



Advisory Council Meeting November 2008

Workshop activity reports

A) Specialist cancer nursing: addressing the diversity of nursing roles or losing the essence of nursing?

Group participants

- Kay Leonard, EONS Board Member, Ireland
- Ulrika Östlund, EONS Board Member, Sweden
- Katarina Lokar, Slovenia
- Helene Schneck, Switzerland
- Giovanni Cavadini, Italy
- Bernadine van der Walle, Netherlands
- Nurgün Platin, Turkey
- Svetec Branka, Croatia
- Dusanka Tadic, Serbia
- Marica Miscancuk, Croatia
- Ingrid Bruyns, Belgium
- Bart Jan Bosch, Netherlands

Specialist Cancer Nursing

Each nurse discussed their experience of specialist cancer nursing in their countries. There was a variety of responses dependent on the country whether or not specialism existed and if the titles were protected.

Ireland

Defined criteria and protected title for Clinical Nurse Specialist (CNS)/Advanced Nurse Practitioner.

Sweden

Specialist nurse (protected title).

Slovenia

No CNS/Oncology or cancer nurse.

Switzerland (French speaking part)

One oncology nurse specialist.

Many different education, title not protected.

Italy

Cancer nurse specialization but no positions. Can do the education but no job title.

Netherlands

Oncology CNS. New protected title from December 2008.

Difference between oncology nurse and CNS.

Turkey

Master's oncology nursing available but no specialisation in oncology.

Croatia

No continuing education or specialization in oncology.

Serbia

No specialization in oncology.

Basic programme for oncology – certificate.

Belgium

Legislation – protected title for specialization.

No monetary reward for CNS.

Specialist cancer nursing - issues discussed

- Site specific versus generalist oncology CNS
 - Suggestion that in a cancer centre should be tumour site specific but in a general hospital oncology CNS.
- Specialities based on the medical model e.g. tumour site, lung not on nursing.
- Need to be careful of roles – site specific too luxurious.
- CNS should be holistic.
- Support to CNS.
- Specialism – nurses losing their role.
- Specialism concentrates on disease or nurse not on the patient.
- Fragments care.
- Nurses need higher education – takes them further away from the patient.
- Oncology nurses should care for patients with cancer.
- Clinical career pathway – education and patient care.
- ‘Over-specialization’.
- Nurses not keeping up with developments e.g. TARGET.
- Mini doctor/maxi nurse
 - Patient wants to see physician
 - Patients accept nurse-led clinics
 - Taking on roles of the physician – who does the ‘nursing’?
 - What will happen to patient care?
 - No research on care assistant delivered care

Summary

- Specialism is good.
- Important that we grow as a profession – opportunity for nurses.
- Is CNS/specialisation for nurses or patients?
- Arguments for and against site specific CNS.
- Not a mini physician.
- CNS for symptom management e.g. pain management, fatigue.
- One CNS per department e.g. Breast, palliative care.
- EONS could define vision/model for European oncology nurses.

B) Drivers and barriers to development of specialist cancer nursing: how can cancer nurses be more visible?

Group participants:

- Maria Dolores Fernandez Peres, (Spain)
- Marjana Bernot (Slovenia)
- Anu Saag (Estonia)
- Jorge Freitas (Portugal)
- Elisabete Valerio (Portugal)
- Bernhard Glawogger (Austria)
- Dimitrios Papageorgiou (Greece)
- Sultan Kav (EONS Board - Turkey)
- Anita Margulies (EONS Board- Switzerland)

Why are cancer nurses not „visible“

- Common terminology (e.g.CNS) is not in practice.
- No political lobbying (also not from national nursing organisations).
- No official oncology specialty MSN in most programs.
- No difference in the work setting if MSN or not – nurse = nurse, formally only on paper.
- The innuendo „Why do you think oncology nursing is different? “ is often stated.
- Salaries are often the same regardless of title.
- Attitude of MD's; interested in experienced RN's but don't want interference in the decision making.
- Monetary reimbursement for CNS not regulated nor planned in hospital budgets.
- Definition of „knowledge“ – who tests, who controls knowledge of oncology issues. There is no common European quality standard available = „free for all“.

How to make cancer nurses visible:

- Autonomy – take responsibility for what we are doing:
 - increase clinical knowledge
 - increase „evidence“ expert based knowledge
 - increase competency based on knowledge
- Carry out nursing research, clinical as well as behavioural, and show positive outcomes.
- Use EONS as a network and as an umbrella organ.
- Increase collaboration with e.g. hospital to get jobs based on qualitative / quantitative outcomes.
- UNIFIED POST GRAD PROGRAM – **UNIFIED EONS CERTIFICATION** with set curriculum, set credit points; **develop a standardized certification exam e.g. ONS, for all European countries.**
- PR communication within the hospital setting.
- PR communication within different hospitals (regional).
- Present group or own activities locally through special interest groups, cancer organisations.
- Availability of physicians; if too few encourages the position of CNS, NP.
- Collaborate with MD's on e.g. side effect management
- Initiate, implement and follow guidelines- everyone should be doing the same thing“.

C) How do we develop education for specialist cancer nurses within Europe?

Members of group

- Chair: Sara Faithfull
- Paul Trevatt
- Franziska Schneider
- Stephen O Connor (individual member)
- Jurgita Gulbiniene (Lithuania)
- Cheryl Vidall (UK)
- Daniela Simova (Bulgaria)

Discussion of existing programmes and the extent of specialist roles within Europe was the focus of initial discussions. In the UK, Netherlands and Sweden specialist curriculum exist for oncology nurses at an advanced level. However differences were described in academic provision across and within countries.

EONS in developing specialist curricula assumed a certain level of specialist skills and discussion in the group was about what those skills may be and how they complemented the site specialist skills being developed in education. The specialist nursing project highlighted consensus in what people thought those characteristics were but a lack of consensus on how these were utilised in roles across Europe. The clinical nurse specialist was seen as a key developmental role for extending and professionalising the role of the cancer nurse in various countries. It was seen that part of the difficulty was in the nurse being able to translate that role into some form of quality metric and how this would then influence clinical outcomes. The group agreed that part of the invisibility of cancer nursing at a policy and decision making level was the lack of evidence and recognition that specialist training or skills would impact on patient outcomes.

Forming a framework of fundamental or generic components of specialist nursing was seen as essential to join the site specific curricula together. Discussion of what those component parts might be raised issues about the difference between advanced and specialist practice. Components identified were: Clinical, education, research and leadership. Different priorities were highlighted depending on the area or type of work of the nurse. A consensus role description for Europe for the cancer nurse specialist would be helpful and competencies for these areas.

Core skills were identified as:

- Advanced communication skills
- Case management
- Symptom management (emotional and physical)
- Change management (economics and quality indicators)
- Applied research (evidence based practice)

Discussion around how to develop this was focused on existing courses in Europe for example the Maastricht distance learning programme on advanced practice but also on existing societies like the European federation of Nursing (EFN).

ACTIONS:

- To liaise with existing European institutions developing specialist cancer nursing programmes (Maastricht)
- Consider new framework within development of post basic curriculum development (2010)
- Contact EFN in relation to specialist nursing framework