2023 OCN Review Course
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CENTRAL CONNECTICUT CHAPTER

Survivorship

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Objectives

- The learner will articulate the elements of survivorship.
- The learner will describe the evidence-based interventions oncology nurses can utilize in their supportive care plan across the continuum

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Introduction

- Time of diagnosis through the rest of his/her life
- National Coalition for Cancer Survivorship has expanded its definition of survivor to include family, friends and caregivers.

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Figure 1. Estimated Number of US Cancer Survivors by Site

As of January 1, 2019	Male		Female	
	Prostate	3,650,030	Breast	3,861,520
	Colon & rectum	776,120	Uterine corpus	807,860
	Melanoma of the skin	684,470	Colon & rectum	768,650
	Urinary bladder	624,490	Thyroid	705,050
	Non-Hodgkin lymphoma	400,070	Melanoma of the skin	672,140
	Kidney & renal pelvis	342,060	Non-Hodgkin lymphoma	357,650
	Testis	287,780	Lung & bronchus	313,140
	Lung & bronchus	258,200	Uterine cervix	283,120
	Leukemia	256,790	Ovary	249,230
	Oral cavity & pharynx	249,330	Kidney & renal pelvis	227,510
	All sites	**8,138,790**	**All sites**	**8,781,580**

As of January 1, 2030	Male		Female	
	Prostate	5,017,810	Breast	4,957,960
	Colon & rectum	994,210	Uterine corpus	1,023,290
	Melanoma of the skin	936,980	Thyroid	989,340
	Urinary bladder	832,910	Colon & rectum	965,590
	Non-Hodgkin lymphoma	535,870	Melanoma of the skin	888,740
	Kidney & renal pelvis	476,910	Non-Hodgkin lymphoma	480,690
	Testis	361,690	Lung & bronchus	398,930
	Leukemia	352,900	Kidney & renal pelvis	316,620
	Lung & bronchus	325,680	Ovary	297,580
	Oral cavity & pharynx	315,750	Uterine cervix	288,710
	All sites	**10,995,610**	**All sites**	**11,174,200**

Estimates for specific cancers account for the fact that some individuals have a history of multiple different cancer types. See Sources of Statistics, page 36, for more information.

Source: Surveillance Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute.

HEALTH CARE PROFESSIONALS

American Cancer Society Survivorship Care Guidelines

The American Cancer Society has created survivorship guidelines for the follow-up care of cancer survivors. Read complete versions of all our guidelines, find patient-friendly versions, and learn more about how ACS develops its recommendations here.

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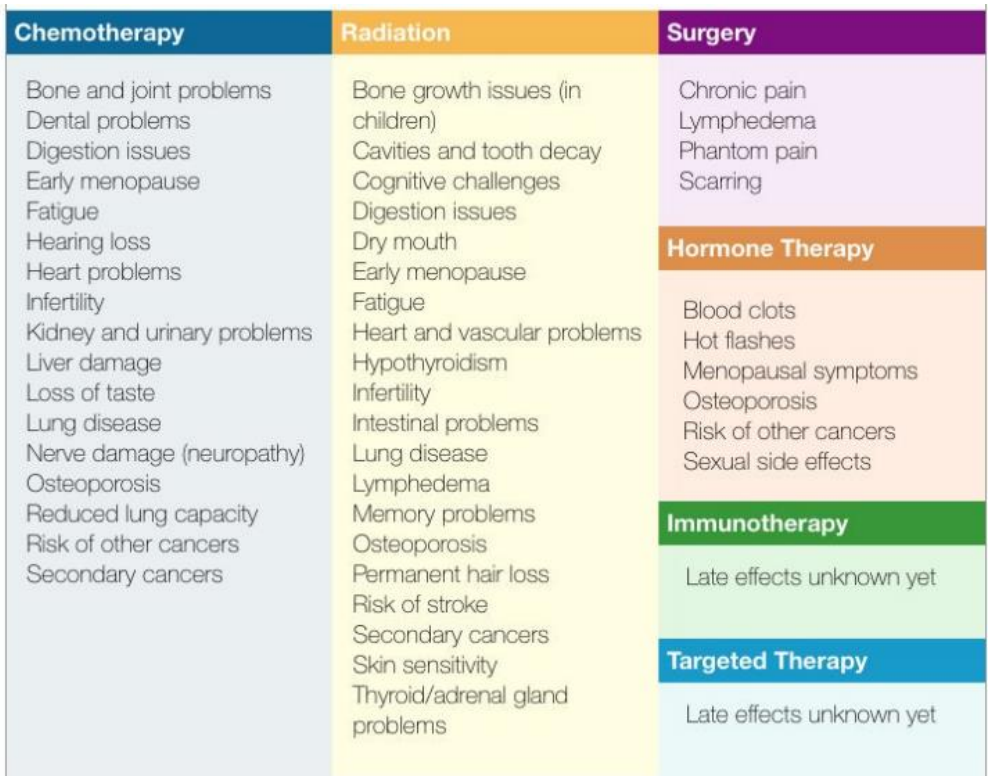
Long term and Late Effects of Cancer Treatment

Long Term Effects: begin as a complication of treatment and may continue after treatment is completed

Late Effects: begin after treatment is completed, and potentially can manifest years later.



Possible Late or Long-Term Side Effects of Cancer Treatment

Chemotherapy	Radiation	Surgery
Bone and joint problems	Bone growth issues (in children)	Chronic pain
Dental problems	Cavities and tooth decay	Lymphedema
Digestion issues	Cognitive challenges	Phantom pain
Early menopause	Digestion issues	Scarring
Fatigue	Dry mouth	**Hormone Therapy**
Hearing loss	Early menopause	Blood clots
Heart problems	Fatigue	Hot flashes
Infertility	Heart and vascular problems	Menopausal symptoms
Kidney and urinary problems	Hypothyroidism	Osteoporosis
Liver damage	Infertility	Risk of other cancers
Loss of taste	Intestinal problems	Sexual side effects
Lung disease	Lung disease	**Immunotherapy**
Nerve damage (neuropathy)	Lymphedema	Late effects unknown yet
Osteoporosis	Memory problems	**Targeted Therapy**
Reduced lung capacity	Osteoporosis	Late effects unknown yet
Risk of other cancers	Permanent hair loss	
Secondary cancers	Risk of stroke	
	Secondary cancers	
	Skin sensitivity	
	Thyroid/adrenal gland problems	

www.TexasOncologyFoundation.org

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Americans with Disabilities Act

Prohibits discrimination based on disability, individualized adjustments and accommodations may promote ability to continue or return to work. (1990)

Survivors have more chronic conditions than non-survivors which negatively impacts productivity and health care expenses.

Financial Impact:

- Change in employment status
- Inability to obtain and retain insurance coverage
- Out of pocket expenses continue with follow up , imaging, device costs and prescriptions

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Risk of Recurrence and Secondary Malignancy

Adult survivors of childhood cancers have a greater risk of developing one or more secondary malignancies:

- Hodgkin lymphoma have an increased risk for recurrence and secondary malignancies related to chemotherapy and radiation
- Women who received chest radiation as children or adolescents have a significantly higher risk for developing breast cancer
- Synergistic: age, lifestyle behaviors, immunosuppression

Secondary malignancies associated with radiation therapy within the treatment field

- Various surveillance recommendations that may prompt earlier screenings i.e. colonoscopies and mammograms

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Survivorship

Version 1.2021 — February 24, 2021

NCCN.org

NCCN Guidelines for Patients® available at www.nccn.org/patients

Continue

https://www.nccn.org/professionals/physician_gls/pdf/survivorship.pdf

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National Comprehensive Cancer Network

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2021
Survivorship

NCCN Guidelines Index
Table of Contents
Discussion

Clinical Trials: NCCN believes that the best management for any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

To find clinical trials online at NCCN Member Institutions, click here: nccn.org/clinical_trials/member_institutions.aspx.

NCCN Categories of Evidence and Consensus: All recommendations are category 2A unless otherwise indicated.

See NCCN Categories of Evidence and Consensus.

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Survivorship

Version 1.2021 — February 24, 2021

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NCCN Guidelines for Patients® available at www.nccn.org/patients

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Game Plan
Everyone Needs One….

"A window of opportunity"

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Essential Components of Survivorship Care

- Assessment
- Identification & Management
- Screening
- Health Promotion
- Treatment Summary/Care Plan
- Communication

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Assessment

History

- Clinical data
- Health behaviors
- Receipt of preventive and screening services
- Genetic testing
- Focused review of symptoms

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Assessment

Physical Exam

- Assessment long term and late effects
- Focused exam for recurrence
- Symptom management assessment (PRO, NCCN, PEP)

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Assessment

Psychosocial Assessment

- Social history
- Risk
- Support systems

Imaging & Laboratory Tests

- Guidance by NCCN/ASCO

Management

Interventions are focused on prevention, mitigation and relief of adverse effects of caner and its treatment.

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Management

1. Referrals to appropriate specialists
2. Encourage physical activity
3. Encourage healthy eating habits
4. Weight management/normal BMI
5. Counsel on tobacco and alcohol

Management

Interventions related to knowledge deficit.

Survivorship Care Plan:

1. Treatment summary
2. Long term/late side effects
3. Follow-up/surveillance & intervals
4. Health promotion behaviors
5. Monitor & manage long term/late effects
6. List of health care team & contacts
7. Institutional & community resources

Management

Interventions to improve communication and coordination among providers

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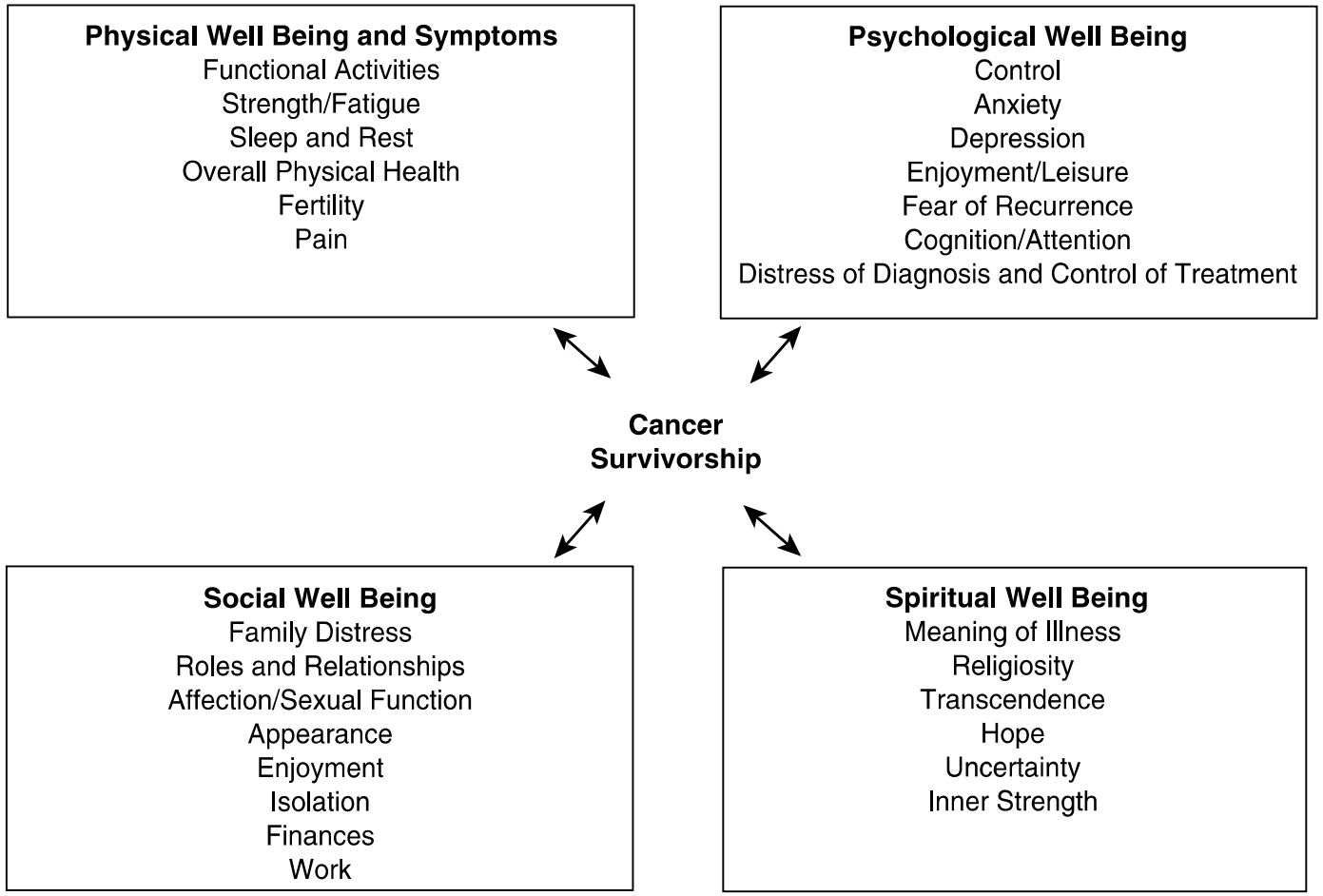
Management

Interventions for adolescent/young adult cancer survivors:

- High risk populations:
- Age 15-39
  - Late physical effects
  - Social concerns
  - High rates under-insured/uninsured

Quality of Life Model Applied to Cancer Survivors



Quality of life: conceptual model.
SOURCE: City of Hope Beckman Research Institute (2004)
Betty R. Ferrell, PhD, FAAN; and Marcia Grant, DNSc, FAAN,
City of Hope National Medical Center.

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In conclusion…focus on

The three “P’s” of Survivorship

1. Palliation
2. Prevention
3. Promotion

Ganz BMC Medicine 2011, 9:14 http://www.biomedcentral.com/1741-7015/9/14

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Palliative & End of Life Care

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Objective

- The learner will define the nurse's role as part of the inter-professional team in assessing, planning & creating the plan of care for oncology patients at the end of life
- The learner will define the role of palliative care as part of the supportive, holistic plan of care for the oncology patient

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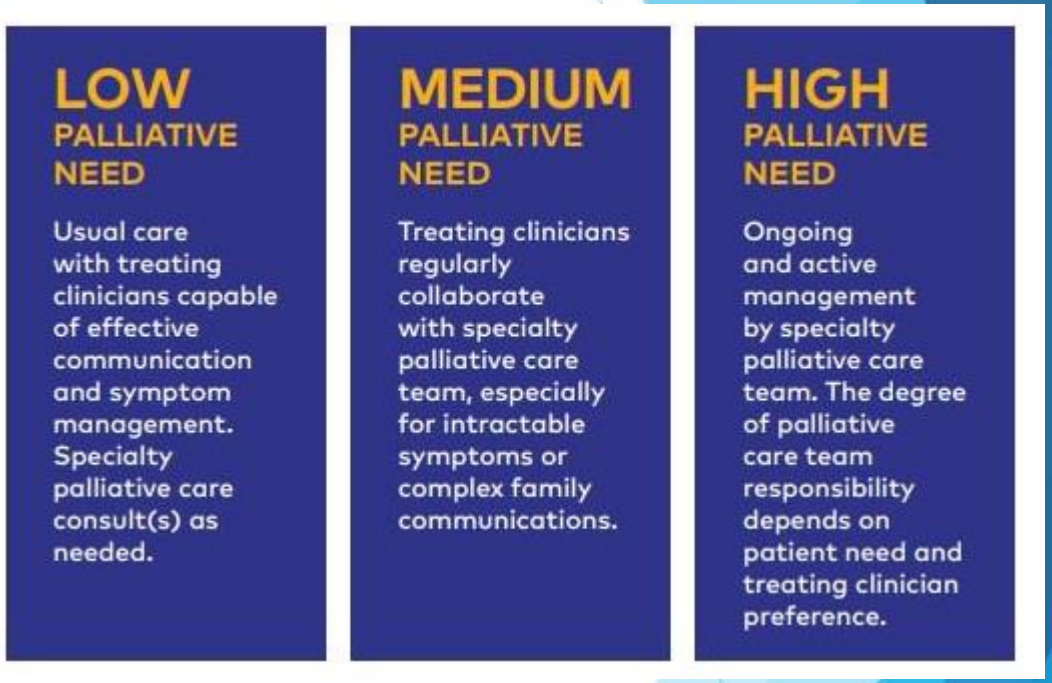
Clinical Practice Guidelines for Quality Palliative Care

4th edition



https://www.capc.org/blog/palliative-pulse-palliative-pulse-september-2017-palliative-care-comes-of-age/

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Overview

Palliative Care

Palliative care focuses on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness. Through early integration into the care plan for the seriously ill, palliative care improves quality of life for the patient and the family.

Clinical Practice Guidelines for Quality Palliative Care, 4th edition

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NCP and NQF: 8 Domains of Palliative Care

- Structure and processes of care
- Physical aspects of care
- Psychological and psychiatric aspects of care
- Social aspects of care
- Spiritual, religious, and existential aspects of care
- Cultural aspects of care
- Care of the patient at the end of life
- Ethical and legal aspects of care

NCP, 2013

Nursing & Medical Organizations That Support Palliative Care

NURSING

- American Association of Nursing (AACN)
- American Association of Critical Care Nurses (AACN)
- Hospice & Palliative Nurses Association (HPNA)
- Oncology Nursing Society (ONS)
- American Nephrology Nurse's Association (ANNA)

MEDICINE

- American Academy of Hospice & Palliative Medicine (AAHPM)
- American Heart Association(AHA) & American Stroke Association (ASA)
- American Society of Clinical Oncology (ASCO)
- American Thoracic Society (ATS)

What is Palliative Care?

- Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

- Palliative Care= High Quality Care

NCP, 2013; NQF, 2008

Palliative Care

Essential component of quality of care for persons with cancer and their family caregivers that optimizes quality of life.

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Key Components

Patient & family centered	Includes physical, psychological, spiritual, emotional, social, cultural & economic
Goals of care & shared decision making	Assessment & management of distressing symptoms
Intentional & Structured Way	Support system to help the family caregiver cope
Based on values & preferences	Support based on needs & preferences, values and goals regardless of prognosis
May change over time	Enhancement of quality of life
Inter-professional team	May change over time

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Older Adult Oncology

Version 1.2021 — May 24, 2021

NCCN.org

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Palliative Care

Version 2.2021 — February 12, 2021

NCCN.org

Continue

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Adult Cancer Pain

Version 1.2021 — February 26, 2021

NCCN.org

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https://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf

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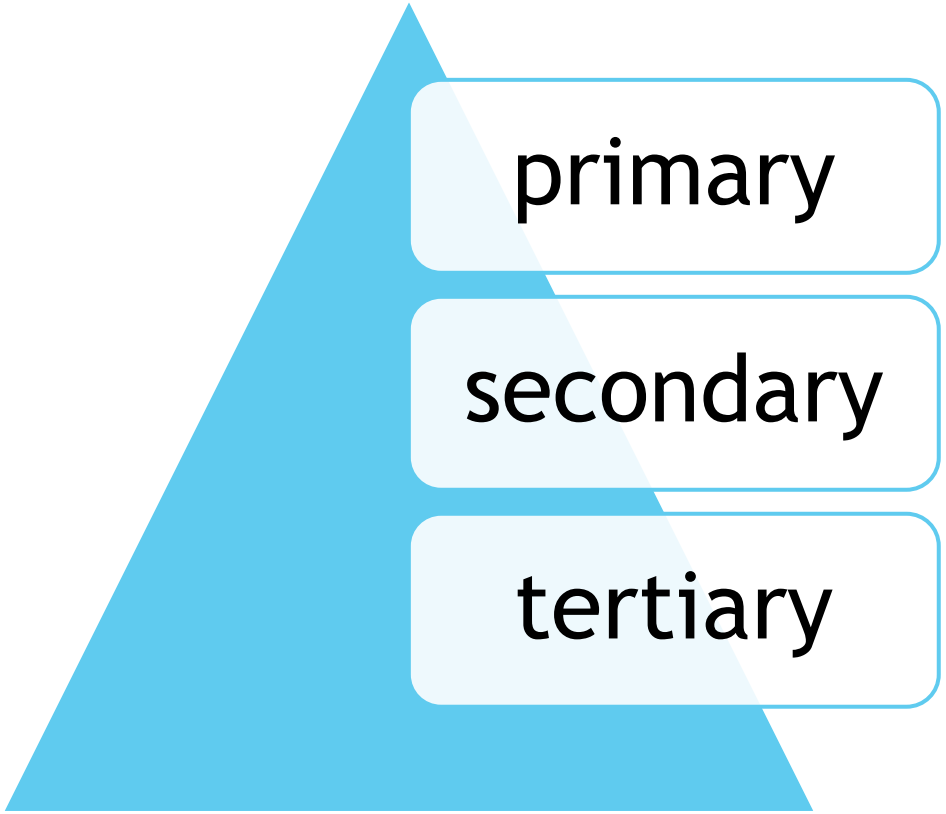
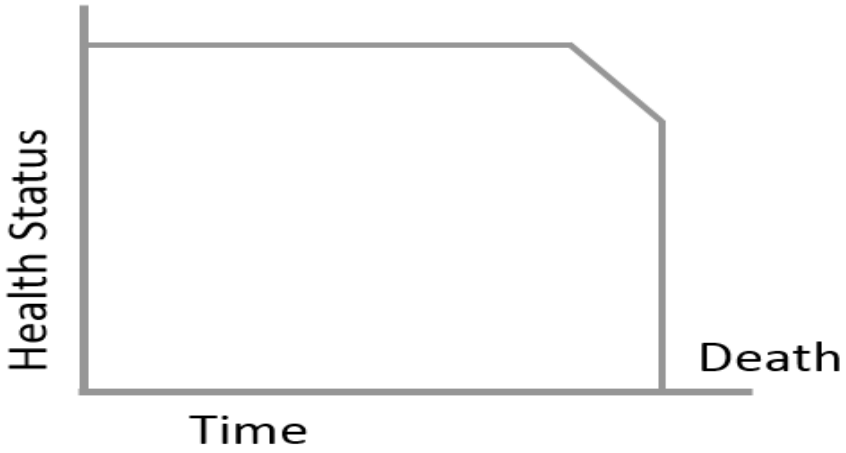
Palliative Care

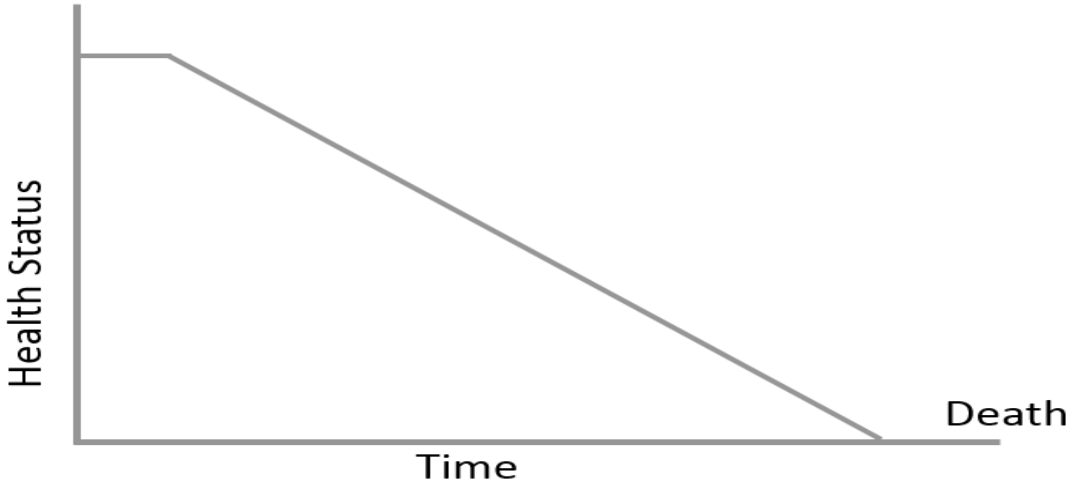


Illness/Dying Trajectories Sudden Death, Unexpected Cause

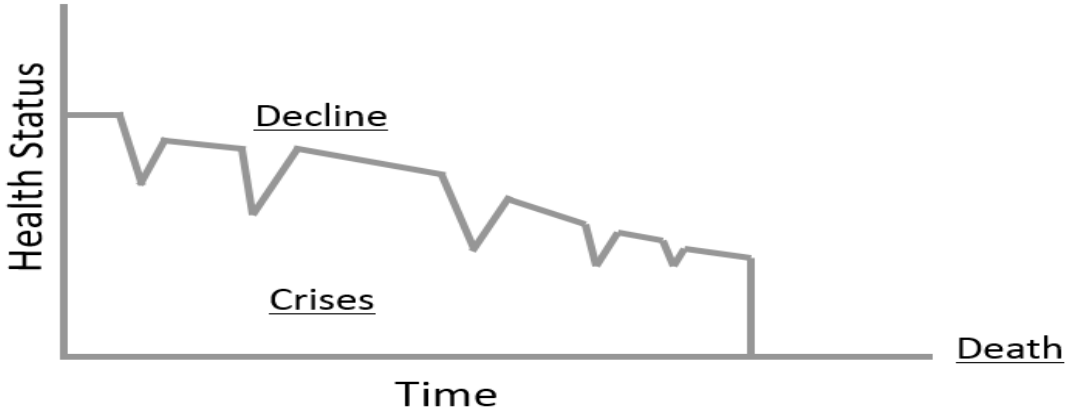
< 10% (MI, accident, etc.)



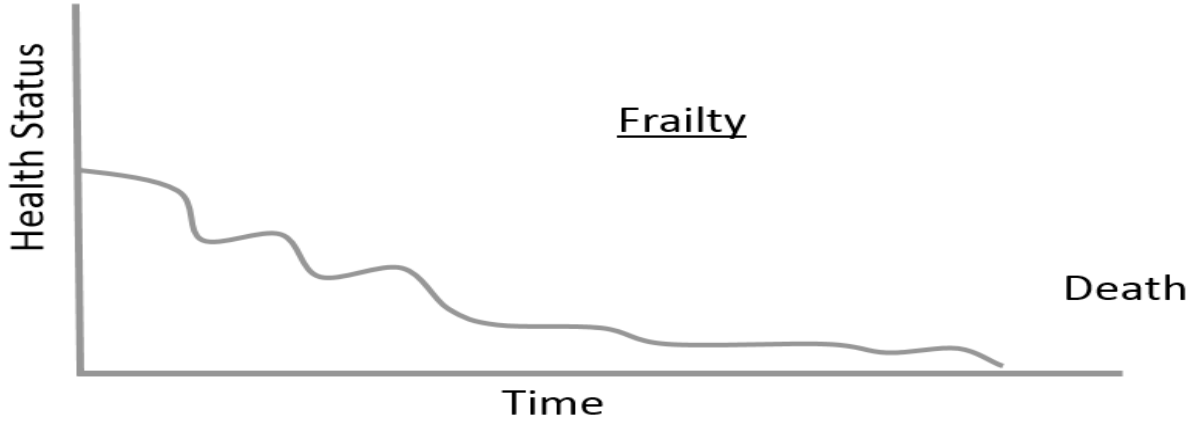
Illness/Dying Trajectories Steady Decline, Short Terminal Phase



Illness/Dying Trajectories Chronic Illness, Periodic Crises, Death

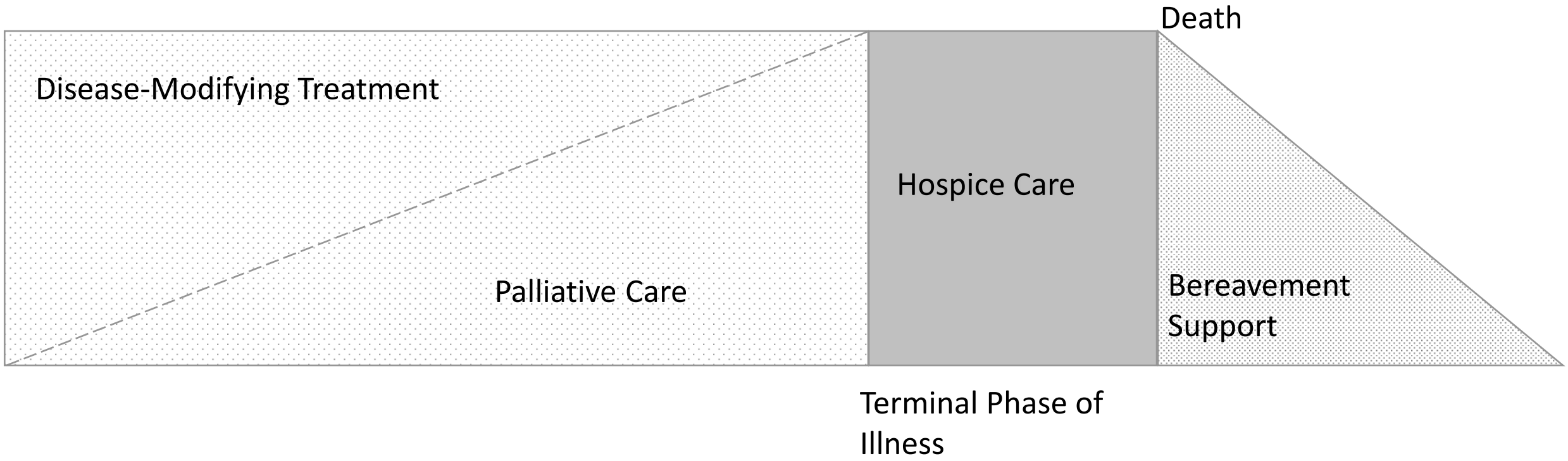


Illness/Dying Trajectories, Progressive Deterioration Expected Death



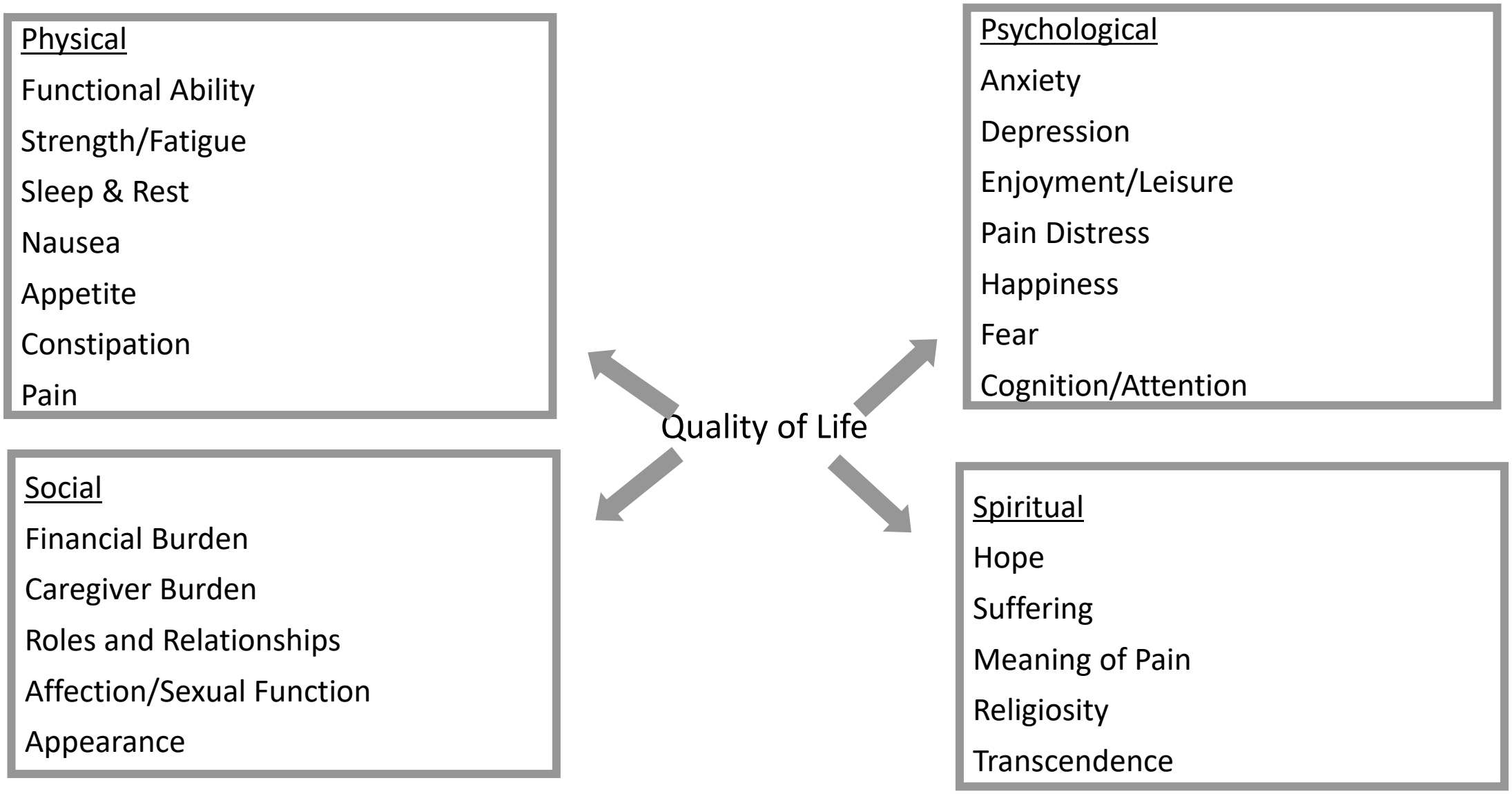
Current Practice of Hospice and Palliative Care

Continuum of Care



Quality-of-Life Model

http://prc.coh.org



Early Integration

- Benefits all oncology patients, early in metastatic cancer or high symptom burden
- Improves quality of life
- Decreased symptom burden
- Advance care planning
- Less aggressive care at end of life
- Improves survival with and provides cost savings

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Hospice Care

- Philosophy of care
- Insurance benefit
  - Two physicians
  - Less than six months to live (usually referring MD and Hospice Medical Director)
  - Stop all aggressive treatments

Hospice based on the premise that dying is part of living and meticulous management of physical, psycho-social and spiritual symptoms will promote quality of life for the patient and their family.

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History

"How people die remains in the memory of those who live on."

Dame Cicely Saunders

Hospice Pioneer Florence Wald Dies

Florence Wald, a humble pioneer of hospice in the United States died Saturday November 8th at her home. She had been receiving hospice services that she helped found and expand from a single program in Connecticut to the thousands of hospice agencies in the United States today. When she began to be involved with the early hospice movement in the early 70's she had already been dean of the Yale School of Nursing from 1959-1966.

The Yale School of Nursing had two profound quotes from her (italics mine):

"Hospice care for the terminally ill is the end piece of how to care for patients from birth on." Dean Wald wrote. *"As more and more people - families of hospice patients and hospice volunteers - are exposed to this new model of how to approach end-of-life care, we are taking what was essentially a hidden scene - death, an unknown, and making it a reality. We are showing people that there are meaningful ways to cope with this very difficult situation."*

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Sutter Health: Advanced Illness Management (AIM)

- Fewer hospitalizations, greater savings
- Improved patient and family satisfaction
- 58% fewer hospital admissions
- 69% reduction in ICU days
- Result: Savings of > $60 million for payers

Sutter Health, 2016

Does Palliative Care Improve Care, Decrease Hospitalizations, and Save Money?

- ↓Hospitalizations
- ↓ICU admissions
- Palliative care triggers
- ↓ED visits
- ↓Costs

CAPC, 2017b

What about Costs for Medicare and Medicaid Patients?

- The seriously ill constitute only 5-10% of patients (more than ½ of the nation's total healthcare costs)
- 10% of Medicare beneficiaries with 5 or more co-morbid illnesses (2/3 of total Medicare spending)
- The 4% of the sickest Medicaid beneficiaries (48% of total program spending)
- 76% of the national Medicaid budget goes to acute hospital services, the most expensive setting of care
- *Palliative care could decrease these expenditures*

CAPC, 2016

Payment for Hospice and Palliative Care

HOSPICE

- Medicare
- Medicaid
- Most private health insurers

PALLIATIVE CARE

- Philanthropy
- Fee-for-service
- Direct hospital support

Hospice Services

- Nursing & Physician services
- Social services & counseling
- Medical equipment
- Medications
- Home health services
- PT/OT/SLP
- Dietician
- Greif and loss counseling
- Volunteer services

- Short term in-patient car for symptom management
- Short term respite care
- Routine/continuous home care
- General in-patient care
- In-patient respite care

CMS 2018

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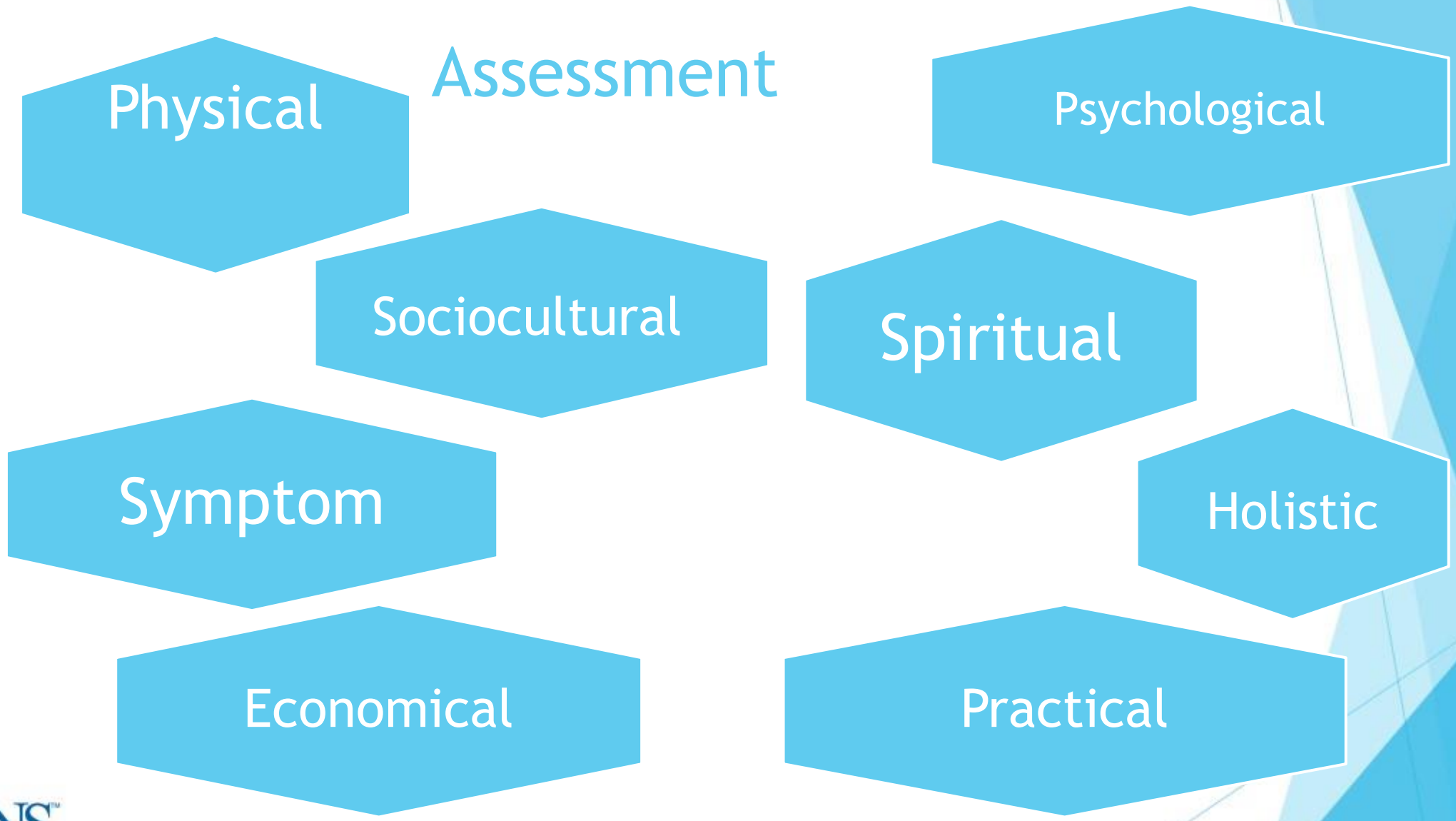
Barriers to Quality Care at the End of Life

- Failure to acknowledge the limits of medicine
- Workforce that is too small to meet demands
- Lack of training for healthcare providers
- Hospice/palliative care services are poorly understood
- Lack of research
- Lack of payment models linked to quality measures
- Rules and regulations
- Denial of death

CAPC, 2015; NHPCO,2014 & 2015

Assessment



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Assessment Tools

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KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS RATING (%) CRITERIA

Able to carry on normal activity and to work; no special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

Performance Status: Measurement "self-report"

ECOG Performance Status

These scales and criteria are used by doctors and researchers to assess how a patient's disease is progressing, assess how the disease affects the daily living abilities of the patient, and determine appropriate treatment and prognosis. They are included here for health care professionals to access.

ECOG PERFORMANCE STATUS*

Grade	ECOG
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair
5	Dead

* As published in Am. J. Clin. Oncol.:
Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., Carbone, P.P.: Toxicity And Response Criteria Of The Eastern Cooperative Oncology Group. Am J Clin Oncol 5:649-655, 1982.

Edmonton Symptom Assessment System Revised (ESAS-r)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetitie
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression

https://www.albertahealthservices.ca/frm-07903.pdf

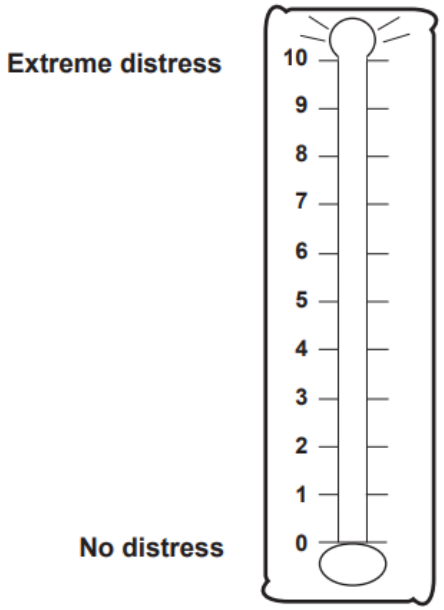
National Comprehensive Cancer Network®

NCCN Distress Thermometer and Problem List for Patients

NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.



PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.
Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Food
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance use
❑	❑	Tingling in hands/feet

Other Problems: _____

_____

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Social Work Assessment Tool (SWAT)

Complete after each social work visit. Rate the patient on how well s(h)e is doing on concerns regarding each issue. Rate the primary caregiver on how well s(h)e is doing on each issue, OR on how well s(h)e is coping with patient concerns regarding the issue. If there are no concerns in an area, circle 5 ("extremely well"). Each issue should be assessed during each client contact.

Patient I.D.#_____ Date of social work visit: _____

	HOW WELL ARE PATIENTAND PRIMARY CAREGIVER DOING?									
ISSUE:	**PATIENT**					**PRIMARY CAREGIVER**				
	1 Not well at all	2 Not too well	3 Neutral	4 Reasonably well	5 Extremely well	1 Not well at all	2 Not too well	3 Neutral	4 Reasonably well	5 Extremely well
1. End of life decisions consistent with their religious and cultural norms	1	2	3	4	5	1	2	3	4	5
2. Patient thoughts of suicide or wanting to hasten death	1	2	3	4	5	1	2	3	4	5
3. Anxiety about death	1	2	3	4	5	1	2	3	4	5
4. Preferences about environment (e.g., pets, own bed, etc.)	1	2	3	4	5	1	2	3	4	5
5. Social support	1	2	3	4	5	1	2	3	4	5
6. Financial resources	1	2	3	4	5	1	2	3	4	5
7. Safety issues	1	2	3	4	5	1	2	3	4	5
8. Comfort issues	1	2	3	4	5	1	2	3	4	5
9. Complicated anticipatory	1	2	3	4	5	1	2	3	4	5

Symptoms and Suffering

- Symptoms create suffering and distress
- Psychosocial intervention is key to complement pharmacologic strategies
- Need for interdisciplinary care

Common End-of-Life Symptoms

- Respiratory
  - Dyspnea, cough
- GI
  - Anorexia/cachexia, constipation, diarrhea, nausea/vomiting, xerostomia
- Psychological
  - Depression, anxiety, post-traumatic stress disorder, delirium/agitation/confusion
- General/Systemic
  - Fatigue/weakness, wounds, seizures, sleep disturbances, lymphedema, and urgent syndromes

Most Common Symptoms in Final Days of Life

- Dyspnea
- Terminal Secretions
- Delirium
- Myoclonus

Clinical Signs of Impending Death

- Pulselessness of the radial artery
- Respiration with mandibular movement
- Decreased urine output
- Cheyne-Stokes breathing
- Terminal secretions
- Non-reactive pupils
- Decreased response to visual stimuli
- Palliative Performance Scale (PPS) of <10%

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Dyspnea: Overview and Incidence

- Subjective experience
- Most reported symptom
- Promotes disability, poor quality of life, and suffering

Balkstra, 2015; Dudgeon, 2015

Causes of Dyspnea

- Major pulmonary causes
- Major cardiac causes
- Major neuromuscular causes
- Other causes

Assessment of Dyspnea

- Use subjective report
- Clinical assessment
  - Physical exam
  - Diagnostic tests
  - Patient experience
- Underlying cause

Dudgeon, 2015

Treatment of Dyspnea

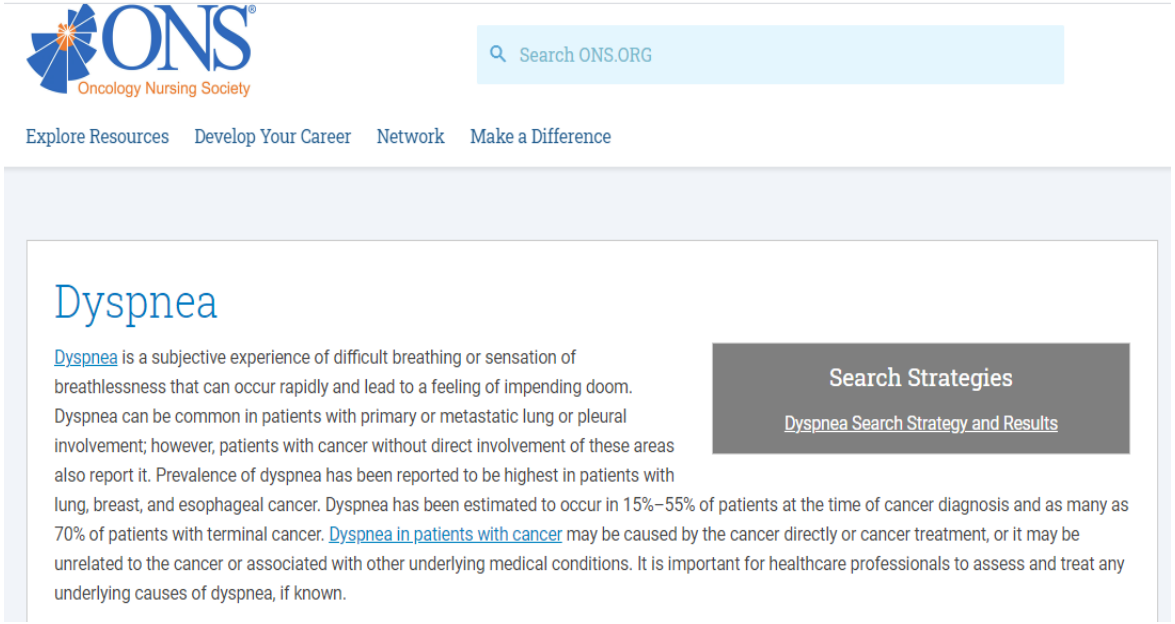
- Treating symptoms or underlying cause
- Pharmacologic treatments
  - Opioids
  - Nonopioids

Dudgeon, 2015; Hui et al., 2016

Treatment of Dyspnea (cont.)

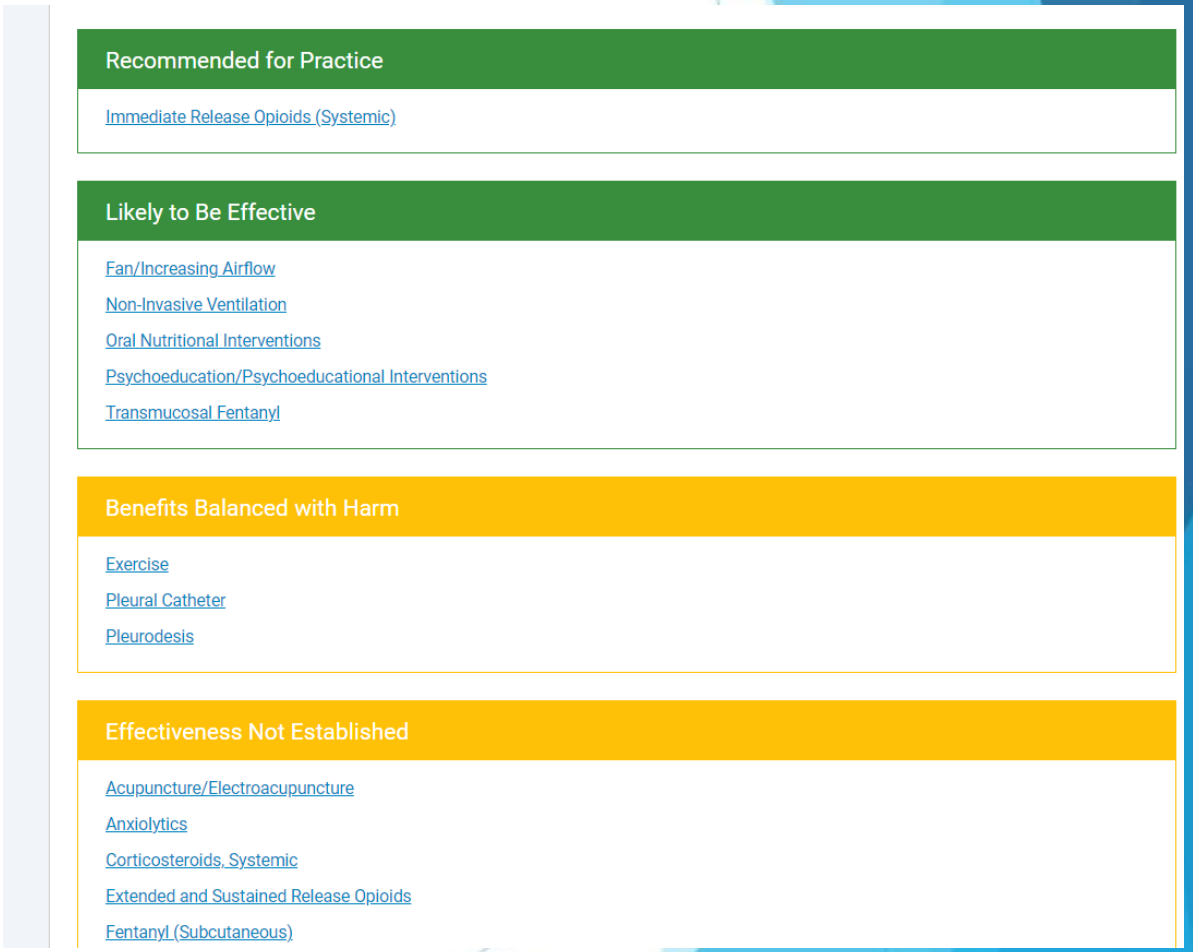
- Nonpharmacologic
  - Non-invasive ventilatory support (oxygen, positive pressure ventilation) if hypoxic
  - Interventional therapies
  - Counseling
  - Pursed lip breathing
  - Energy conservation
  - Fans, elevation
  - Positioning
  - Other

Broglio, 2016; Kravits, 2015



https://www.ons.org/explore-resources?source=1506&display=results&sort_by=created&items_per_page=50

https://www.ons.org/pep/dyspnea?display=pepnavigator&sort_by=created&items_per_page=50



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SYMPTOM INTERVENTIONS AND GUIDELINES

Oral Anticancer Medication

Oral anticancer medications (OAMs) have been used for decades to treat and reduce the risk of a variety of cancers. With the exponential increase in the number of oral med...

Read Now »

SYMPTOM INTERVENTIONS AND GUIDELINES

ONS Guidelines™

ONS Guidelines are evidence-based resources on prevalent cancer treatment-related side effects. Guidelines are available on several common cancer treatment-related side effects.

...

Read Now »

SYMPTOM INTERVENTIONS AND GUIDELINES

Chemotherapy-Induced Diarrhea

Chemotherapy-induced diarrhea is the abnormal increase in stool liquidity and frequency associated with the administration of chemotherapeutic agents.

Read Now »

SYMPTOM INTERVENTIONS AND GUIDELINES

Skin Toxicities

A number of different types of cutaneous reactions that affect the skin, hair, and nails can occur with cancer treatment.

Read Now »

SYMPTOM INTERVENTIONS AND GUIDELINES

Radiodermatitis

Radiodermatitis is the integumentary system's response to exposure to ionizing radiation, which can range from erythematous rash to desquamation and necrosis.

Read Now »

SYMPTOM INTERVENTIONS AND GUIDELINES

Prevention of Infection: Transplant

Patients undergoing transplantation are at high risk for infection with a variety of pathogens at multiple phases in their care.

Read Now »

SYMPTOM INTERVENTIONS AND GUIDELINES

Prevention of Infection: General

Patients receiving standard chemotherapy regimens for solid tumors are at lower risk for development of febrile neutropenia and infection than patients who undergo b...

Read Now »

SYMPTOM INTERVENTIONS AND GUIDELINES

Prevention of Bleeding

These general prevention of infection resources refer to cancer-related or cancer treatment-related infection, not including transplantation.

Read Now »

https://www.ons.org/explore-resources?source=1506&display=results&sort_by=created&items_per_page=50

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Terminal Secretions

- Non-pharmacologic management (raise head of bed)
- Shallow oral suctioning NOT deep
- Pharmacologic: Anti-cholinergics
  1. Scopolamine,
  2. hyoscyamine (Anti-Tremor and Gut antispasmodic)
  3. glycopyrrolate (Robinul)
  4. atropine

What About Artificial Nutrition & Hydration at End of Life?

- Perceptions of “starving to death”
- Hydration does not decrease “dry mouth”
- Arguments for and against hydration

Fainsinger, 2015;
Prince-Paul & Daly, 2015

Hard Choices for Loving People: CPR, Artificial Feeding, Comfort Care, and the Patient with a Life-Threatening Illness

Hank Dunn

A & A Pub.,Incorporated, 2009 - Artificial feeding - 80 pages

★★★★★

0 Reviews

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Grief & Bereavement

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Types of Grief

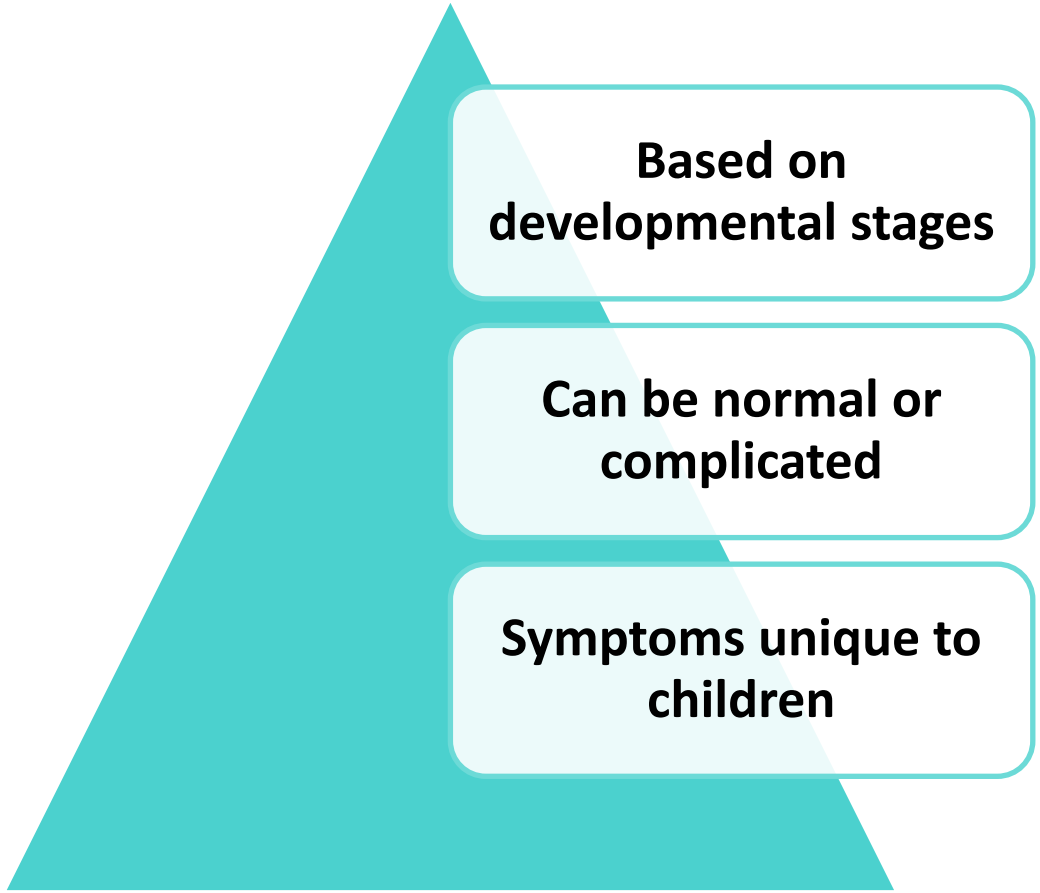
- Anticipatory Grief
- Acute Grief
- Normal Grief
- Complicated Grief
- Disenfranchised Grief

Corless 2015; Shear, 2015

Section II: Factors Influencing the Grief Process in Families

- Survivor personality
- Coping skills, patterns
- History of substance abuse
- Relationship to deceased
- Spiritual beliefs
- Type of death
- Survivor ethnicity and culture

Children's Grief



Nurse's Role

- Assess the grief
- Assist the patient with grief
- Support survivors

Professional Practice Issues

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Standards

Standards for professional nursing practice:

"Authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty are expected to perform competently"

ANA, 2015

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Scope of Practice

Scope of practice describes the services that a qualified health professional is deemed competent to perform, and permitted to undertake – in keeping with the terms of their professional license.

Scope of practice defined in nursing

The Nursing Scope and Standards of Practice describe the "who," "what," "where," "when," "why," and "how" of nursing practice:

- **Who:** Registered Nurses (RN) and Advanced Practice Registered Nurses (APRN) comprise the "who" constituency and have been educated, titled, and maintain active licensure to practice nursing.
- **What:** Nursing is the protection, promotion, and optimization of health and abilities; prevention of illness and injury; facilitation of healing; alleviation of suffering through the diagnosis and treatment of human response; and advocacy in the care of individuals, families, groups, communities, and populations.
- **Where:** Wherever there is a patient in need of care.
- **When:** Whenever there is a need for nursing knowledge, compassion, and expertise.
- **Why:** The profession exists to achieve the most positive patient outcomes in keeping with nursing's social contract and obligation to society.

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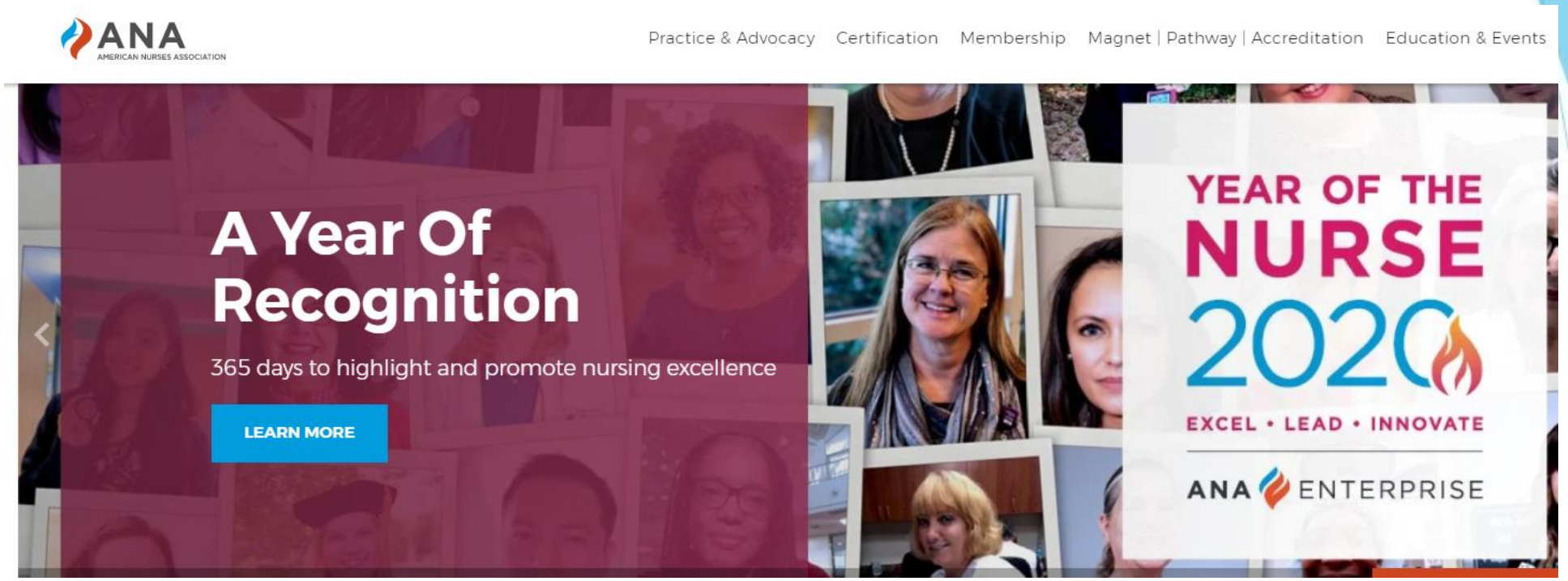
https://www.nursingworld.org/practice-policy/scope-of-practice/



- Nursing Scope of Standards and Practice
- Code of Ethics for Nurses with Interpretive Statements

The Code, consisting of nine provisions and their accompanying interpretive statements:

- Provides a succinct statement of the ethical values, obligations, and duties of every individual who enters the nursing profession;
- Serves as the profession's nonnegotiable ethical standard; and
- Expresses nurses' own understanding of our commitment to society.

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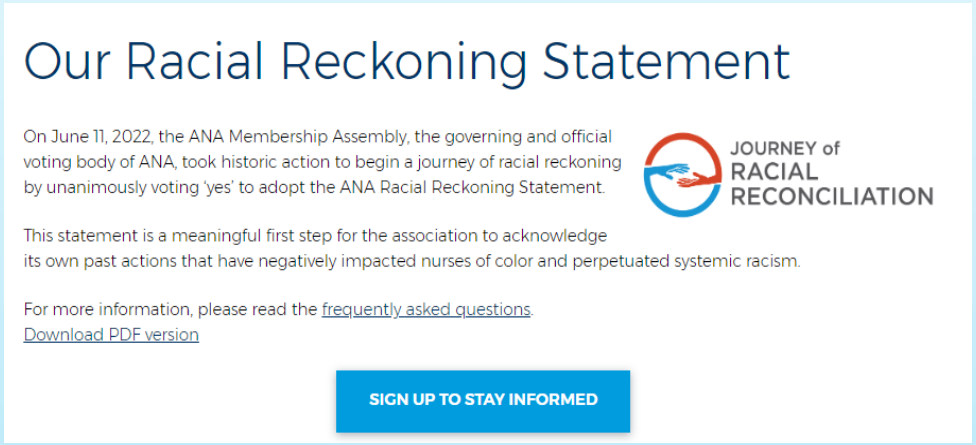
Culturally Competent Care & Equity



Our Racial Reckoning Statement

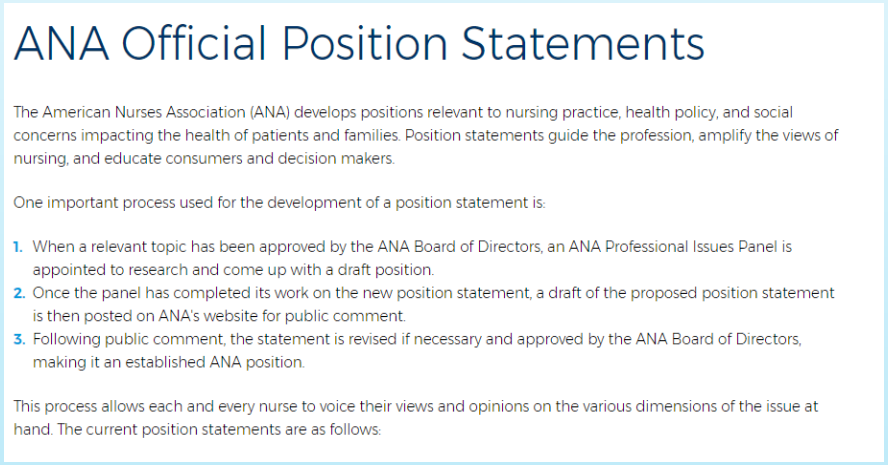
On June 11, 2022, the ANA Membership Assembly, the governing and official voting body of ANA, took historic action to begin a journey of racial reckoning by unanimously voting 'yes' to adopt the ANA Racial Reckoning Statement.

JOURNEY of RACIAL RECONCILIATION

This statement is a meaningful first step for the association to acknowledge its own past actions that have negatively impacted nurses of color and perpetuated systemic racism.

For more information, please read the frequently asked questions.
Download PDF version

SIGN UP TO STAY INFORMED



ANA Official Position Statements

The American Nurses Association (ANA) develops positions relevant to nursing practice, health policy, and social concerns impacting the health of patients and families. Position statements guide the profession, amplify the views of nursing, and educate consumers and decision makers.

One important process used for the development of a position statement is:

1. When a relevant topic has been approved by the ANA Board of Directors, an ANA Professional Issues Panel is appointed to research and come up with a draft position.
2. Once the panel has completed its work on the new position statement, a draft of the proposed position statement is then posted on ANA's website for public comment.
3. Following public comment, the statement is revised if necessary and approved by the ANA Board of Directors, making it an established ANA position.

This process allows each and every nurse to voice their views and opinions on the various dimensions of the issue at hand. The current position statements are as follows:

https://www.nursingworld.org/practice-policy/workforce/racism-in-nursing/

Central Connecticut CCONS Oncology Nursing Society

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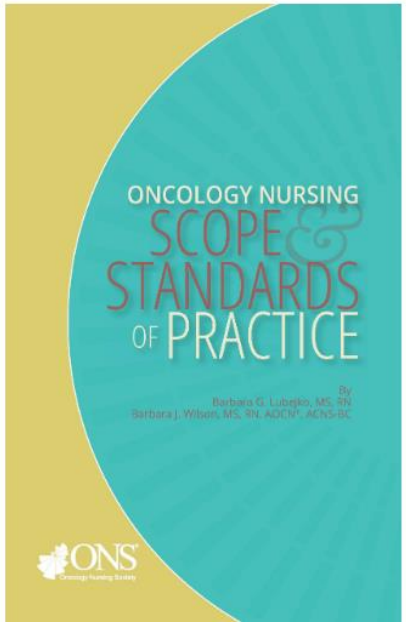
Oncology Nursing Scope and Standards of Practice

Defines Standards for oncology nursing practice across settings, patient populations and sub-specialties.



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Standards of Oncology Nursing Practice and Professional Performance

Standards of Practice

- Assessment
- Diagnosis
- Outcomes Identification
- Planning
- Implementation
- Coordination of Care
- Health Teaching & Health Promotion
- Evaluation

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Standards of Oncology Nursing Practice and Professional Performance

Standards of Professional Performance

- Ethics Culturally Congruent Care
- Communication
- Collaboration
- Leadership
- Education
- Evidence Based Practice
- Quality of Practice
- Professional Practice Evaluation
- Resource Utilization
- Environmental Health

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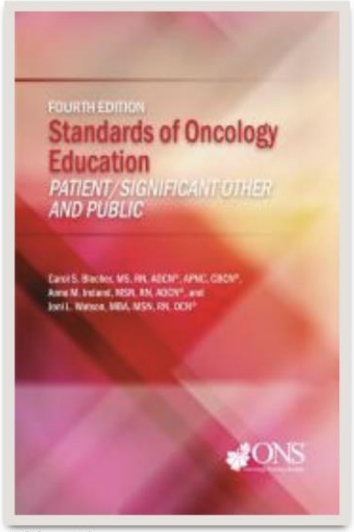
Standards of Education

Nursing

- Generalist
- Advanced Practice

Patient/Significant Other & Public



Edition: 4th

Standards of Oncology Education: Patient/Significant Other and Public (Fourth Edition)

The fourth edition of the ***Standards of Oncology Education: Patient/Significant Other & Public*** provides comprehensive guidelines for nurses to develop, implement, and evaluate education programs for patients with cancer, their significant others, and the public. This fourth edition is the first revision of the standards since 2005. The new edition reflects changes in nursing education, the workplace, and society, in general, with new information on technology in education and the changing roles of oncology nursing in education.

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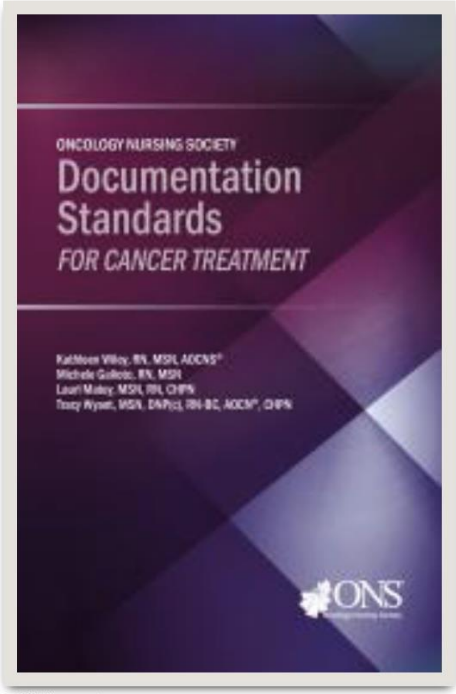
ONS Nursing Documentation Standards for Cancer Treatment

(Wiley, Galioto, Matey & Wyant, 2017)

- Chemotherapy & biotherapy administration
- Radiation therapy
- Blood &marrow transplantation
- Surgery
- Treatment with a central venous access device
- Blood product transfusion
- Extravasation management



Edition: 1st

Oncology Nursing Society Documentation Standards for Cancer Treatment

★★★★★

The Oncology Nursing Society (ONS) is proud to introduce new documentation standards for cancer treatment. The standards were developed by a task force of experts in various specialty treatment areas and ONS nursing staff using recommended elements of documentation established by the American Nurses Association to ensure accuracy, thoroughness, and applicability to practice. Practitioners following these standards can feel confident they are providing the highest level of care to their patients with cancer.

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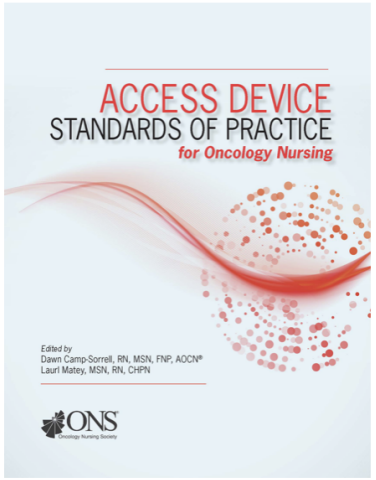
Access Device Standards of Practice for Oncology Nursing

- Provide guidance on best practices in the the care of people with cancer who have access devices
  - Strength of evidence

Access Device Standards of Practice for Oncology Nursing



Nonmember Price: $91.00

Member Price: $65.00

Quantity:

1 ADD TO CART

ISBN: 9781935864905

Published By: Oncology Nursing Society

Copyright Year: 2017

Pages: 224

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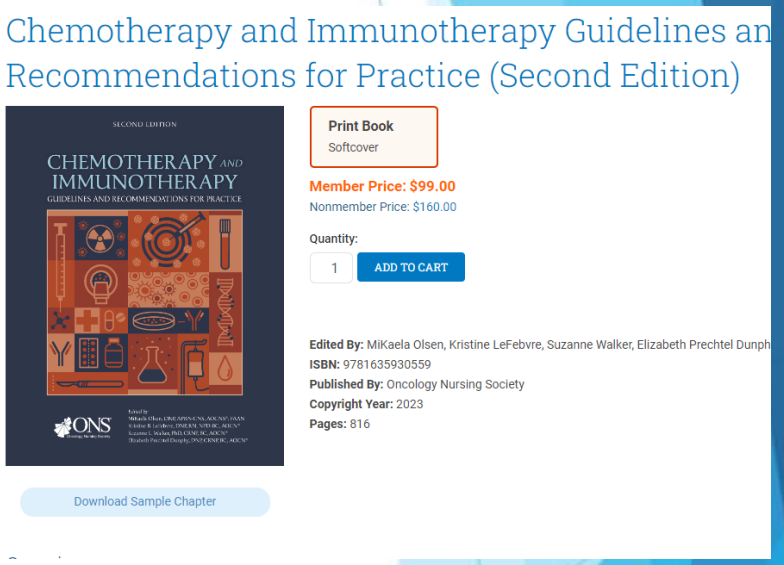
ASCO/ONS Chemotherapy Administration Safety Standards

Inter-professional standards that outline best practices to reduce the risk of error during the process of chemotherapy provision.

Topics:

- Staffing & policies
- Planning, consent & education for patients and caregivers
- Ordering, preparing & administering parenteral & oral routes
- Documentation
- Monitoring, adherence, side effects & complications

https://www.ons.org/ascoons-chemotherapy-administration-safety-standards



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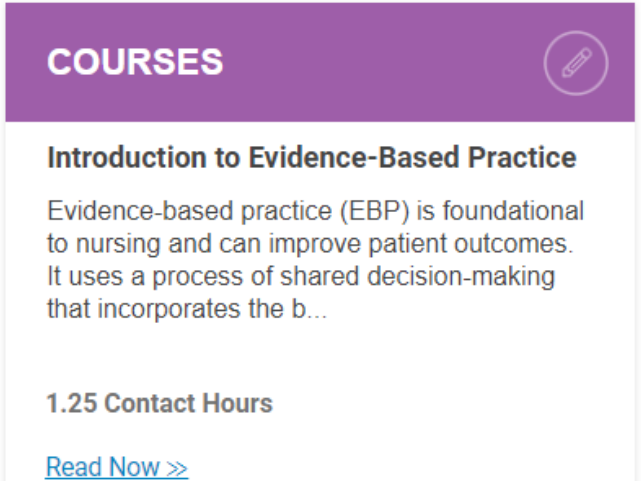
Evidence Based Practice

- High quality health care
- Improved patient outcomes
- Decreased health care costs



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Components

Definition:

Integration of the best possible research evidence with clinical expertise & patients needs and preferences.

- Pay for performance programs, non-payment for complications when EBP not followed
- Without EBP it can take decades for evidence to impact practice
- Can increase nurse satisfaction and retention

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EBP Process:

https://www.ons.org/clinical-practice-resources/writing-picot-question

1. Cultivate a sense of inquiry & create an EBP culture
2. Identify problem & stakeholders
3. Search the literature using PICOT question:
    1. P –Patient/population of interest
    2. I-Intervention or issue of interest
    3. C-Comparison intervention or control group
    4. O-Outcomes
    5. T-Time frame

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Writing a PICOT Question

What is a PICOT question?

The PICOT question is a consistent "formula" for developing answerable, searchable questions that result in an effective literature search that yields the best, most relevant information.

PICOT is an acronym of the following:

EBP Process

Level of evidence	Study design
I	Systematic reviews and meta-analysis of RCT
II	RCT
III	Non-randomised controlled trial (quasi-experiment
IV	Case–control or cohort studies
V	Systematic reviews of qualitative or descriptive studies
VI	Qualitative or descriptive studies
VII	Opinion of authorities and/or reports of expert committees

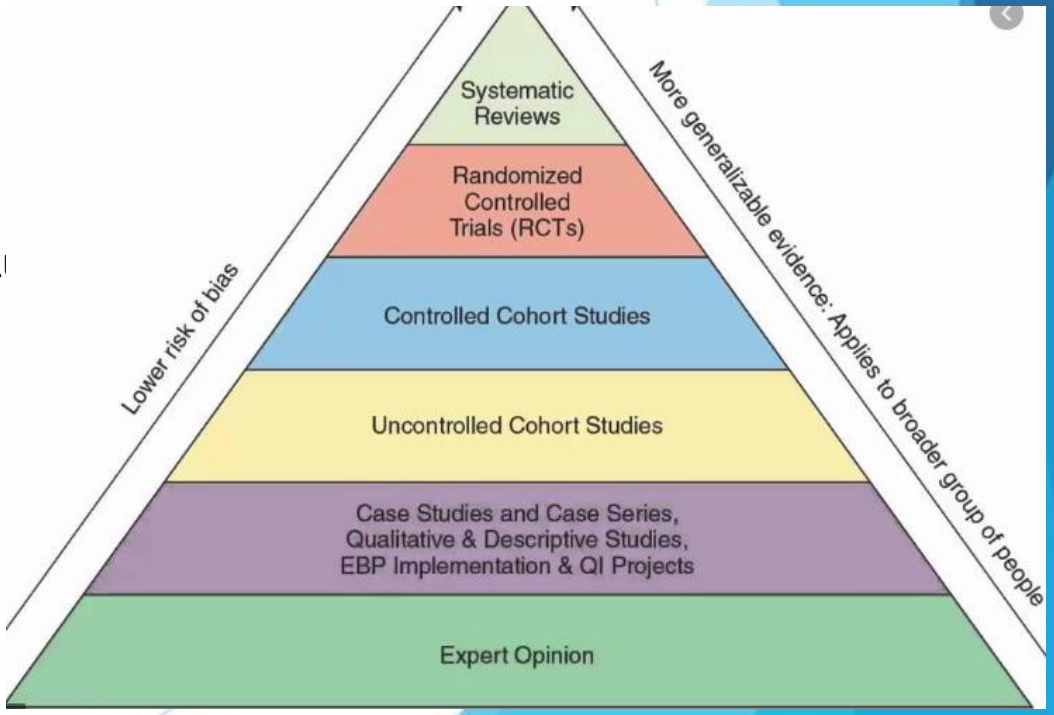
RCT, randomised controlled trials.

4.) Critically appraise the evidence

Quantitative Evidence & Qualitative Evidence

- Level 1 Systematic review of RCTs (highest level)
- Level 2 Single site RCT
- Level 3 Quasi-experimental stidies
- Level 4: Case or Cohort studies
- Level 5: Systematic reviews of of descriptive/qualitative st
- Level 6: Single descriptive or qualitative study
- Level 7: Expert Opinion (lowest level)

https://www.researchgate.net/figure/Hierarchy-of-evidence-Melnyk-Fineout-Overholt-2011_tbl1_281819754



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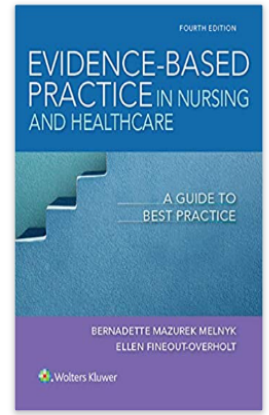
EBP Process

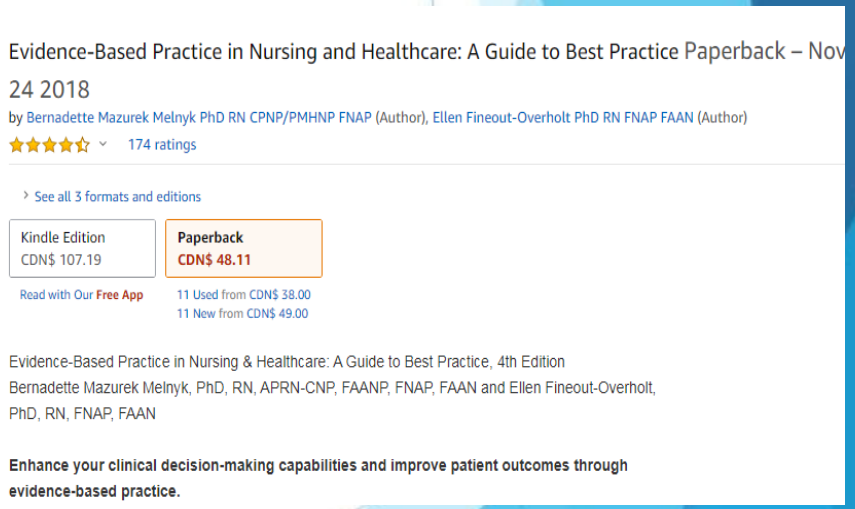
5.) Pilot a practice change

6.) Evaluate practice change and outcomes

7.) Disseminate outcomes & results

- oral & poster presentations
- Panel presentations
- Roundtable discussions
- EBP grand rounds
- Nursing journals
- Institutional or national health care policies





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Nurse Generalist

- Identify practice problems by observing patient populations and quality improvement activities
- Participate in evaluation of existing research or clinical evidence
- Collaborate with inter-professional colleagues to identify and implement a possible solution to a specific clinical problem
- Participate in research activities with guidance
- Clinical trials

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Critique & Question Prior to Implementation

- Are the results clinically significant & can they be generalized?
- Are implementation strategies discussed by the researcher desirable/feasible in practice?
- Are institutional support and resources adequate to implement the study findings?
- Can the outcomes of implementing study findings be measured?

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Principles of Education & Learning

Patient Education

- Needs Assessment (includes caregiver)
- Goals & Objectives
- Teaching Plan
- Evaluation

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Goals & Objectives

- S-specific
- M-measurable
- A-attainable
- R-realistic
- T-timely

- A -audience
- B-behavior
- C-condition
- D-degree

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Evaluation

- **Assessing knowledge:**

1. Multiple choice
2. Essay
3. Short answer

- **Assessing Skills :**

1. Case studies
2. Case presentations
3. Discussion & written questions

- **Knowledge Application:**

1. Simulation
2. Observation

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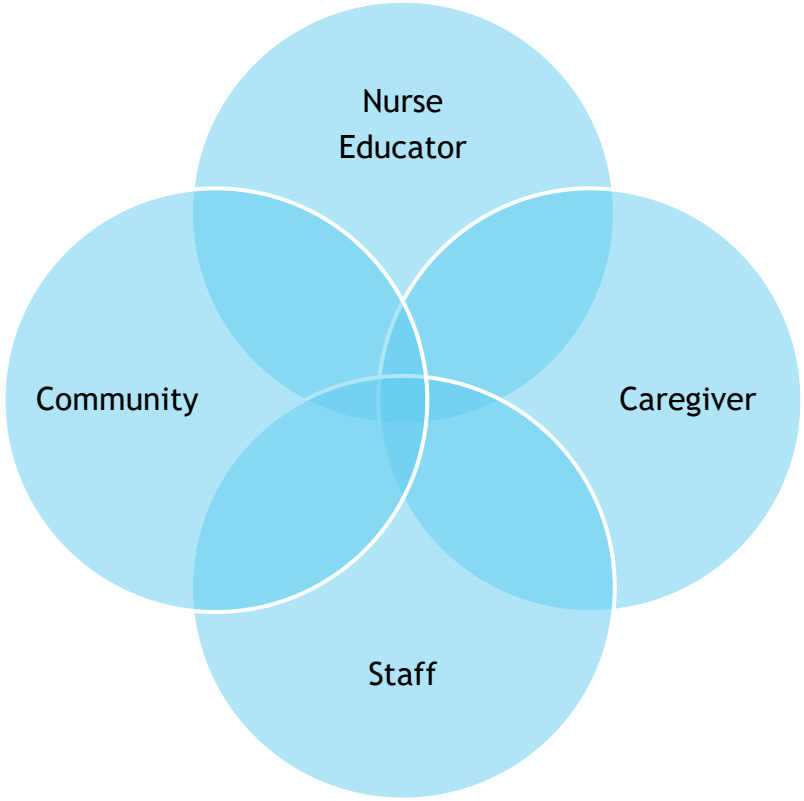
Education



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Legal Issues

- **State boards of nursing (BoNs)** provide oversight of nursing practice by enforcing the state nurse practice act to protect the health, welfare and safety of the public.
- **Patient's Bill of Rights in Health Care:**

1. Affordable Care Act
2. American Hospital Association Bill of Rights

Legal Issues

Standards of Practice

1. Nursing professional practice standards (ANA)
2. Oncology practice standards (ONS)
3. Accreditation and certification agencies

Oncology specific accreditation:

ONCC

ACS-COC

QOPI

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Patient Issues

- Legal issues for individuals with cancer
- Practice issues.
- Legislative policy issues

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Common Causes

Lack of informed consent

Improper medical device use

Not following standards of care

Failure to communicate appropriately

Inadequate treatment of care

Medication errors

Inappropriate delegation

Inadequate documentation

Practice Issues

1. Adverse drug reactions
2. Iatrogenic/HAC (Falls, infection)
3. Inadequate patient/family education
4. Proper use of telephone triage
5. Treatment related errors
6. Vesicant Administration
7. Withholding and withdrawing life support

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Strategies & Interventions

- Development of inter-professional communication skills
- Maintaining knowledge & skills
- Job description = scope
- Legal Documentation:

1. Patient centered
2. Actual work of nursing
3. Objective clinical judgment
4. Logical & sequential
5. Real time
6. Variances in condition

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Ethical Issues

Individuals perceive ethical issues differently based on :

- Individual values
- Knowledge
- Reflective thinking/reasoning

Code of Ethics (2015)

- Articulates nursing's core values to the public and the discipline
- Nine Provisions

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Contents

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Ethical Principles

Autonomy: Making one's own decision

Beneficence: Intending to do good

Non-maleficence: Intending to do no harm

Justice: Providing equal access

Ethical Issues

Communication
Patients and families
Truth telling
Ineffective can cause distress to nurse & poor clinical outcomes
Age culture personalities
Lack of skills

Confidentiality & Privacy
Expectation/Law
Health Insurance Portability & Accountability Act (HIPPA 1996)
Minimum amount of protected health information (PHI) required to care for patients be accessed or shred
Genomics Personalized Medicine
Social Media (privacy & boundaries)

Ethical Issues

Ethical Climate of Practice Environment
Respect (horizontal violence, incivility, physical/emotional assault)
Resources & Support
Shared governance

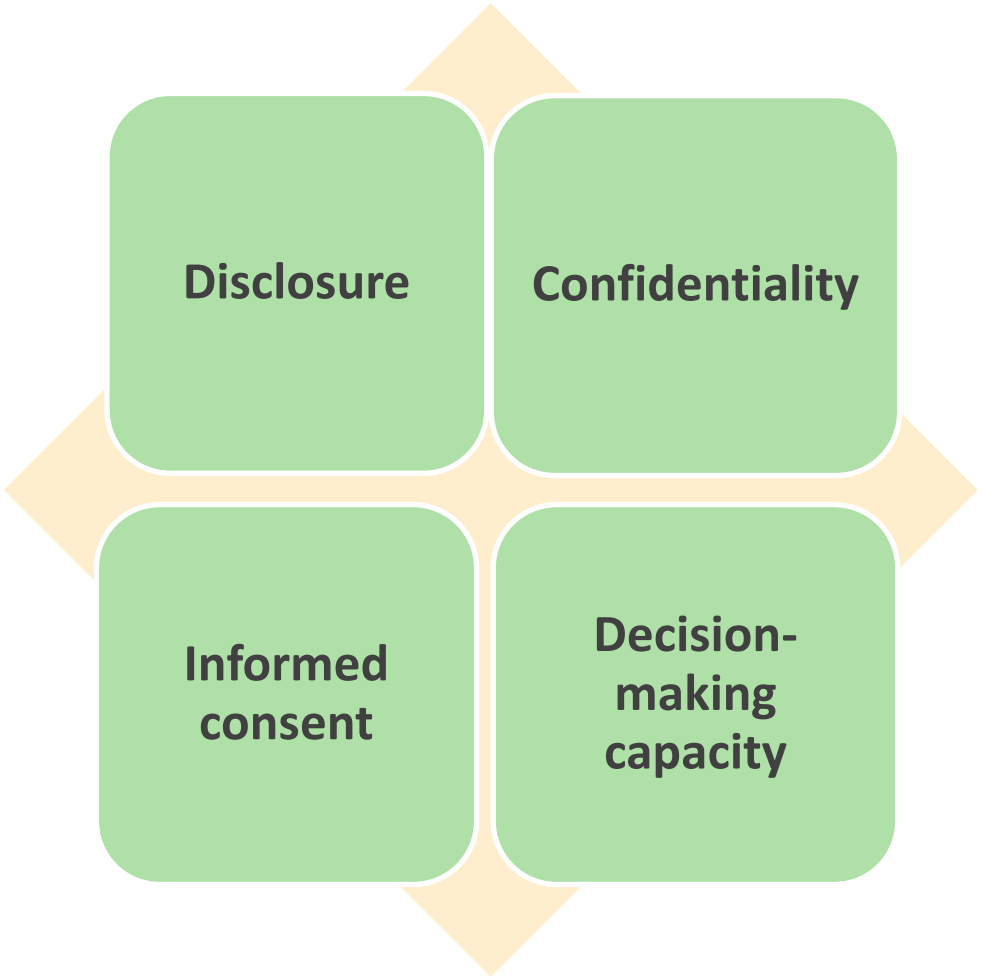
Clinically Challenging Patient Care Situations
Nurse unable to deliver optimal care
Moral distress caused by lack of communication between team members
Goals of care, informed consent
Lack of resources for discharge

Ethical Issues

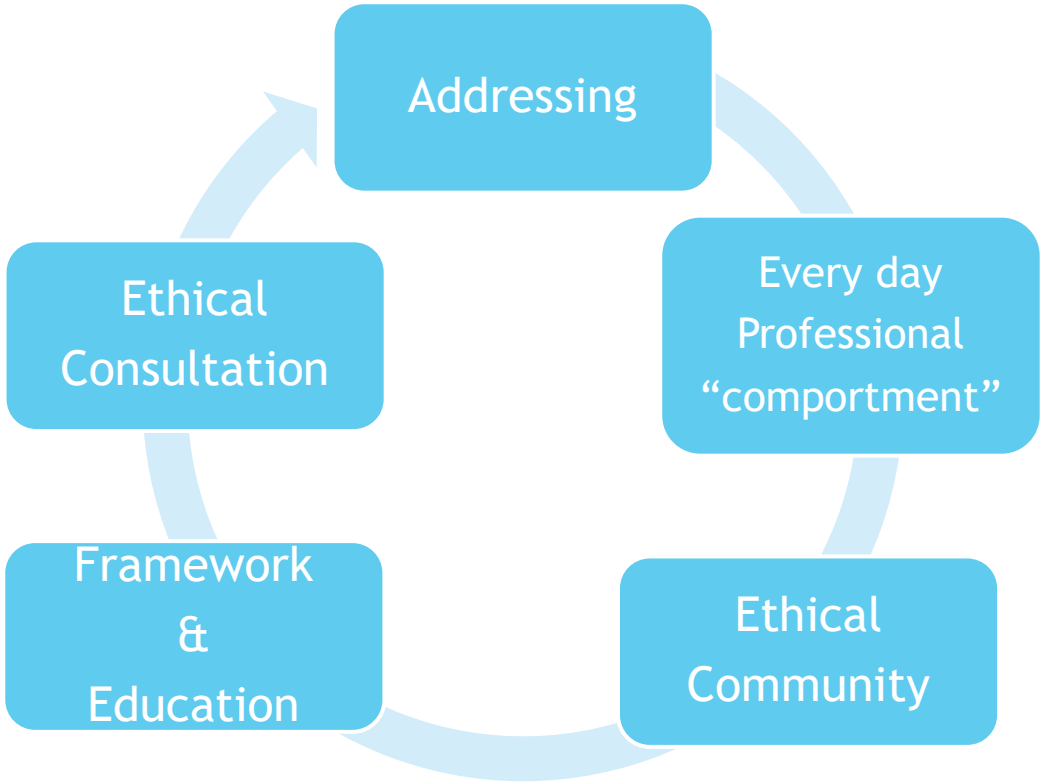
End of Life Care
Increased technology/prolonging the dying process
Advance directive: not always done and available
Lack of palliative/symptom management
Assisted dying/suicide/euthanasia
Cultural/Religion/Languages

Decision Making
Shared decision making
Informed consent: risks, benefits, alternatives and consequences of treatment
Capacity/competency (legal)
Pediatric (assent 7 years of age)

Issues of Communication and Shared Decision-Making



Resources to Manage Ethical Issues



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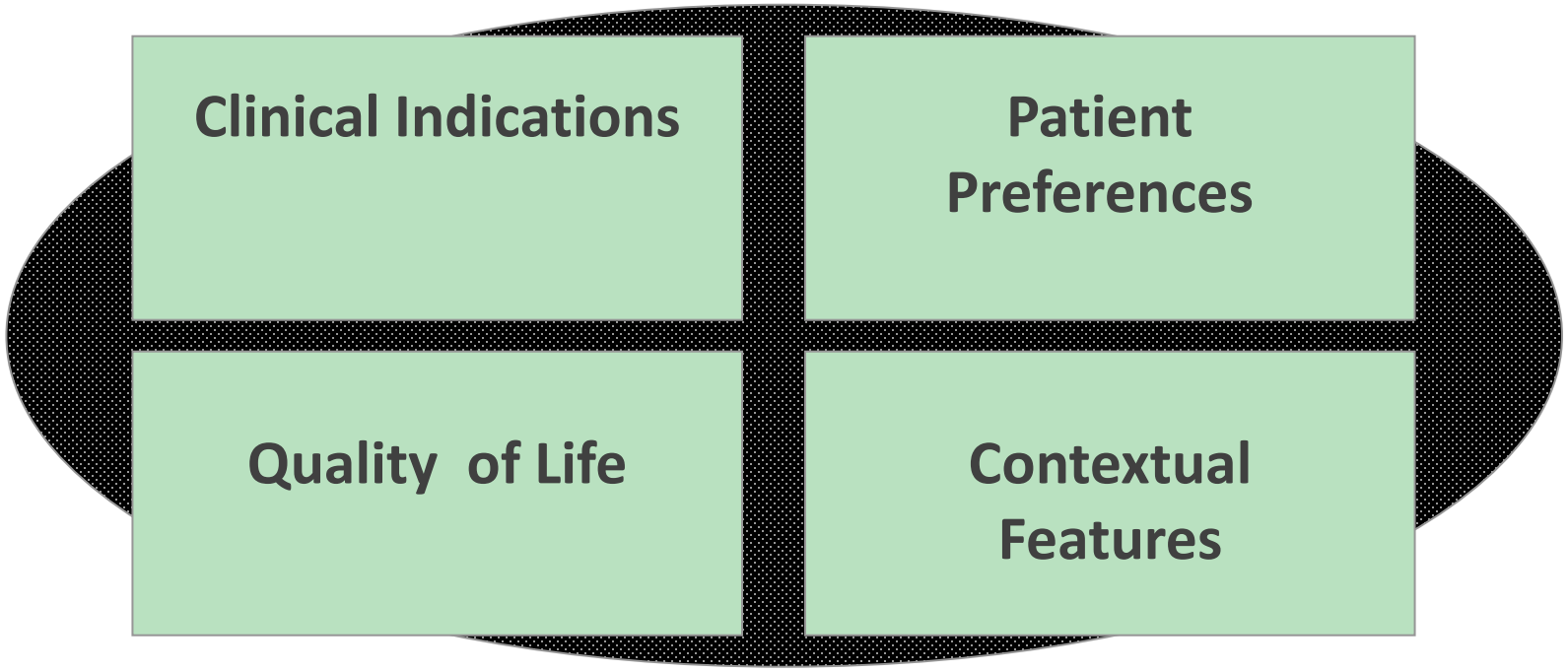
Facilitating Ethical and Legal Practice

The Four Box Method



Jonsen et al., 2015

Professional Issues

Quality Improvement

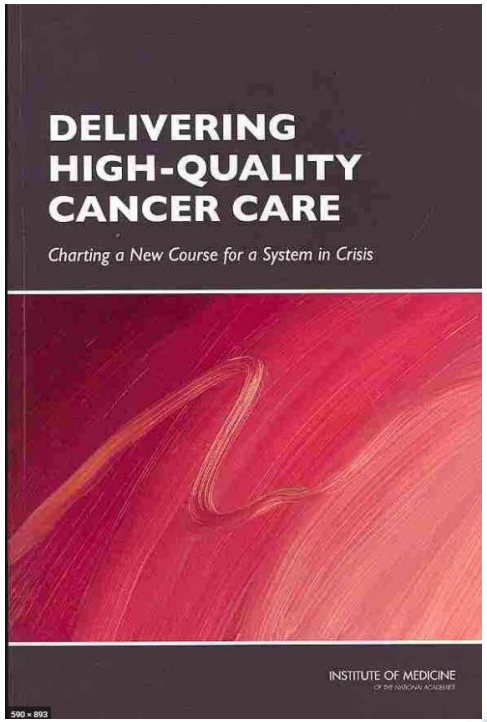
Creating a culture of safety

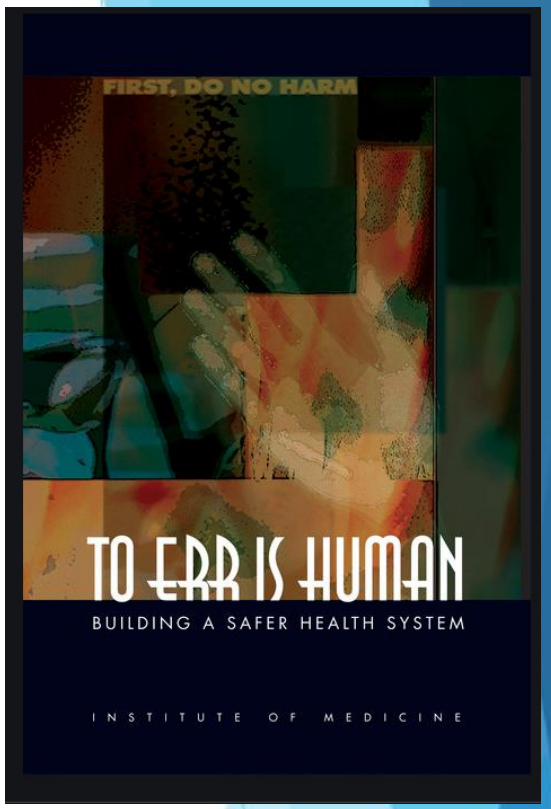
Center for Patient Safety

Reducing Preventable Harm

PATIENT SAFETY CULTURE | INTEGRITY | EXCELLENCE | ADVOCACY

https://www.centerforpatientsafety.org/





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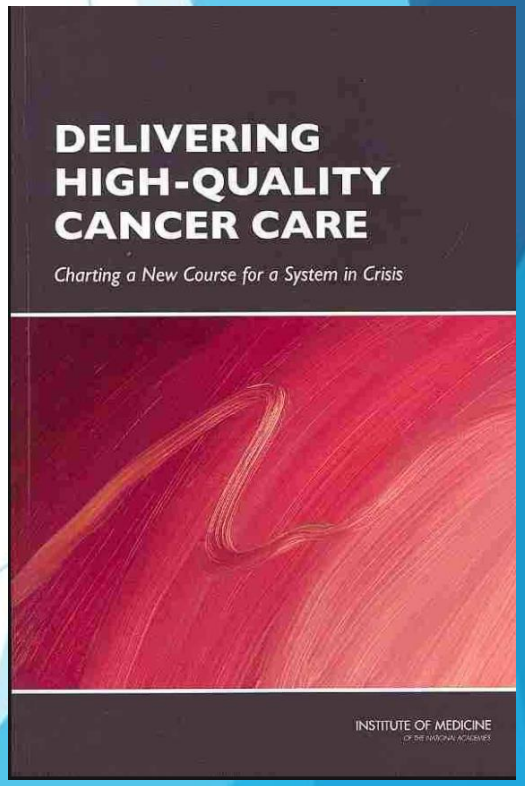
Conceptual Framework for High Quality Cancer Care

1. Engaged patients
2. Optimally trained and coordinated workforce for team based cancer care
3. Evidence based cancer care
4. Health care information technology (IT) system that meets meaningful use criteria
5. Translation of evidence into clinical practice , quality measurement & performance improvement
6. Accessible, affordable cancer care to reduce disparities and reform traditional fee-for-service payment reimbursement to newer payment models



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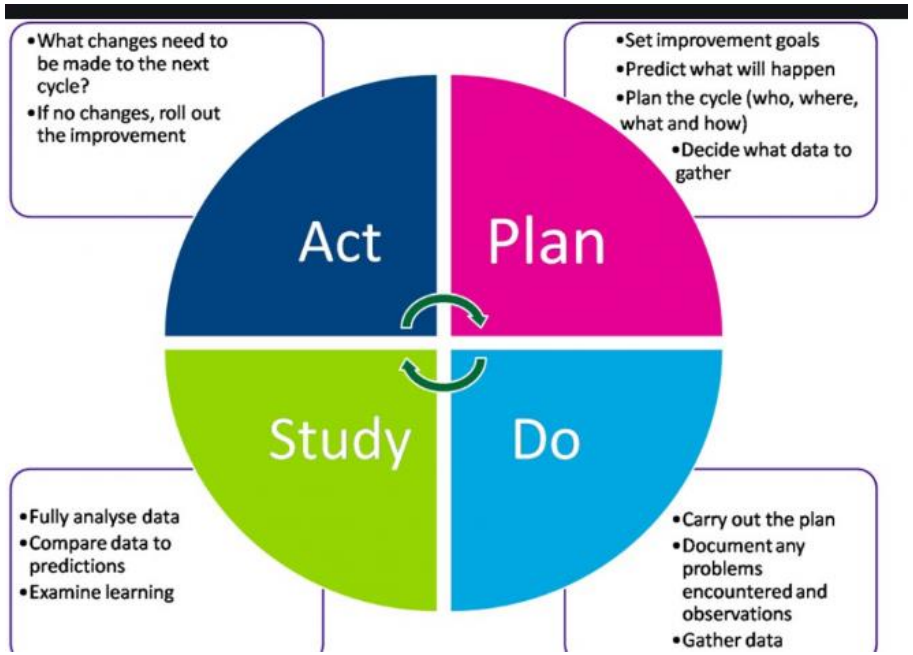
Model for Quality Improvement



Three Fundamental Questions

What is our goal?

How will we know that a change is an improvement?

What changes can we make that will result in improvement

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Interdisciplinary Collaboration

Barriers

- Lack of clearly defined, distinct domain of influence
- Lack of understanding scope of practice
- Overlapping and changing domains of practice that produce competition
- Lack of recognition for knowledge & expertise
- Legal responsibility

Opportunities

- Tumor Board
- Disease Management Teams
- Family Meetings
- Change of Shift Hand-Off
- Care across the care continuum

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Patient Advocacy
"Support for a cause"

1. Simplistic
2. Paternalistic
3. Consumer advocacy
4. Consumer-centric
5. Existential

Risks

1. Autonomy
2. Conflicting demands/pressures
3. Challenging issues: pain management, end-of-life decisions

Avenues

1. Work setting
2. Community Setting
3. Professional Organizations

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Educational & Professional Development

https://campaignforaction.org/

- Nurses practice to the full extent of their education & training
- Nurses achieve higher levels of education and training through improved education systems
- Nurses engage as full partners with physicians and healthcare professionals in re-designing healthcare
- Nurse develop effective workforce planning and policy making through better data and information infrastructure

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Educational & Professional Development

- Need for the proportion of nurses with a bachelor od science degree in nursing to 80% by 2020
- Professional education through national organizations seminars, webinars, conferences
- Graduate education
- Oncology nurse practitioner fellowships

Certification (ONCC)

Six certifications:

1. OCN
2. AOCNP
3. AOCNS
4. CPHON
5. CBCN
6. BMTCN

ONCC Oncology Nursing Certification Corporation

95% of certified nurses agree: certification validates specialty knowledge, enhances credibility and provides satisfaction.

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Hazards in the “Helping Professions”

“Everyone who cares about patients is at risk of eventually being injured, to a greater or lesser extent, by the hazards of frequent encounters with illness, injury, trauma, and death—not because we did something wrong, but because we care. Ironically, those who are burned out, worn down, fatigued, and traumatized tend to work harder.”

Fox et al., 2014

Cumulative Loss

Is it Compassion Fatigue or Burnout?

- Compassion Fatigue: Physical, emotional, and spiritual result of chronic and continuous self-sacrifice and/or prolonged exposure to difficult situations
  - Difficult and unable to love, nurture, care for, or empathize with another's suffering

- Burnout: Physical and psychological, with a decrease in loss of motivation. Triggered by:
  - More workplace demands
  - Lack of resources,
  - Interpersonal stressors
  - Organizational policies that can lead to diminished caring, cynicism, and ineffectiveness

Harris & Griffin, 2015

A Word About "Bullying"

- Repeated mistreatment and abusive conduct that is threatening, humiliating, or intimidating, work sabotage, or verbal abuse
- 27% stated that they have had past or present experience with being the victim of workplace bullying
- 72% of the American public are aware of workplace bullying
- 72% of employers deny, discount, encourage, rationalize or defend it
- Bosses are the majority of bullies
- Institutions must have a robust approach to address bullying and harassment and provide policies and access to confidentially report these behaviors
- https://www.myamericannurse.com/bullying-toolkit-available/

Kane, 2017

Be an “up-stander”

https://www.myamericannurse.com/bullying-toolkit-available/

Leading by Example

"Administrators set the tone for the organization. It is vital that they provide a workplace where people are valued for not only what they can do for the institution, but what they can contribute in their homes, the next generation, and to communities. Understanding the importance of being well-rounded, taking time off for reflection and rest, and caring for needs outside of the institution are valuable traits of an administrator. "

Malloy et al., 2013

Factors Influencing the Nurse's Adaptation

- Professional education
- Personal death history
- Life changes
- Support systems

Vachon et al., 2015

Management

Self Care

- Good sleep habits
- Exercise (3-4 times per week for 20-30 minutes
- Nutrition/eating well
- Massage
- Hobbies
- Preventative and medical appointments
- Set time aside to do something for self
- Keep a self-care journal

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Management

Grief Support/Counseling

- Verbalization
- Mindfulness based interventions
- Healthy supportive work environments with strong management/leadership support
- Self-reflection exercises

1. Journal
2. Make time for prayer & meditation
3. Take pride in personal accomplishments

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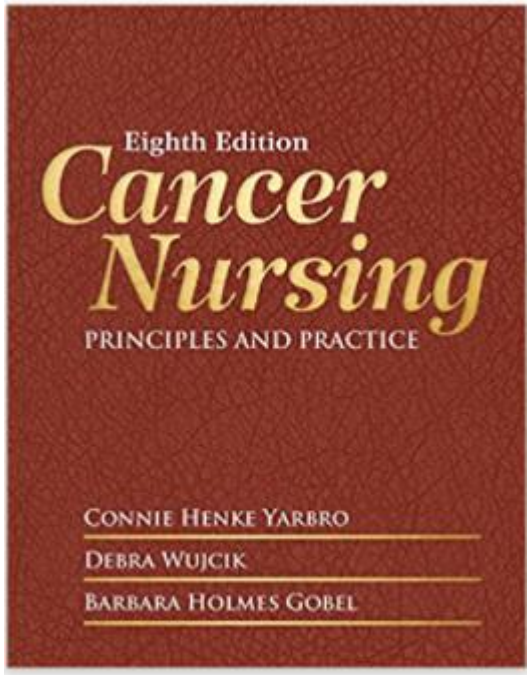
Question References



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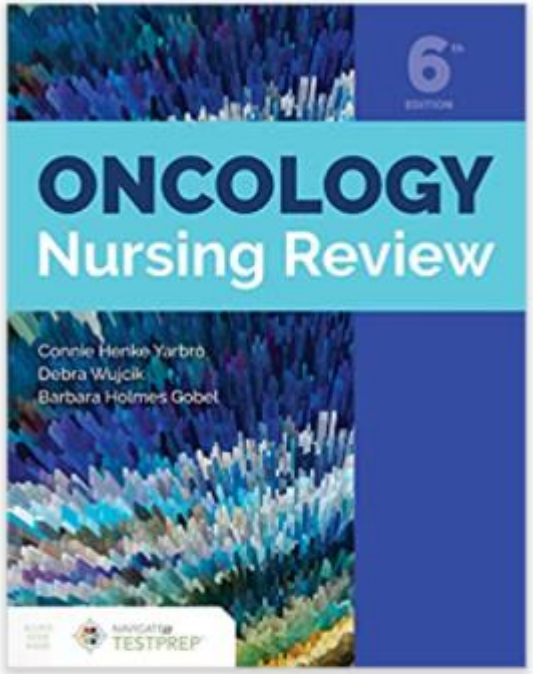

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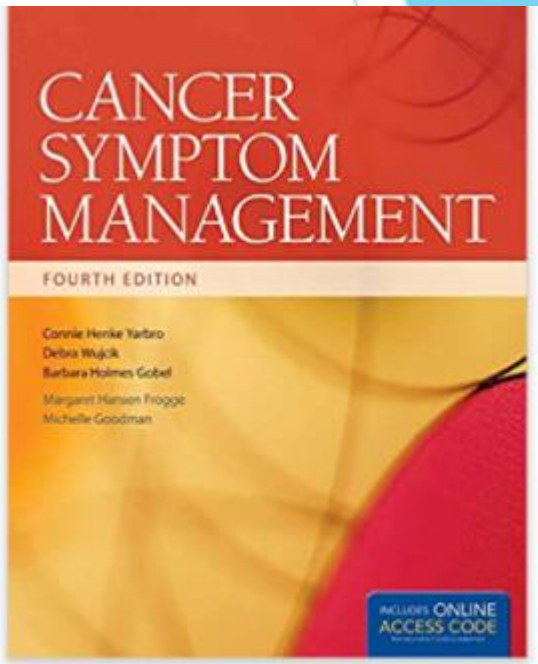

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Question #1

Demographic trends show that the number of cancer survivors continues to increase due to:

A. Aging population and improvement in cancer detection.

B. Aging population and improvement in cancer detection and treatment

C. Aging population and increased number of breast cancer survivors

D. Aging population and increased number of breast and prostate cancer survivors

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Answer: B

- The actual cancer incidence has decreased but the number of cancer survivors continues to climb due to population growth, aging population, and improvements in cancer detection and treatment. Breast cancer survivors are the largest group followed by prostate and colorectal survivors, but there are other groups of survivors as well. (CNPP, Page 2020)

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Question #2

The overall goal of rehabilitation for the person with cancer is to?:

A. Return to baseline performance before the cancer

B. Anticipate and prepare physically for future debilitating effects of cacner

C. Achieve optimal functioning within the limits of cancer

D. Maintain an active, busy life

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Answer: C

- Rehabilitation refers to the process by which individuals, within their environments, are assisted to achieve optimal functioning within the limits imposed by cancer. The goals are to improve the quality of life for those experiencing cancer and to help the individual regain wholeness. CNPP, Page 2007-2041

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Question #3

The recognized professional authority for oncology nursing practice is?:

A. American Nursing Association

B. American Academy of Nursing

C. Oncology Nursing Society

D. National Institute of Oncology Nursing

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Answer: C

- The recognized professional authority for oncology nursing practice is the Oncology Nursing Society. (CNPP, Page 2091)

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Question #4

One of the four ethical principles guiding clinical practice is non-maleficence. To what does this term refer?

A. Helping the patient to balance the benefits against the risks
B. Distributing the resources in a fair and reasonable way
C. Helping the patient make decisions that are right for themselves
D. Avoiding practices that will do harm to the individual

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Answer: D

- Non-maleficence means to do no harm. The other ethical principles guiding clinical practice are autonomy, beneficence, and justice. Autonomy is the process of helping patients make the decisions that are right for them. Beneficence is shown by helping the patient balance the benefits against the risk of harm. Justice is the distribution of resources in a fair and reasonable way. (CNPP Page 143-144)

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Question #5

Individuals with low annual income:

A. Are more likely to die of Cancer than those with high annual incomes
B. Rarely experience a definable difference in survivorship or treatment
C. Are twice as likely to experience recurrence, treatment failure, or death as those with higher incomes
D. Are less likely to receive curative therapy

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Answer: A

- Individuals with a low annual income are more likely to die of cancer than those with high annual income

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Question #6

When a patient at the end of life complains of dyspnea, the nurse should *most appropriately* focus on which of the following?:

A. Determine the degree of dyspnea by assessing arterial blood gases and pulmonary function tests

B. Monitor pulse oximetry to determine need for oxygen

C. Administer opioids to lessen the sensation of breathlessness

D. Administer bronchodilators as needed.

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Answer: C

- Although continuous pulse oximetry is used widely, patients and family members often focus on the monitor, which can cause anxiety and fear. Opioids are the first-line therapy in relieving dyspnea without causing respiratory depression. Bronchodilators can relieve bronchospasm but can also increase anxiety. (CNPP, page 2078)

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Question #7

The two *most important* nursing considerations as death approaches are:

A. Placing intravenous lines for hydration and parenteral nutrition

B. Greater attention to hygiene and activities of daily living

C. Family preparation and symptom management

D. Symptom management and palliative sedation

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Answer: C

- The two most important nursing considerations as death approaches are expert symptom management and family preparation. (CNPP, Pages 2080-2081)

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Question #8

Risk factors for compassion fatigue include:

A. Older age and high levels of empathy

B. Older age and low levels of empathy

C. Younger age and high levels of empathy

D. Younger age and low levels of empathy

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Answer: C

- Risk factors for compassion fatigue are younger age, high levels of empathy, unresolved personal trauma or loss, lack of professional or institutional supports, and frequent exposure to trauma or loss. (CSM, Pages 713-715)

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Question #9

In recent years what condition has prompted litigation for nurses?

A. Medication errors

B. Inadequate pain management

C. Violations of the Health Insurance Portability and Accountability Act

D. Hypersensitivity reactions

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Answer: B

- In recent years, the under-treatment of pain by nurses has prompted litigation and state licensing board actions (CNPP, Pages 2122)

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Question # 10

What is the most important assessment for dyspnea?:

A. Patient's self-report

B. Blood gas evaluation

C. Oxygen saturation level

D. Pulmonary function tests

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Answer: A

- Dyspnea is a subjective experience and may not correlate with findings of hypoxia, hypercarbia or tachypnea. Thus the best test for dyspnea is the patient's self-report of dyspnea, shortness of breath (CNPP, Page 2078; CSM, Pages 317, 319-320)