional cancer centre and completed baseline surveys. The Memorial Symptom Assessment Scale (MSAS) was used to measure symptoms. The Physical Component Summary (PCS) and Mental Component Summary (MCS) subscales of the Medical Outcome Short Form 12 (SF 12) were used to measure cancer related function. The most prevalent symptoms reported at baseline were lack of energy (68.6%), difficulty sleeping (56.4%), worrying (54.1%), feeling drowsy (53.4%) and pain (52.5%). Mean symptom scores generally declined over the course of the year. PCS and MCS scores and the EORTC subscale scores for role function, social function and global quality of life generally improved over the course of the year. Physical function declined by 6 months and returned to baseline at 12 months. Higher baseline symptom scores were associated with poorer function on most subscales at 6 and 12 month follow-up.

P-33
NEUTROPENIA IN CHILDREN WITH CANCER: MEANING AND NEEDS AT HOME BY CAREGIVERS

Maria Gaby R. Gutierrez, Professor, Débora D. Gelesson, student, Liliane Y. Hiraishi, student, Leticia A. Pereira, student, Sonia Regina Pereira, professor, Edvane B. L. De Domenico, professor. UNIFESP, São Paulo, Brazil.

Introduction: The antineoplastic chemotherapy-induced neutropenia can increase the morbidity and mortality of patients, the family should receive guidelines for caring at home. Objectives: 1. Understand the meanings assigned by caregivers on the process of caring for a neutropenic child at home; 2. Meet the needs of guidelines for the care of these children at home. Method: Descriptive, qualitative study, held at the Institute of Pediatric Oncology (IOP-GRAAAC), in the city of Sao Paulo (SP, Brazil), after submission to the Ethical regulations. Data were collected (October 2007) through a semi-structured interview, with eleven caregivers of children with cancer in chemotherapy treatment. Data were organized according to the technique for analysis of content and interpreted from the reference of Theoretical Social Representations. Results: Process of taking care of the child was described as a generator of changes: in the physical environment, in people and in human relationships. Statements showed the phases of crisis and transition to stability that caregivers face, the positive and negative aspects. Care that generated questions were: management of hyperthermia, body care, environment and food, risk of interpersonal contact and special care (central venous catheters, probes). Conclusion: Results indicated the need of preparing caregivers for confronting the difficulties pointed out, including technical and emotional preparation of worsening conditions. Keywords: Education, Pediatric, Neutropenia, Nursing.

P-34
POLI: PEDIATRIC ONCOLOGY LEARNING INITIATIVE

Jennifer A. Brinklow, BScN, Brennah Holley, BScN, Cindy Cook, RN, Rosemary Horlin, BScN, M.Ed CON (C). Children's Hospital of Eastern Ontario, Ottawa, ON, Canada.

The purpose of POLI wasto replace an existing outdated ‘self-learning module’ with a didactic based pediatric oncology curriculum. This would provide a standardized knowledge base for all pediatric oncology nursing staff. POLI was started in the spring of 2006 by three inpatient nurses. The APHON curriculum was selected and adapted for our Canadian institution by an interdisciplinary team. The goal: 85% of inpatient and 75% of outpatient nursing staff would complete the curriculum within a one year period. The course was presented by an interdisciplinary team covering the history of pediatric cancer, clinical trials, common pediatric malignancies, principles of chemotherapy, oncological emergencies, and supportive care totaling 16 hours of education. The outcome after presenting the POLI core curriculum 5 times within 12 months was 97.5% participation rate by inpatient staff and 28.1% participation rate by outpatient staff. Upon completion of POLI, which is now mandatory, new nursing staff are able to work towards attaining chemotherapy administration competencies, developed in reference to CANO core competencies. Staff members have expressed increased confidence in their knowledge of, and in caring for the pediatric oncology patient.

P-35
LYMPH Listens - A COMMUNITY BASED REPORT ON LIVING WITH LYMPHEDEMA IN ONTARIO

Susan Bowles, BScN, RN1, Anna Kennedy2.
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Lymphedema is a chronic condition that many cancer survivors...
say is a more devastating diagnosis than cancer itself. Cancer has a beginning and an end, whereas lymphedema goes on indefinitely for life.

The LYMPH LISTENS project was a community based project with funding from the Canadian Breast Cancer Foundation - Ontario Chapter. Its purpose was to gain a clear, objective and thorough understanding of what the needs were within the lymphedema community. The project goals were:
• To learn more about how breast cancer survivors were living with lymphedema in Ontario and coping with the disease and what programs, services and initiatives they regarded as essential.
• To build a strong knowledge base by identifying, documenting and analyzing what services, support and educational material are available to breast cancer survivors, lymphedema patients and health care professionals working with lymphedema.
• To identify and document gaps between the community identified needs and the services and information available.
• To develop a decision matrix tool for use in determining future project activities that would have a significant impact on the quality of life for breast cancer survivors and lymphedema patients. This poster presents the framework for the study including the context, stakeholders, tools and methodology, key learnings and recommendations.

P-36
IN MEN RECEIVING ADT FOR PROSTATE CANCER, WHAT IS THE EFFECT OF COGNITIVE OBJECTIVE INFORMATION (COI) AND EXERCISE, IN COMPARISON TO UsUAL CARE, ON FATIGUE?

Lia Kutzscher, RN(EC), MSn, CON(C), AOCNP, PhD (student).
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In Canada, over 47% of men diagnosed with prostate cancer are over the age of seventy with the majority diagnosed over the age of sixty (Canadian Cancer Society/National Cancer Institute of Canada [CCSNCIC], 2007). Improvements in early detection and treatment has led to increased five-year survival rates and a decline in mortality rates leading to a higher number of older men living longer with this chronic disease (CCSNCIC, 2007).

Androgen deprivation therapy (ADT) has become a standard treatment provided to men with prostate cancer (Cancer Care Nova Scotia [CCNS], 2006; National Comprehensive Cancer Network [NCCN], 2007a; Cancer Care Ontario [CCO], 2003). The goal of ADT is to reduce the levels of circulating testosterone to suppress the growth of prostate tumor delaying the progression of disease. Although ADT in specific clinical situations has been reported to be efficacious (Kumar et al., 2006; Aibhai et al., 2006), it is not without side effects including fatigue, diminished muscle strength, and sarcopenia. This loss of energy may impair physical performance further reducing normal activity tolerance creating higher levels of fatigue, diminished functional capacity and subsequent debilitating comorbidities (i.e., osteoporosis, cardiovascular disease, obesity, and diabetes), reduced independence, a reduced sense of well-being and diminished overall quality of life (QOL) (Blanchard, Baker, Denniston, et al., 2003; Schag, Ganz, Wing, Sim & Lee, 1994). The effect of exercise on fatigue has been tested most often in the young breast cancer patient population using high intensity aerobic exercise.

Drouin (2004) notes that a diagnosis of cancer in combination with aging contributes to functional losses that exceed those related to aging. An exercise intervention that takes into account these functional changes and targets the unique needs of the older adult with a chronic disease would be more feasible in the prostate patient population. This poster presentation will provide an overview of a theory based tailored cognitive objective information and exercise intervention on preventing fatigue in the older prostate cancer patient receiving ADT.

P-37
PROPHYLACTIC TREATMENT OF RADIATION INDUCED DERMATITIS: A FEASIBILITY STUDY

G. Anne Hughes, RN, BSN, MN(C), CON(C)1, Frankie Goodwin, RN, BN, June Blanchini, RN, CON(C)2.

In 2007, over 500 patients with head and neck cancer were treated with radiation therapy (RT) at the study institution. Skin toxicity is a major problem in patients receiving RT and can lead to infection and pain. The onset of radiation induced dermatitis can be observed during the early phase of treatment and may impact quality of life. Severe reactions can interfere with the patient’s ability to adhere to treatment, ultimately reducing its efficacy. Currently, the standard for RT skin care at the study institution includes promoting cleanliness, avoiding irritants and maintaining hydration of the skin by applying a moisturizing cream. No other prophylactic measures to decrease severity or prolong time to onset of RT dermatitis are currently recommended. In order to investigate potential prophylactic interventions, a feasibility study was conducted by a multidisciplinary team within a provincial cancer agency. The study objectives included evaluating the effect of silver sulfadiazine compared to standard care and standard care plus saline compresses on skin integrity and quality of life. In addition, acceptability and feasibility of proposed recruitment strategies, intervention protocols and compliance issues were examined. Over one year, 64 patients were recruited to the study from four cancer centres. Data was collected using the Skin Toxicity Assessment Scale and the SF36 quality of life instrument. The outcomes of this research could provide much needed evidence to inform oncology nursing practice. This poster presentation will illustrate the study design and findings.

P-38
THE INFUSION OF AUTOLOGOUS STEM CELLS BY REGISTERED NURSES

Kristen L. Brazel, Bachelor of Science in Nursing1, Erin E. Mutterback, Bachelor of Science in Nursing2.
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The purpose of this poster is to describe the procedures used for the safe infusion of autologous stem cells (ASC) by clinical hematology nurses. This procedure allows nurses to work within their full scope of practice, combining both theoretical and clinical skills throughout the transplant process. Resource allocation, educational strategies and clinical outcomes will be illustrated. Specialized education was developed incorporating theory, policies and procedures and a clinical practicum. The education session addresses safety issues related to the stem cell infusion including: temperature monitoring of water bath, length of time between the chemotherapy administration and infusion and patient monitoring for risks of a DMSO reaction. A core group of experienced hematology nursing staff have been educated to perform ASC transfusions. The critical factors necessary to make this program a success include an interdisciplinary approach, implementation of specialized knowledge and skill and adherence to accreditation standards. An evaluation of the current ASC infusion program will be demonstrated by analyzing feedback forms from staff as well as performed audits.

P-39
**CONTACT DERMATITIS AND PERIPHERALLY INSERTED CENTRAL CATHETERS: A CONUNDRUM**

Lia I. T. Kutzscher, RN(EC), MScN, CON(C), AOCNP, PhD (student)\(^1\), Pamela Savage, RN, MAEd., CON(C)\(^2\). \(^1\)Royal Victoria Hospital, Simcoe Muskoka Regional Cancer Program, Barrie, ON, Canada, \(^2\)University Health Network, Princess Margaret Hospital, Toronto, ON, Canada.

In oncology nursing, skin rashes are a common phenomena found in patients receiving cancer treatment. Over the last several years, oncology nurses have identified a skin irritation localized to the dressing area and insertion site of peripherally inserted central catheters (PICCs) in patients receiving fluorouracil based chemotherapy protocols. The initial rash presentation is confined to the area of the dressing and manifests as a scalded skin appearance (burn) with papules and/or vesicles on an erythematous patchy background with possible weeping and/or edema present. The rash is often preceded by a burning sensation in the area exposed to chlorhexidine gluconate antiseptic used to cleanse the skin around the PICC insertion site during dressing changes. A thorough history and evaluation of the skin by nurses is essential in order to successfully treat the affected area while maintaining PICC securement and access, preventing infections and optimizing patient comfort. Oncology nurses at several institutions have successfully implemented various interventions that promote healing within 24 to 48 hours. The most common intervention has been the elimination of chlorhexidine gluconate and the transparent dressing suggesting the skin reaction is likely a contact dermatitis. The absence of contact dermatitis type reactions in other patients with PICC devices not receiving fluorouracil and the rapid resolution of the rash has led nurses to hypothesize the rash may be the result of an interaction between chlorhexidine and fluorouracil leading to increased sensitivity of the skin. A literature review has yielded no findings on this topic and has raised the question: In patients receiving fluorouracil chemotherapy, what is the effect of Chlorhexidine gluconate skin antiseptic on the incidence of irritant contact dermatitis? This presentation will discuss the importance of oncology nurses sharing observations of patients’ reactions to treatments, sharing interventions to resolve side effects and underscore the importance of collaborative practice to encourage nursing research to validate expert opinion and promote evidence-based nursing care.

P-40
**LES SOINS DE FIN DE VIE: L’EXPÉRIENCE VÉCUE PAR DES INfirmières DANS UN CONTEXTE DE SOINS CURATIFS**

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Selon le rapport État de la situation des soins palliatifs au Québec de Lambert et Lecompte (2002), plus de 90% des personnes en phase terminale meurent dans les hôpitaux et la majorité d’entre elles sont soignées dans des unités non spécialisées en soins palliatifs. Pour des infirmières qui travaillent dans ces unités dites « de soins curatifs » et qui doivent prendre soin de personnes en fin de vie, il s’agit là d’un contexte dont la philosophie de soins, centrée sur la guérison et la sauvegarde de la vie, contraste de façon marquante avec celle préconisée dans les soins d’accompagnement en fin de vie. Une étude phénoménologique a été menée dans le cadre d’un mémoire de maîtrise afin d’explorer le sens accordé à l’expérience de prendre soin de personnes en fin de vie pour des infirmières oeuvrant sur des unités de soins curatifs. Les résultats de cette étude nous indiquent que cette expérience est tout aussi enrichissante qu’elle est déchirante pour les infirmières. Ces résultats nous aide à mieux comprendre ce que vivent les infirmières et ainsi offrent des pistes de réflexion afin d’améliorer le soutien et la formation en soins palliatifs pour les infirmières qui œuvrent dans un contexte de soins curatifs.

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**BRINGING IT HOME, A PALLIATIVE CARE EDUCATION WORKSHOP FOR THE FRONTLINE WORKER**

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A need was identified on the acute care Oncology unit at the Saint John Regional Hospital, for palliative care education for the frontline worker. No formal education program existed in Atlantic Health Sciences Corporation. Through reseach a Palliative Care Front-Line Education program was discovered to be available through Cancer Care Nova Scotia at Capital Health QELL. Becoming one of the first out of province participants in May 2007, I was able to become a facilitator and bring the program to New Brunswick. In September 2007 with co-facilitator Debbie Neil, this program was presented in Saint John. Due to the success with our 64 participants (recommended limit...
was 60) representing several disciplines and expert presenters, this program has been accepted by the New Brunswick Cancer Network and is being translated into the French language. With this initiative, the program will be both accessible and available to other facilities throughout the province. One Nurse can make a difference!

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BIBLIOMETRIC REVIEW: THE EDMONTON SYMPTOM ASSESSMENT SCALE (ESAS)

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BACKGROUND: The Edmonton Symptom Assessment Scale (ESAS) is a simple patient assessment tool that is routinely used in many countries around the world. AIMS: We are studying the uptake and use of the ESAS over time, by geographical locale and by professional groups, as evidenced by citations within peer-reviewed and “grey” literature. METHODS: Bibliometric methodological studies can plot uptake of new knowledge, over time, by evaluating how key articles are cited in published literature. Using ten standard databases including Medline, CINAHL and others, we identified papers where the tool was first cited. The radar graph (spider web) analysis technique includes an examination of: the pattern of citation statistics, year and frequency, subject disciplines of the citing works’ journals, and other domains. RESULTS: A preliminary analysis indicates a rapid and multinational uptake of the tool, evidenced by its citation within diverse specific clinical settings, professional groups and countries. Analysis of factors that appear instrumental to the successful launch and uptake of the ESAS within academic and clinical communities will be presented. CONCLUSIONS: The intended outcome of this research is to identify communities of practice associated with the early adoption and publication of this effective symptom assessment tool in order to identify attributes of effective diffusion of innovation, to inform future programs of knowledge transfer in palliative and end of life care.

P-43
THE SCOOP ON POOP, TEACHING A NATION ABOUT A NOVEL THERAPY IN TREATING REFRACtORY OPIOID-INDUCED CONSTIPATION

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This presentation describes the collaborative process of developing interprofessional health care education for Methylaltrexone (MNTX), a new therapy for treating refractory opioid-induced constipation (OIC) in cancer patients. Constipation is a frequent and persistent side effect of opioid treatment negatively affecting quality of life. As disease burden grows and symptoms intensify, conventional laxatives may be rendered ineffective or become burdensome because of polypharmacy or side effects. A recent systematic review of peripheral opioid receptor antagonists supports how MNTX acts on the gut’s myenteric plexus by blocking opioids from mu receptors. Analgesia is preserved because MNTX is neither absorbed systemically, nor does it cross the blood brain barrier (1). Food and Drug Administration Canada accelerated approval of MNTX for the treatment of refractory OIC in palliative care patients. How do clinicians manage refractory OIC now and where does MNTX fit into current treatment algorithms? In 2007, medical, nursing and pharmacy Advisory Boards were established to seek direction from leaders on current practice and challenges in managing OIC. Data acquired from multiple sources guided an interprofessional team to develop a national guideline on OIC assessment and management, including the role of MNTX. A national education program was developed considering educational needs of different disciplines working in urban, community, and rural settings. MNTX will be released in Canada in August 2008. 1 Becker, G., Galandi, D. and Blum, H. (2007). Peripherally acting opioid antagonists in the treatment of opiate-related constipation: A systematic review. Journal of Pain and Symptom Management, 34 (5), p 547-65.

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TLS: WHAT NURSES NEED TO KNOW

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Tumor lysis syndrome (TLS) is a potentially life threatening oncological emergency. It is a constellation of symptoms ranging from hyperkalemia, hypocalcemia, hyperphosphatemia and hyperuricemia putting the patient at risk for renal failure and cardiac dysfunction (Cantril & Haylock, 2004; Doane, 2002). TLS most commonly occurs as a result of chemotherapy-induced electrolyte and metabolic disturbance, but some malignancies alone have the potential to cause TLS. Many patients remain susceptible to consequences of TLS either because of lack of vigilant patient monitoring and identification OR simply due to unpredictable patient responses to treatment. Nurses have a critical role in patient care - including patient and family education; the initiation of prophylactic strategies and intense monitoring. These interventions can mean the difference between life and death for patients. In addition to early identification of and intervention for symptoms of TLS, it is crucial the nurse increase their knowledge of and emphasize prevention of complications of therapy. Knowing the population at risk for TLS can help the nurse to formulate a plan of care, identify signs and symptoms which may provide clues, and initiate prompt interventions to prevent and treat this serious complication of cancer treatment (Hoffman, 1996). This poster will review/outline TLS incidence and epidemiology, pathophysiology, clinical manifestations, management, and nursing consideration.

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FEBRILE NEUTROPENIA - A GUIDELINE AND CLINICAL ALGORITHM
Neutropenia is the most common dose-limiting toxicity in myelosuppressive chemotherapy, and has been recognized for many years as the major risk factor for the development of infections in this population. Since the neutropenic patient is unable to mount an inflammatory response to invading bacteria, fever is often the only sign or symptom of infection. Febrile neutropenia is an oncological emergency, and requires immediate attention. These patients must be promptly assessed by a nurse practitioner or physician, have a septic work-up performed, started on empiric intravenous antibiotics, and admitted to hospital. The care of the febrile neutropenic patient is complex, thus standardization of care is helpful. “Guidelines for Infection Prevention and Management of Febrile Neutropenia,” a handbook, was developed by the Hematology and Medical Oncology Divisions to assist physicians and nurses in the care of febrile neutropenic patients. A clinical algorithm was developed by the Nurse Practitioner-Specialist, Hematology, as a quick reference for medical and nursing staff. Both the handbook and the clinical algorithm are especially useful in teaching facilities such as ours, as well as in patient care areas where staff may be unfamiliar or uncomfortable with febrile neutropenia. This poster will outline febrile neutropenia, the febrile neutropenia guidelines, and the clinical algorithm.

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IN THEIR OWN WORDS: HELPING CHILDREN UNDERSTAND THEIR PARENT’S CANCER

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After a cancer diagnosis, patients often have to relay this difficult information to their children. While health care professionals provide information to patients about their cancer, helping children understand the diagnosis is left up to the patient. Literature is available to help parents plan a discussion with children about cancer; however, there is a paucity of age-appropriate resources aimed directly at children. A lack of school-aged literature about parents with cancer prompted a patient to write the book, “Where’s Mom’s Hair? A Family’s Journey through Cancer” to help her sons understand what she would be going through. Her goal was to make her book available to breast cancer patients undergoing chemotherapy. A partnership between an oncology nurse and the author enabled funding to purchase 1000 books. Testimonials of the book have been encouraging and a formal evaluation is underway. The evaluation survey is designed to determine whether the book was helpful for children in understanding cancer treatment. The books, along with the evaluation form are given to women before starting chemotherapy. If the formal evaluation is consistent with the testimonials, a qualitative study assessing the utility of age-appropriate literature for children who have a parent with cancer could be carried out. Study results could assist health care organizations in decisions to invest in age-appropriate literature for patients and families.

P-47
DEVELOPMENT OF A PAPER-BASED HEMOGLOBIN MONITORING PROGRAM: PROMOTING SAFETY & IMPROVING QUALITY OF LIFE OF PATIENTS ON ERYTHROPOIETIN STIMULATING AGENTS (ESA)

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ESA improves QOL by increasing the oxygen-carrying capacity of red blood cells. However, ESA use is not without risks, especially when not carefully monitored. Undershooting Hb yields dissatisfying results, whereas overshooting imposes potential danger of venous clotting, elevated blood pressure, and other side effects. The new 2007 ASH/ASCO anemia treatment guidelines stress the importance of frequent monitoring of cancer patients on ESAs. A comprehensive Hemoglobin Monitoring Program for cancer patients has been developed at our cancer clinic. We have had approximately 110 patients enrolled in the program, with approximately 30 active patients at any given time. The program sets criteria for inclusion, exclusion and cautionary use. Algorithms and carepath of two ESA are mapped out and identified. Pre-ESA work-up includes blood work and identifying patient with risk factors for side effects. The role of iron therapy in supporting erythropoiesis is critical and is included as part of the monitoring process. An ESA starter folder for each patient includes diet sheets, an ESA information booklet, hemoglobin and blood pressure monitoring sheets, lab requisitions and enrollment forms. All pertinent data for ESA monitoring is recorded on a one-page flow sheet that encompasses all relevant data, displayed in weekly columns for each visit to the clinic. This presentation will discuss the benefits and challenges of our Hb monitoring program from the nurse’s perspective.

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IMPLEMENTING A PATIENT HAND OVER TOOL IN A REGIONAL AMBULATORY ONCOLOGY CANCER CENTRE

Tanis I. Watkins, RN, BScN, CON (c)1, Tracey L. Das Gupta, RN, MN, CON (c)1, Elaine Avila, RN, BScN2, Angela Boudreau, RN, MN, CON (c)1, Arlene Court, RN, BScN, CON (c)1, Lynn Faitl, RN1, Shari Moura, RN, MN, CON (c), CHPN (c)2, Sharon Ramagnano, RN, BScN (E), MN/MA (c), ENC (c)2. 1Sunnybrook Odette Cancer Centre, Toronto, ON, Canada, 2Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

Patient care and safety are improved when hand over to other health care professionals is given in a concise, systematic way, using familiar language and an organized tool to ensure no loss of information occurs in the transfer. At a regional ambulatory cancer centre, health care professionals experience many unique challenges in transferring patient care from the ambulatory setting to the emergency department.
Both patient care areas are busy, with many distractions disrupting the communication of vital information. In addition to these challenges, the care of oncology patients has become increasingly more acute and complex, requiring new methods to ensure that the receiving care provider understands the comprehensive needs of the patient and family. A Patient Hand Over Tool was implemented in order to facilitate the transfer of care in a concise, organized fashion, thus promoting patient safety.

This poster presentation provides an overview of the implementation and evaluation of the Patient Hand Over Tool. It explores the Tool's effectiveness to structure communication, improve patient safety, and enhance interprofessional relationships both within the Centre and upon patient transfer to the emergency department, from the perspective of the nurses within these settings.

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**Moving Patient Assessment to the Next Level**

Angela Boudreau, RN, MN, CON(C), Kathy Beattie, RN, CON(C). Odette Cancer Centre, North York, ON, Canada.

Patient Assessment and documentation are an integral step to the delivery of safe, comprehensive care in the ambulatory patient setting. In the chemotherapy unit, patients may not see either the physician or the primary nurse when coming for treatment. The chemotherapy nurse becomes the primary contact with responsibility for ensuring that the patient is well enough to receive treatment, for assessing the patient for potential side effects of treatment or symptoms related to the disease. Assessment is multifaceted requiring a knowledge base that incorporates the patient condition, the treatment protocols, general side effects and side effects unique to the individual protocol. This knowledge base is an intricate component to the assessment and is an acquired skill over time. All nurses are expected to participate in patient assessment. However, within the novice to expert framework on which our orientation program is built, expectations around a novice nurse assessment are different from that of the expert. Building on learned initial assessment skills is key to the development of an advanced assessment. Our unit has taken the novice to expert approach in our assessment and developed a framework from which to work. This poster will share our assessment approach and tools used in advanced assessment of the patient receiving chemotherapy.
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