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Cancer Nursing Practice

January 2024 / Volume 23 / Number 1 cancernursingpractice.com

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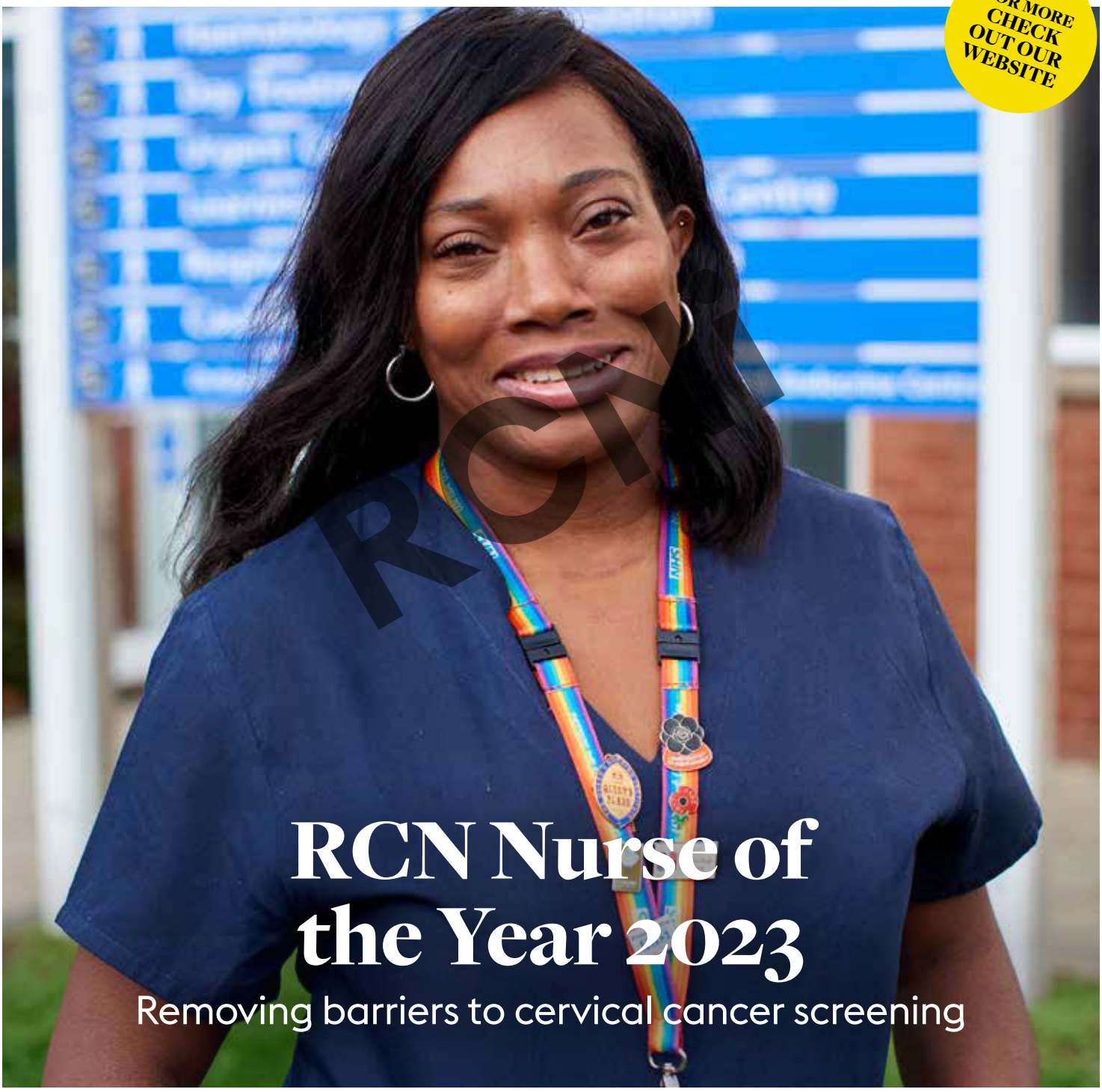

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RCN Nurse of the Year 2023 Julie Roye wins award for removing barriers to cervical screening. News, page 6, and Feature, page 14

Cover credit: John Houlihan

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Meet the contributors

ABBIGAIL LANGSTONE-WRING is a **complementary practitioner and clinical reflexologist** at a private practice in Dorset. She has 30 years of experience as a self-employed complementary practitioner, and has been a college tutor, author, researcher, conference delegate and presenter, and accredited training provider. She also delivers reflexology at a local hospice, and is a public hospital governor and board member of the International Council of Reflexologists. Her co-writer JUDITH WHATLEY is a **senior lecturer** in complementary healthcare at the School of Health Sciences, Cardiff Metropolitan University, Wales.
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DANIELLE CASEY is a **haematology and stem cell transplant nurse educator** at the Royal Marsden Hospital, London. She began her career in Australia and has more than 12 years' experience in haematology. She has worked in different roles including being a stem cell co-ordinator and clinical nurse specialist in pre and post-transplant and CAR-T-cell therapy. Ms Casey has an interest in improving nurse education and resources for staff. Her co-authors are JOANNE CONWAY, a **haematology advanced nurse practitioner**, and ELAINE TOMLINS, a **chemotherapy nurse consultant**, both at the Royal Marsden Hospital, London.
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HELEN KERR is a **specialist practice nurse in cancer** and **senior lecturer** at the School of Nursing and Midwifery, Queen's University Belfast. In this role, she is also pathway lead for the specialist practice in cancer pathway. Her educational research focuses on introducing and evaluating innovative digital approaches, such as virtual reality methodology, into the cancer education curriculum, while her health service research concerns the effect of advanced and specialist nurse roles on patient outcomes. Her co-writer, SHANNON PORTER is also a **lecturer** at Queen's University Belfast and has a clinical background in haematology nursing.
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editorial

Too many people are still being diagnosed with cancer too late

As another new year begins, it is time to recognise the wonderful and diverse reality of working in cancer nursing, not only in the UK, but across the world. Many of you may already have been engaged with the Global Power of Oncology Nursing (GPON) network, a growing global movement of cancer nurses who promote, reflect on, and share the achievements and challenges of cancer care, particularly in low resource countries.

By Barry Quinn
senior lecturer cancer and palliative care, Queen's University Belfast, Northern Ireland

In these countries, many people with cancer do not have adequate access to essential nursing care, cancer treatments or support.

The GPON brought this to the attention of the world at its virtual conference at the end of last year, when 300 nurses from 43 countries came together to learn about the challenges of cancer nursing amid poverty, deprivation, famine, floods, war and environmental destruction.

Sadly, many people around the world are being diagnosed with advanced cancer too late, cannot access treatments and, therefore, do not survive.

Greater equity and inclusion was also an important theme at the UK Oncology Nursing Society annual conference in Wales.

More than 500 delegates learnt from fellow cancer nurses about listening to, and working with, those people whose voices are not always heard – older people, children and young people, people with disabilities – while recognising the rich cultural diversity around us.

There are many strong examples of greater inclusion in cancer services, and we can creatively build on them by working with the communities concerned and by making care settings welcoming places accessible to all.

Every nurse working in the field of cancer counts and makes a difference, just as every person with cancer needs to be heard.

'Every nurse working makes a difference, just as everyone with cancer needs to be heard'

Our mission
Cancer Nursing Practice aims to inform, support and educate nurses caring for people with cancer. Focusing on new developments in cancer that affect the nursing sector, the journal seeks to inspire and share professional excellence in cancer nursing to improve practice and enhance patient outcomes. It is available in print or digital formats and includes unlimited access to our website.

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ISSN 1475-4266 (print)
ISSN 2047-8933 (online)

Printed by Stephens and George, Merthyr Tydfil, on acid-free paper

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Cancer nurses recognised at RCN Nursing Awards

Queen's Nurse Julie Roye named Nurse of the Year 2023 for her work to boost smear tests at Cauldwell Medical Centre, Bedford

By Jennifer Sprinks @RCNi_Sprinks

Cancer nursing and research initiatives gained recognition for their contribution to improving outcomes in patient care at the RCN Nursing Awards 2023, held in Liverpool in November.

Julie Roye, Queen's Nurse and head of nursing for primary care at East London NHS Foundation Trust was named Nurse of the Year 2023 after winning the Leadership category for her work to boost smear tests among eligible 25-64 year olds at Cauldwell Medical Centre, Bedford. She increased uptake from 52% to 80% in nine months, improving equitable access for the diverse patient population.

Ms Roye and her multidisciplinary team, including experts in outreach and education, focused on making appointments more convenient and found new ways to engage with the community.

'This shows a deprived borough can achieve the same healthcare as privileged areas with the right leadership and by accepting change,' Ms Roye said.

Roxanne Crosby-Nwaobi, lead research nurse at Moorfields Eye Hospital NHS Foundation Trust, won the Researcher of the Year Award.

She led a campaign to raise awareness about taking part in research opportunities among minority ethnic groups and people from deprived areas.

Dr Crosby-Nwaobi created a digital platform to engage with patients and encourage them to sign up for clinical trials. Her work with focus groups to co-produce promotional materials has been translated into several languages, including Gujarati, Punjabi, Hindi, Urdu and Bengali.

rcni.com/nurse-awards

In brief

Plans to bridge the gap between the supply of systemic anticancer therapy drugs and the rise in their demand are being unveiled in new planning guidance.

Speaking at the UK Systemic Anticancer Therapy (SACT) Board conference in November last year, Anne Rigg, NHS England national specialty adviser for chemotherapy, said there is an urgent need to tackle the 'mismatch' between demand and capacity for SACT delivery. She explained how demand for SACT has surged against a backdrop of workforce challenges and drug supply issues.

'The number of patients receiving SACT is increasing,' said Dr Rigg, a member of the NHS England SACT capacity task and finish group. 'We are seeing a growth rate between 6% and 7% per annum.'

Under new guidance, there will be regular assessments of SACT supply and demand to be communicated with cancer alliances. The National Institute for Health and Care Excellence will also publish a supply assessment template for new drug approvals to help organisations establish resources needed for their delivery.

The UK SACT Board will disseminate good practice from the guidance across all four nations.

A campaign to raise awareness of triple negative breast cancer (TNBC) and ensure people with the disease receive appropriate support has been launched by the biopharmaceutical company MSD in partnership with the UK Charity for TNBC.

TNBC is a type of breast cancer where the cancer cells do not have receptors for the hormones oestrogen and progesterone or the HER2 protein. This means there are fewer treatment options for people with TNBC compared with other breast cancers.


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Managing expectations of new cancer treatments and trials

Cancer drugs are developing rapidly but may not always be readily available to patients and communicating this sensitively is important

By Norman Miller
health journalist

New cancer treatments are being developed at lightning fast pace. An online search will reveal a proliferation of stories about a 'promising new treatment' or a 'potential breakthrough'.

This has positive implications for our treatment of cancer in the future. However, for those who have the disease right now, it can be easy to get a false impression that such treatments are readily available, when in reality they may be years away from being approved for use.

Macmillan Cancer Support chief nursing officer Claire Taylor says: 'We often hear breaking news stories about drugs that are in very early phases of development which are not available commercially or are yet to be approved in this country, which is important when managing expectations.'

New treatments will go through at least three phases of trials sometimes over a period of more than a decade, before being considered for approval.

Understanding information

People who hear about such treatments in the media may hope to take part in a clinical trial themselves, and may have questions about it for their cancer clinical nurse specialist (CNS). The CNS can play a vital role in helping them interpret and understand information they may have read about.

'Time is needed with the patient to explain the phases of clinical trials, and how it can take time for trials to progress to the next phase of recruitment,' says Catherine Hunter, Macmillan lung cancer clinical nurse specialist at University Hospitals Sussex NHS Foundation Trust.

Anyone can research what trials are recruiting patients through publicly available resources. Cancer Research UK (CRUK) provides a great starting point with a clinical trial database and a cancer nurse helpline. Another source of trial information is the National Institute for Health Research.

Recruiting to trials

CRUK says its trials recruit on average more than 25,000 patients per year. Recruitment was hit by COVID-19, according to the Institute of Cancer Research, but the yearly average for the three years before the pandemic was 67,057.

If a trial is suitable, the patient will need to discuss it with their consultant. To be accepted on to a trial, patients must be referred by their own doctor or consultant to the clinical lead who is running the trial.

At this stage a CNS can offer support to the patient and answer any questions they may have. Once the trial actually begins, however, the patient will probably see less of their CNS and more of a specialist research nurse attached to the trial.

'During a research trial, patients are likely to have most contact with their research nurse, who coordinates care while they are on the trial, including organising investigations and taking blood samples,' explains Ms Taylor.

'There may be negotiation with the CNS to establish who will act as the patient's key contact during the trial; and it might be a shared role. The research nurse will support the patient for the duration of the trial.'

Before anyone starts a trial, a research nurse provides

detailed patient information sheets explaining the trial rationale, procedures, possible side effects, consent process and confidentiality. However, as these can be dozens of pages long and filled with medical terminology, the CNS has a vital role to explain what is involved in a way that allows a patient to give informed consent for a trial.

'It is important for the cancer CNS to break things down to a human level,' says Ms Hunter. 'For example, if you take part in this trial you will need to come to hospital every second Monday for a full day of treatment/blood tests/ECGs.'

Importantly, the nursing team – CNS and research nurse – should make it clear to a patient that they can choose to leave a trial at any point if they wish.

Patient choice

'Research nurses provide education at the start of a trial and throughout to keep the whole team informed and up to date – but each nurse has their own role in the patient's care,' says Wendy Cunningham, oncology clinical research nurse in the Northern Ireland Cancer Trials Network at Belfast City Hospital. 'But it is as important to educate the patient in the treatment specifics or other support services they may need.'

Patients must be clear on what the trial will demand of them.

Judith Hogg, specialist research nurse in haematology at Hull University Teaching Hospitals NHS Trust, says: 'Participants on trials may need to attend extra visits and testing or treatment schedules, which may involve more time travelling and waiting at clinics.' In addition, extra travel could end up costing the patient more money.

Before a patient agrees to take part in a study, they can ask a research nurse any questions they need answering, or get clarification on anything they do not understand. This can be an opportunity to gently address the participant's expectations, Ms Cunningham says.

'It is hard to manage patient's expectations so that they are completely realistic, but we have a close relationship with the patient – so if we identify unrealistic expectations we can address them gently. Other issues can include lack of control in randomisation – the patient must be happy to have either the new treatment or placebo. There are also risks with all trials, although safety is the priority. It is important they know that, should a safety risk be identified, they will be informed and carefully monitored.

'It is important for the cancer clinical nurse specialist to break things down to a human level'

Catherine Hunter, Macmillan lung cancer clinical nurse specialist, University Hospitals Sussex NHS Foundation Trust

'Having cancer is already emotionally difficult, but being in a clinical trial brings its own difficulties. The good thing is that trial patients have the research nurse working closely with them wherever they go – outpatient, inpatient, surgery, radiotherapy, systemic anticancer therapy.'

This can be a double-edged sword, however. 'The difficulty comes when the patient reaches the end of the trial and the close relationship with the research nurse officially comes to an end,' says Ms Cunningham. 'It is important at this stage to pass the patient on to the CNS to minimise this abandonment and maintain good care.'

Clarity about treatment

If the trial has not had a positive outcome, this can be an especially challenging time, so the role of the CNS is crucial.

'As a CNS, I would check with the treating consultant what the next steps are and then arrange an oncology review or a discussion with the multidisciplinary team to clarify what, if any, future treatment options there may be and the follow-up schedule,' explains Ms Taylor.

'I would then contact the patient to assess how they are feeling and what concerns and questions they have.'

Should the patient's situation improve, the situation must also be handled carefully by a CNS.

'The response will depend on factors, such as the relationship they have with that patient – whether they are the clinician managing their follow-up care, or whether they have a more supportive role,' says Ms Taylor.

'The CNS needs to be clear about whether treatment is being given with curative or palliative intent – and then clarify with the patient how they feel, what they understand, and check what they know about any "improvement".

'Cancer CNSs will want to give the patient some hope, but this needs tempering with some realism about what they will want to assess in the next cycles of therapy and if we can maintain this until our next review,' she concludes.

'There has to be a balanced view and careful use of language,' says Ms Hunter. 'The CNS should be pleased "the patient is feeling better in themselves" or that latest scans show "a partial response for now". But the word cure isn't often used in cancer nursing.'

Further information

Cancer Research UK (2022) Phases of Clinical Trials. **tinyurl.com/CRUK-clinical-trials**

Cancer Research UK (2023) Find a Clinical Trial. **tinyurl.com/CRUK-find-clinical-trial**

Institute of Cancer Research (2021) Clinical trials in Cancer. **tinyurl.com/ICR-clinical-trials**

National Institute for Health and Care Research (2021) What Happens on a Study? **tinyurl.com/NIHR-be-part-of-research**

Nursing Standard (2023) Well-chosen words: how what you say affects patient outcomes. **rcni.com/well-chosen-words**

Tips on communicating with patients

» Give the patient a chance to tell you what they need to know and use this to inform the conversation
» Be guided by and reflect the patient's use of language
» Try not to sound too scripted or rehearsed
» Remember the power of a pause in the conversation
» Speak with authenticity and empathy
» Do not say 'I understand how you feel' as you may not

Source: Nursing Standard (2023)

What waiting time target changes mean for nurses

The NHS had its worst year for cancer waiting times in 2022, but a streamlining of standards may lead to improvement

By Kathy Oxtoby
health journalist

NHS targets for waiting times in cancer treatment have been streamlined from ten standards to three. NHS England (NHSE) says the reduction will simplify standards it sees as outdated.

But the change comes against a backdrop of targets routinely being missed and reports of some patients having operations cancelled two or more times. So what will these changes mean for nurses?

What are the changes to cancer treatment waiting time targets and why have they been changed?

NHSE received government approval to implement changes to cancer waiting time standards in England from 1 October. The move follows a consultation on their proposed changes in 2022.

The changes involve the streamlining of ten waiting time targets to three outcomes-focused standards that are broader and encompass the previous ones. These are:

- **Faster diagnosis standard:** patients to receive a diagnosis or have cancer ruled out within 28 days of referral (75% of patients).
- **31-day treatment standard:** all cancer patients to commence treatment within 31 days of a decision to treat (85% of patients).
- **62-day treatment standard:** patients to commence treatment within 62 days of being referred either by a GP or through cancer screening or from consultant upgrade (96% of patients).

The 31- and 62-day standards are in line with Scotland and Northern Ireland, while Wales has its own Suspected Cancer Pathway targets. Northern Ireland also has a specific two-week red flag referral target for those with suspected breast cancer.

There could be an opportunity for more nursing contact at the screening/diagnostic pathway point, to support patients with their concerns and fears

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How were services doing with the previous targets?

Cancer waiting time targets were routinely being missed. Macmillan Cancer Support chief nursing officer and nurse consultant Claire Taylor says that while there were 'minor improvements' for some cancer waiting times in July compared with the previous month, 'all but one of the national targets were missed once again, showing that NHS cancer services in England are still struggling under intense pressure'.

This situation follows analysis by Macmillan earlier this year showing that performance against current waiting time targets in 2022 was the worst on record across the UK.

Why are most of the targets being merged?

The two-week wait target was introduced 20 years ago and more targets were added since then, so the process for measuring performance had become 'increasingly unwieldy for trusts to manage as well as confusing for patients,' says Dr Taylor.

The new standards are 'more in line with the requirements of modern cancer care, with a greater focus on outcomes over process', says NHSE. The standards will 'ensure equitable access to care because the new treatment standards will measure waiting time for all patients regardless of their route of referral into the system and the type of treatment they receive'.

What has been the reaction to the changes?

NHSE says there has been 'widespread clinical support for reforming NHS cancer standards to speed up diagnosis for patients'.

Dr Taylor says there has been 'a mixed reaction' to the changes. Macmillan's view is that 'these changes will help shift us towards a focus on whole system performance and outcomes for patients, rather than individual parts', she says. 'But this needs to come with concerted efforts from the UK government to address the systemic workforce challenges in cancer treatment and care.'

'We all want these targets to translate into a benefit for patients'

Claire Taylor, Macmillan Cancer Support chief nursing officer and nurse consultant

She says some have concerns about how these targets will be accurately collected and reported, while others worry that patients may be missed from upgrades in this more streamlined system.

Ruth Hammond, UK Oncology Nursing Society board member and education lead, as well as a clinical service manager, says the revised cancer waiting targets 'are aligned to the National Cancer Strategy – the need for early diagnostics and early treatment/intervention', and appear to be focused on 'optimising health outcomes and quality of life'.

However, she says with fast-track pathways 'we need to ensure patients are psychologically supported – so there may be a need for advanced nurse practitioners and clinical nurse specialists to have greater involvement in the front end of the diagnostic pathway'.

Cancer Research UK's director of evidence and implementation Naser Turabi says the changes to waiting time targets for England are positive and will be helpful for people affected by cancer. But changing the targets will not address systemic challenges in cancer care, he adds. 'To accelerate research, boost our cancer workforce, and diagnose more cancers earlier, we need long-term funding and a clear, ambitious strategy for cancer.'

Will a simplification of targets enable nurses to have greater capacity and time to focus on diagnosis and treatment?

The changes 'should reduce the admin burden for nurses,' says Dr Taylor. 'But it won't necessarily mean that they have more time. It depends on their role and the extent to which they are involved in the diagnostic process. There may be more impact on certain specialist nursing roles such as acute oncology, or those who work in primary care or are based at the rapid diagnostic centres.

'It's also important to remember that only a relatively small proportion of those referred in via an urgent referral to the acute trust will be found to have cancer.'

Ms Hammond says the simplification of waiting time targets may also make it easier for nurses to support and manage patient expectations.

How could the revised targets change nursing roles and work pressures?

The waiting time changes themselves 'should not affect nurses' roles and work pressures', says Mr Turabi. But he adds: 'Wider improvements to the pathway should see opportunities for nurses to develop diagnostic skills, such as in endoscopy.'

Dr Taylor says the revised targets should 'help nurses to focus on helping people through the whole diagnostic period – to be able to give them a diagnosis or rule out a diagnosis faster – rather than focusing as much on getting the first appointment or test done in time'.

Will the targets be any easier to hit?

Dr Taylor says: 'It's unlikely that changing the targets will make it much easier to reach them, but it does make it clearer what healthcare professionals are working towards.'

The targets may also 'offer more parity as there is now the same standard to be working towards for those referred with symptoms, regardless of their route into the system', she says.

Will nurses have fewer patient contact opportunities?

Patient contact 'will vary from one role to another', says Dr Taylor. 'It is unlikely to impact Macmillan nurses as they are most likely to start seeing patients at the point of diagnosis.'

Ms Hammond says there could be an opportunity for 'greater nursing contact at the screening/diagnostic pathway point, to support patients with their concerns and fears'. She adds: 'This may require consideration of how specialist support services are designed and delivered.'

'We all want these targets to translate into a benefit for patients,' says Dr Taylor, 'as we know that more timely care and treatment makes a difference to patient experience and can have a positive impact on outcomes and even survival.'

Further information

Cancer Research UK (2023) Cancer News. Cancer Waiting Times: Latest Updates and Analysis. **tinyurl.com/CRUK-waiting-times-latest**

NHS Confederation (2023) Press Release: Patients Now Often Experiencing Two or More Cancelled Operations Due to Industrial Action, with Cancer Patients Increasingly Affected. **tinyurl.com/NHSC-pr-cancellations**

NHS (2023) National Cancer Waiting Times Monitoring Dataset Guidance. **tinyurl.com/NHS-cancer-waiting-times**

NHS England (2023) Changes to Cancer Waiting Times Standards from 1 October 2023. **tinyurl.com/NHSE-cancer-waiting-times**

Changes in the cancer treatment waiting time targets

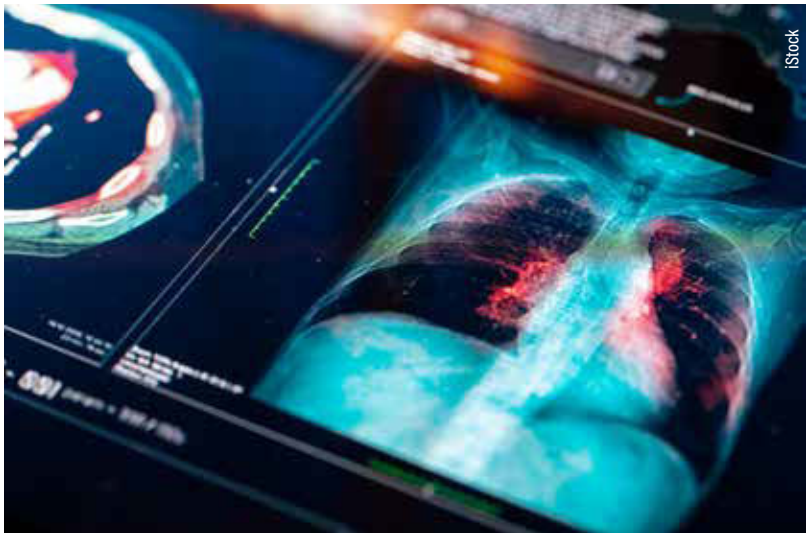
Old targets

- A maximum two-week wait from urgent referral to first outpatient attendance
- A maximum two-week wait from referral to hospital of a patient with breast symptoms where cancer is not suspected
- A maximum four-week wait from referral to patient being informed of diagnosis or ruling out of cancer
- First treatment within 31 days of diagnosis for all treatments, radiotherapy, surgery or chemotherapy
- A maximum 62-day wait for first treatment from urgent referral, urgent referral from NHS Cancer Screening Programme (breast, cervical or bowel) or consultant upgrade

Current targets

- Faster diagnosis standard (FDS): patients to receive a diagnosis or ruling out of cancer within 28 days of referral. This replaces the old two-week wait target. The FDS gives patients a definitive diagnosis of cancer or rules it out. The old two-week wait standard marked when the first appointment happened and further tests and appointments were almost always required
- 31-day treatment standard: patients to commence treatment within 31 days of a decision to treat
- 62-day treatment standard: patients to commence treatment within 62 days of being referred

Source: Cancer Research UK (2023) and NHS England (2023)



COMMENT

How to spot the signs of non-smoking lung cancer

Lung cancer numbers are rising among people who have never smoked but nurses can identify symptoms promptly

By Vicki Anderson
lung cancer nurse specialist at Newcastle upon Tyne Hospitals NHS Foundation Trust and a committee member for Lung Cancer Nursing UK

Further information

Natiional Institute for Health and Care Excellence (2015) Suspected Cancer: Recognition and Referral. **nice.org.uk/guidance/ng12/chapter/Recommendations-organised-by-site-of-cancer**

See Through the Symptoms campaign **www.egfrpositive.org.uk/news/cancer-awareness-month2022**

Lung cancer in never-smokers – meaning people who have smoked fewer than 100 tobacco cigarettes in their lifetime – is now the eighth most common cause of cancer-related deaths in the UK and the seventh most prevalent cancer in the world.

This trend plays out in my practice, where increasingly more patients are in their thirties and forties with mutation-driven rather than smoking-driven lung cancers. Many have had a protracted pathway to diagnostic imaging and diagnosis, because even when they present with persisting symptoms the absence of a smoking history means red flags are not picked up promptly.

As a result, their disease is often advanced by the time they are diagnosed. In a 2020 survey of non-smoking lung cancer patients and carers, 86% of the 167 respondents indicated that diagnosis was at stage 4, meaning curative treatment is no longer an option. This compares with 48% of all lung cancers.

The See Through the Symptoms campaign, which ran in November last year to coincide with Lung Cancer Awareness Month, aimed to change this. It encouraged primary care professionals to consider lung cancer in differential diagnosis, regardless of the patient's age and smoking status, and refer for appropriate investigations.

Disparities between smokers and never-smokers in symptom severity and help-seeking behaviour have been the focus of recent research.

Symptoms of lung cancer are typically the same whether smoking is a factor or not. They include persistent cough, recurrent chest infection, breathlessness, blood in sputum, fatigue, unintentional weight loss and chest, upper back or shoulder pain.

Smokers tend to have multiple symptoms that are more bothersome, alongside comorbidities such as asthma. When they experience new or worsening symptoms, they get them checked out, thinking it is an exacerbation, and follow up if a course of steroids and antibiotics does not work. By comparison, symptoms in people who have never smoked are usually less severe and do not affect their everyday lives to the same extent. So they brush it off, attributing respiratory symptoms to a cold or hay fever, for example.

False assurance may lead to delays

It is natural to assume that symptoms in non- and never-smokers are benign and to try to put patients' minds at ease. They leave the clinic and do not give the prospect of lung cancer a second thought. Consequently, they encounter delays in accessing diagnostic testing, primarily chest X-rays.

A National Institute for Health and Care Excellence guideline says an urgent (within two weeks) chest X-ray should be offered to patients with two or more unexplained symptoms who are aged 40 and over. The threshold is lower for patients with a smoking history, who need to have only one symptom.

Any patients who do not meet the criteria for referral or investigations should be reviewed within a planned timeframe. This is where the campaign message is most pertinent, because it is an opportunity to capture under-forties and never-smokers with ongoing or concerning symptoms who might otherwise fall through the gaps.

'Any patients with recurring, unexplained symptoms should be referred for a chest X-ray'

The nurse's role is pivotal, not just in picking up symptoms that could be sinister, but in highlighting the importance of vigilance to non-smokers and encouraging them to come back to clinic for a review, especially if things do not improve. The message for nurses is that any patients with recurring, unexplained symptoms should be flagged to GPs and referred for a chest X-ray to rule out lung cancer, irrespective of their age and smoking status.

Right to a second opinion could empower nurses

A new framework – Martha's rule – could help nurses raise concerns in hospitals, a sepsis nurse specialist believes

By Clare Hird
sepsis and infection nurse specialist at Oxford University Hospitals NHS Foundation Trust

Media coverage of the events leading up to the death of Martha Mills, a 13-year-old girl who died in hospital while under the care of a paediatric team, has brought attention to the issue of how clinical teams respond to concerns raised by relatives.

After falling from her bike, Martha sustained trauma to her pancreas. Although this is a severe and rare injury, the overwhelming majority of children survive with good outcomes. Given this rarity, she was under the care of a specialist team with expertise in paediatric pancreatic trauma. Indeed, there are only three national centres with this level of specialty.

During her admission, she exhibited signs of sepsis and deterioration and her parents repeatedly raised concerns with clinical staff. Despite a serious deterioration in her clinical condition and the family's concerns, there was a delay in transferring Martha to intensive care for higher-level treatment.

Listening to relatives

At the inquest into her death, the coroner found that Martha would probably have survived, had she been transferred to intensive care sooner.

This case highlights key issues about relatives not being listened to by clinical teams, and the workplace hierarchical system that can make communication challenging.

One outcome of this devastating case is the emergence of a campaign for the introduction of 'Martha's rule'. Like Ryan's rule in Australia, this would provide a legal framework giving patients, families or carers the legal right to a second opinion from senior medical practitioners in the same hospital if their loved one is deteriorating and they believe their concerns are not being heard.

Hospitals remain hierarchical in structure, creating an environment where it is difficult to challenge senior staff and raise concerns. I can give numerous examples from my personal experience where I have felt 'shut down' by doctors or senior colleagues when asking questions about aspects of patients' care.

'Nurses will be central to this cultural change given their role as patient advocates'

Often in these interactions, the overriding attitude is one of dismissiveness. It is inevitable that these sorts of attitudes and interactions provide barriers to good communication, which is fundamental for delivering safe, effective care.

Rather than preserving this archaic top-down approach, we should be striving towards a flat structure where anyone, regardless of role – be they clinical staff or relative – should feel they have the freedom to speak up and be taken seriously when raising concerns about clinical care.

Empowering patients

The introduction of a Martha's rule would be an important and welcome move. It would essentially provide a mechanism in law that empowers individuals to raise their voice and be heard.

Although this rule specifically is about empowering patients and relatives, I believe it has the potential to drive a change in hospital culture.

Nurses will be central to this cultural change, given their patient advocate role and should embrace any framework, like Martha's rule, that bolsters this advocacy.

We cannot know for sure if the introduction of a Martha's rule would improve safety. This is a question that can only be answered satisfactorily by a large clinical trial. However, we can make inferences about the likely outcome from what is already known.

Martha Mills, who died after a delayed transfer to intensive care for higher-level treatment

'The implementation of a Martha's rule would be a positive, progressive step for healthcare in the UK'

At the Royal Berkshire Hospital in Reading, the Call 4 Concern (C4C) system was developed, where the critical care team is directly accessible to patients and relatives through self-referral. This team has published its experiences and has demonstrated enhanced quality of care for patients and relatives with high levels of patient satisfaction.

It is similarly hard to know how such a rule would affect nurses. There is perhaps some trepidation that a Martha's rule could be invoked inappropriately and overused, leading to frequent referrals for second opinions, increasing the workload of already stretched staff.

Again, the experience of nurses working in trusts operating the C4C system seems to suggest otherwise. The C4C helpline receives around three calls a month, according to the trust's former chief nurse, who says such systems can be implemented with existing staff and resources.

Easing pressure on nurses

If implemented appropriately, Martha's rule may help ease pressure on nurses looking after unwell, deteriorating patients because it would increase the likelihood of prompt critical care review.

It is desperately sad that it should take the death of a 13-year-old girl in hospital for the health service as a whole to wake up to the fact that patients and their relatives need to be taken seriously when expressing concerns about clinical deterioration.

The implementation of a Martha's rule would be a positive, progressive step for healthcare in the UK. In addition to empowering patients and their relatives, it has the potential to initiate cultural change in the system, challenging the hierarchical structure that for so long has been a barrier to effective communication. So nurses should embrace Martha's rule as a framework that enhances their advocacy for patients.

Further information

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RCN Nurse of the Year 2023: ‘We empower patients with choice’

Julie Roye’s drive and commitment to break down health inequalities and improve access to care improved the uptake of smear tests among a diverse patient group

By Elaine Cole
RCNi special projects editor

An inspirational nurse who is transforming care in GP surgeries with her drive to reduce health inequalities has been named RCN Nurse of the Year 2023.

Queen’s Nurse Julie Roye oversaw an increase in the uptake of smear tests at Cauldwell Medical Centre in Bedford which saw rates among 25-64 year olds go from 54% to 80% in nine months, after she helped to break down barriers to access for a diverse patient population.

Ms Roye, who is head of nursing primary care at East London NHS Foundation Trust (EFLT), was named overall winner at an evening awards ceremony, held at Liverpool Cathedral in November. She won praise for her ‘truly inclusive’ and comprehensive approach, co-production of services with the people who use them and her focus on staff development.

RCN chief nurse Nicola Ranger said: ‘Ms Roye is a passionate nurse and an incredible role model. Her leadership in improving cervical screening uptake in a diverse patient population is exceptional. Her drive to address health inequalities is outstanding and she is ensuring this work can benefit other communities too. She deserves this accolade.’

Low uptake

East Bedford Primary Care Network had experienced a consistently low uptake of cervical screening when Ms Roye took up her post.

‘Bedford is one of the most deprived areas in our integrated care board,’ she said. ‘It’s important to bring up standards for this community. We knew we needed to improve access for trans men, people with learning disabilities and people from different ethnic communities.

‘This initiative addressed the disparities, enhanced care in the community and fostered team development. It brings a sense of value and of real equity into the care that we give our patients.’

Using a quality improvement approach, Ms Roye assembled a multidisciplinary team including nurses, other healthcare professionals, patients and experts in outreach and education.

She says: ‘For some, smear tests are an intimate, embarrassing examination. It can be overwhelming if you don’t understand what the clinician is doing. In my previous role, I had screening numbers over 80% and wanted to achieve that in other areas.

‘This diverse team brought unique perspectives and experiences, ensuring a well-rounded approach to addressing screening disparities.’

As its lead, she focused on ensuring the project

Genuine co-production with patients: ‘my contributions are taken seriously’

Joyce Tucker (pictured), a patient representative on Julie Roye’s quality improvement team, describes their work as ‘genuine co-production’.

‘My contributions are taken seriously and my suggestions are taken on board,’ she says. ‘I help the team remember the patient experience within the NHS processes.

‘My experience of cervical screening in this country had previously been horrible. In America, cervical screening was part of an annual check with a gynaecologist with whom you built a trusting relationship.

‘I experienced the improvements the team had made and had been talking so passionately about.

‘Nurses recognised my issues’

‘I was extremely impressed with the appointment, as the nurse recognised my issues and really listened to me. It was a positive experience.

‘Upskilling the nurses has made a real difference. Ten years ago when I had a job and two young children, I would not have been able to go to the daytime clinic and that was all that was on offer.

‘Julie is passionate about empowering patients and staff. She fights for her nurses to get them what they need to do a great job. And her focus is always on the patient’s needs. For example, ideas such as giving oestrogen to people with vaginitis before their smear test is not standard practice.

‘There is a lot of criticism about healthcare, but it’s been nice to see how hard nurses work behind the scenes to do their best for people.’

Julie Roye oversaw an increase in the uptake of smear tests at Cauldwell Medical Centre in Bedford

was person-centred, that progress was driven by data and that the culture of the organisation was transformed. The team identified capacity, opportunity and experience of care as the main drivers of screening uptake.

Screening opportunties

'When I arrived there was only one nurse trained for cytology,' says Ms Roye. 'I recruited and arranged training and assessment for three additional staff nurses. It was challenging. Cauldwell was known as a failing practice, so people did not want to work there. All staff had bespoke training and supervision.'

The training enabled nurses to pick up screening opportunities at other appointments.

'I went to the cervical screening board to tell them to expect an increase in numbers,' says Ms Roye. 'Standard operating procedures were reviewed and updated to make sure the recall timescales for different needs – such as for women with HIV and those with previous abnormal screening results – were adhered to.'

Next, Ms Roye and her team focused on making appointments more convenient and finding new ways to engage with their community.

'We empowered patients with autonomy over their choice of appointment time and nurse. Evening and drop-in clinics were offered in response to feedback.'

A decision to send screening reminders by text that also enable people to book their own appointments delivered a huge spike in screening.

The teams found that if the recipient uses their phone in their first language, messages are automatically translated into that language.

'Some ethnic groups didn't recognise the need for screening, were not being reached because of language barriers, or feeling fearful, uncomfortable or embarrassed about the process'

Julie Roye, Queen's Nurse and RCN Nurse of the Year 2023

'We also offer people a telephone conversation to ask questions when we send out the text messages,' Ms Roye says.

If people did not respond, the team sought to find out why by sending a questionnaire that took ten seconds to complete.

People who had experienced sexual trauma or were concerned about pain were offered the opportunity to talk about what adjustments could be made. Some were given longer appointments.

Double appointments

They were reassured that it was okay to visit, see the equipment, ask questions and still decline. Double appointments were offered to people who did not speak English fluently, with a translator available by phone.

Education material was developed for each target group and the language used in communications adjusted. For example, the wording of recall letters was changed because it made some recipients feel they were being admonished, patient feedback showed.

Ms Roye says: 'We also engaged with our LGBTQ+ community and charity Jo's Cervical Cancer Trust to inform our approach. We made our language more inclusive and offer special clinics that have a safe and affirming environment.'

People who are not comfortable attending the medical centre are signposted and supported to access specialist services. There is easy-read information for people with learning disabilities, who can visit to talk through the procedure beforehand and, if the waiting room is too stimulating, can text their arrival and be taken straight to the nurse's room.

Practitioners are trained to offer culturally competent care. This includes sensitivity to cultural practices and religious beliefs, and information and

communication is translated into more than 20 languages.

Ms Roye says: 'Some ethnic groups didn't recognise the need for screening, were not being reached because of language barriers, or feeling fearful, uncomfortable or embarrassed about the process. So we held webinars, workshops and a coffee morning, involving peers reflecting local ethnic diversity, to raise awareness, talk about their experiences and provide reassurance.'

There were challenges. 'I was confident that the initiative would be successful, but people can be resistant to change,' says Ms Roye. 'I realised that the level I was working at was not normal, so I was gentle but robust. I communicated the vision for change and recognised staff for each successful step, reassuring them it would contribute to the achievement of our aim.

'There was backlash, but if it means I'm improving patient care I will press on. Collecting and reviewing data at monthly practice meetings was important, with graphs showcasing the tangible progress made.'

Greater awareness

The data are impressive. In nine months, screening uptake had increased from 54% to 73% for patients aged 25-49 years, and from 62% to 82% in those aged 50-64 years, with a continuing upward trajectory in both age groups.

'Other benefits include a greater awareness around the cultural needs of women and a better understanding of how to address barriers to healthcare faced by marginalised groups,' says Ms Roye,

'Non-English speaking people are better engaged because of our tailored approach, and this includes other services such as maternal and child health. The work has prompted proactive interventions in other areas such as immunisations. The booking system is now also used in other areas, such as respiratory and diabetes.

'Feedback shows improved patient experience from a programme co-designed with their needs in mind. A reduction in the percentage of appointments not attended or cancelled saves time and resources.'

Inclusive approach

Staff say Ms Roye's 'inclusive and impactful' approach has improved morale. 'The practice has been able to demonstrate how much it values and cares for its patients,' Ms Roye adds.

Ms Roye is 'delighted and humbled' to be named RCN Nurse of the Year 2023.

'I'm grateful for my fantastic team to have this project recognised nationally,' she says. 'They believe in me when I come up with ideas for improvement. It has shown that a deprived borough can achieve the same healthcare as privileged areas with the right leadership and by accepting change.'

'I was confident that the initiative would be successful, but people can be resistant to change... There was backlash, but if it means I'm improving patient care I will press on'

Julie Roye

Ms Roye's next focus is producing videos explaining services. 'It is all very well sending letters out and translating them into lots of languages, but we need to cater for the high levels of poor literacy in all our communities,' she says.

She also plans to use the award as a platform to drive improvements in primary care services in her area and beyond.

'By addressing different groups' unique needs, we've made significant strides in reducing healthcare disparities and promoted a culture of inclusivity and equity in the care we give,' she adds. 'It is a very replicable model.'

Making change happen: 'who do we need around the table?'

Julie Roye won the Leadership category at the RCN Nursing Awards before being named RCN Nurse of the Year 2023. Her team has praised her supportive leadership.

Cauldwell Medical Centre lead advanced clinical practitioner Christina Guevara says: 'I've never heard Julie say no to an idea on how we can improve patient care. She says immediately: "How can we make this happen, who do we need around the table?"

'She covers so many GP surgeries and knows what's going well and what the problems are at each of them. She understands and solves problems, keeping things moving forward in so many ways.

'She keeps everyone motivated. Staff have been offered jobs elsewhere but they stay because they are being developed and they are giving excellent patient care. This is directly due to her leadership.'

Practice nurse Lois Nana-Osei adds: 'Julie is phenomenal. Under her leadership, I'm really proud of how I contribute to care, and patients can see how we work to cater for their needs. Julie has helped me understand my strengths and I've become more confident and in turn I make sure nurses who have joined us feel supported.

'Patients feel they have autonomy'

'She's approachable and relatable, offering support when I tell her about a need I have seen or something I want to do. She asks what you think and takes what you say on board. She doesn't say: "It's got to be done my way," but shares her experiences to help you understand.

'She is the same with her patients. I've been privileged to observe the way she interacts with them in appointments. The assessment starts as soon as they walk through the door. The patient feels they have autonomy and are listened to. It has been great for my learning.'

How nurses can lead change and improvement in palliative care

The NHS wants palliative care to be better coordinated and more person-centred – but are nurses and services always equipped to address individuals' needs?

By Nick Evans
health journalist

Not everyone gets the care and support they need to die with dignity and in as much comfort as possible. For years, nurses have led improvement in palliative and end of life care. We take a look at some recent developments – and what role nurses can play in the continuing improvements.

Although they are sometimes used interchangeably, the two terms are distinct. End of life care is treatment and support for people who are near the end of their lives. That is normally defined as those expected to die within 12 months and includes those whose death is imminent.

While palliative care can involve end of life care, it is much broader and can last a lot longer. The aim is to improve the individual's quality of life by preventing or relieving suffering and pain, whether physical, mental or spiritual, and providing practical support.

Long-term palliative care

Offering palliative care does not necessarily mean the person is expected to die soon – some people can receive palliative care for years.

Nurses are central to the provision of palliative care, along with multidisciplinary colleagues. District nurses play a key role alongside GPs and some patients need specialist support from palliative care nurses, doctors and therapists.

According to the Association of Palliative Medicine and Marie Curie an estimated 90% of people who die in the UK would benefit from palliative care – a figure based on the numbers dying with progressive conditions such as cancer, heart disease and dementia.

Lack of palliation, the charity says, causes distress and pain, not just to the individual but their families too. Gaps in provision are inefficient for the health service too, leading to unnecessary and expensive hospital admissions.

Office for Health Improvement and Disparities data show around 15% of emergency admissions are of people who are in the final year of life, with two thirds of people experiencing at least one emergency admission in the final three months.

Yet there are significant gaps in the provision of palliative care. The 2022-23 National Audit of End of Life Care for England and Wales highlights a number of areas where improvement is needed, including:

- Communication.
- Use of advance care plans.
- Access to specialist support seven days a week.

There are some people, though, who do not access any palliative care.

Demand for care

The Marie Curie research estimates as many as one in four people who need palliative care do not receive it. And the charity warned that demand for care was only going to increase, thanks to an ageing population and growth in complex conditions.

Marie Curie chief executive Matthew Reed says: 'The UK has an end of life problem. To put it bluntly, you only die once – and the last chapter of life has not been right for many people.

'What is needed is more – much more – support for people in their own homes. That care is often better, and cheaper, than what is available in hospital.'

'Training is important and there are a variety of ways to access it... but it is not consistently available'

Sandra Campbell, RCN pain and palliative care forum member

Barry Quinn, senior lecturer in the school of nursing and midwifery at Queen's University Belfast, and an expert in palliative care, agrees.

'Until we recognise that dying is a natural part of life, we will end up over-medicalising a natural process. Yes medicine is important, but it needs to be complemented by care.'

He believes there has been an over-specialisation in palliative care.

'Most good end of life care is delivered by community and ward-based nurses and doctors,' Dr Quinn says.

'It should be about collaboration and support – and more focus on moving resources from the acute sector to the place where people want to die. But people are not willing to let go of precious funding.'

Across the UK, work to improve palliative care services is ongoing. Each nation has published its own strategy for offering more choice and support for people who are dying. England's 2021-26 framework sets out six ambitions:

1. Each person is seen as an individual.
2. Each person has fair access to palliative and end of life care.
3. To maximise comfort and the individual's well-being.
4. Care is coordinated.
5. All staff are prepared to care.
6. Each community is prepared to help.

NHS England funded the Open University in producing a 'grab and go guide' on how to improve palliative care. It sets out how the framework's ambitions can be achieved and includes advice on increasing the use of advance care plans and making services seamless.

Keech Hospice Care end of life practitioner and University of Bedfordshire lecturer Chris May believes there are good intentions behind plans being put in place, but it is another development – in England at least – that will have the most far-reaching impact on services.

Legal duty

After a long-running campaign by Baroness Finlay, a professor of palliative medicine, the 2022 Health and Care Act created a legal duty in relation to palliative care, making integrated care boards in England accountable for commissioning and overseeing services.

Mr May says: 'It is the first time any part of the NHS has had this responsibility. It is one of the most encouraging changes for many years. It should lead to more money being invested, and better planning.'

He says for too long end of life care has been over-reliant on the voluntary sector, with hospices and charities playing a key role in care provision.

'They have had to resort to fundraising. It is not something you necessarily see in other areas of the NHS.

'You would not, for example, expect to have coffee mornings to raise money for a hip replacement. We need to rethink how we view end of life care if we are going to see real progress.'

About 30% of hospital patients and about 80% of care home residents are in their final year of life, so nurses working in NHS and social care settings may have opportunities to influence the palliative care people receive.

Macmillan consultant nurse in palliative and end

Further information

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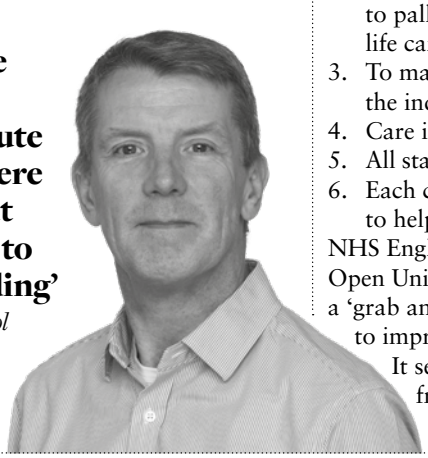
NHS England (2021) Ambitions for Palliative and End of Life Care: A National Framework for Local Action 2021-2026. **tinyurl.com/NHSE-apelc**

Open University (2023) Small Steps, Big Vision – Grab and Go Guide to Support the Realisation of the Ambitions for Palliative and End of Life Care. **tinyurl.com/OU-palliation**

'There should be more focus on moving resources from the acute sector to the place where people want to die. But people are not willing to let go of precious funding'

Barry Quinn, senior lecturer, school of nursing and midwifery, Queen's University Belfast

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of life care Sandra Campbell, an RCN pain and palliative care forum member, says one of the biggest challenges is that while palliative care is 'everyone's business', not everyone takes responsibility for it.

'More palliative and end of life care is provided by non-specialist staff than specialist,' she says.

'It is only the most complex cases where specialists need to be involved, although there should always be access to specialist advice.

'The key things that health and care staff need to know about include assessment and care planning, managing symptoms such as pain, agitation, nausea and vomiting and excessive secretions, assessing physical, psychological, social and spiritual needs.

'It is also important to recognise dying, and to understand how to assess for reversible causes of deterioration.

'Training is important and there are a variety of ways to access it, including from universities, hospices and specialist palliative care teams. But it is not consistently available.'

Advance care plans

Mr May agrees front-line staff need more support. 'Opportunities are being missed as hospital staff in particular do not always know what is available. You hear of cases where people are told they are not eligible for hospice care because it is only available for cancer patients.

'We are still seeing half of people dying in hospital when we know that is not where they want to die. We need to think much more about end of life care as a society – and talk about it. It is still only a minority of people who have advance care plans.'

He wants to see all health and care staff promoting advance care planning and even initiating plans. 'It is not just something for the GP or district nurse to do.

'And you do not have to finish them. By doing more to encourage people to fill them in we would empower people and that, in turn, would help drive change.'

4 ways to ensure palliative care is seamless and person-centred

Open University's 'grab and go guide' is mainly aimed at managers and service leads, but includes advice that front-line staff can use:

1. **Be proactive in ensuring advance care plans are in place** This includes adapting the plans for certain groups, such as people with learning disabilities and those whose first language is not English
2. **Ensure plans are shared** between staff in primary and secondary care
3. **Support the family, friends and carers of the dying person** Show them how to become involved in the care and provide pre-bereavement and bereavement help
4. **Access training** e-lfh.org.uk/programmes/end-of-life-care includes 120 free online modules

Source: Open University (2023)

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PLANNING YOUR ARTICLE

Why creating a framework is worth the effort

You have an idea and know roughly what you want to say, but you need a plan. The simplest plan is a beginning, a middle and an end.

Whether your article is 300 words or 3,000, it should start with an indication of its purpose. Build it with supporting evidence or argument and conclude in a way that encourages readers to pause and reflect.

Creating a first draft

Whatever type of article you are planning, jotting down some headings can give the first draft a logical flow. These can be broad headings, such as 'Introduction', 'Main text', 'Conclusion', but, with three or four bullet points under each heading, your article will soon take shape.

It often helps to start with the main points in the conclusion that you want readers to take away with them, and then work backwards from there, so that you know where you are leading them. After all, we plan an unfamiliar journey by establishing the destination first and then working backwards to map it out.

Example

Sheila wants to write a comment article about what she perceives as unthinking ageism that she has witnessed in hospital settings. Her plan for the article so far looks like this:

Introduction

Aim: to encourage reflection on interactions with older patients. Why now? Why they matter.

Main text

» What is ageism?
» An incident in a care setting.
» Ageism and the law and in healthcare.
» Suggest practical interventions.

Conclusion

» What does improvement look like and how is it achieved?
» Individual and collective responsibilities.

More detail

A second version of Sheila's plan includes more detail under each of the bullet points. For example:

» Suggest practical interventions: raising awareness; teaching sessions; poster campaign; informal lunchtime discussions; what matters to older people.

The planning process takes time but will serve you well. It can clarify your thinking and help you to write an article that has a logical flow and a well defined purpose. It can also help you to write to length because you can attribute so many words to different sections.

Work hard on the introduction. Rewrite it until you are certain it has the power to engage and draw in your audience.

If your first few sentences are dense and difficult to comprehend, readers are more likely to give up reading.

*For a comprehensive range of free author resources go to **rcni.com/publish-article-with-rcni***

Also in this issue

CANCER TREATMENTS

Developing a standardised pre-SACT safety checklist for nurses on a haematology unit
p29

CPD

Supporting preregistration nursing students on specialist cancer practice placements
p35

Why you should read this article:

- To read about a service evaluation of a clinical foot reflexology service for patients with cancer
- To appreciate the importance of evaluating patients' experience of supportive interventions such as reflexology
- To recognise the beneficial effects of foot reflexology on symptoms associated with cancer and cancer treatments

Patients' experiences of clinical foot reflexology in a hospital cancer service

Abbigail Langstone-Wring and Judith Whatley

Citation
Langstone-Wring A, Whatley J (2023) Patients' experiences of clinical foot reflexology in a hospital cancer service. Cancer Nursing Practice. doi: 10.7748/cnp.2023.e1841

Peer review
This article has been subject to external double-blind peer review and checked for plagiarism using automated software

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Conflict of interest
None declared

Acknowledgements
The authors would like to thank Dorset County Hospital NHS Foundation Trust (DCHFT) clinical audit department staff for their assistance and technical support and trust chief executive Patricia Miller, who provided access to the trust's office staff which supported the development of local NHS clinical reflexology governance policy, standard practice and audit documents.
This audit was carried out under the guidance of clinical nurse specialists at the DCHFT cancer service and University Hospitals Dorset NHS Foundation Trust and Poole Hospital radiotherapy team at the Robert White Centre radiotherapy site at DCHFT

Abstract

Reflexology is a complementary therapy that involves applying alternating gentle and firm pressure to the feet or hands to induce relaxation. In the context of cancer care, reflexology treatment aims to provide symptom relief and improve patients' quality of life. Since 2014 a clinical foot reflexology service has been offered at Dorset County Hospital NHS Foundation Trust cancer service for patients receiving cancer treatments. This article describes the foot reflexology service and the treatment offered. It also reports the findings of a service evaluation that involved a retrospective review of patient combined consent/evaluation forms to identify patient concerns (symptoms), to measure patients' self-reported levels of concern before and after reflexology treatment and to capture patients' experience of the service.

Author details

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Keywords

cancer, cancer treatments, clinical, complementary therapies, medicines, outcome measures, patient experience, patient outcomes, professional, signs and symptoms, symptom management

Background

Reflexology involves the application of alternating gentle and firm pressure to mapped areas on the feet that are, according to the theory of this complementary therapy, linked to organs and systems of the body through neural pathways (Tiran and Mackereth 2011). This theory is supported by studies that propose the mechanism of action of reflexology is via dermatomes – an area of skin supplied by sensory neurons that arise from a single dorsal root of a spinal nerve (Lee et al 2008) – and the 'neuromatrix' theory of pain, which involves afferent impulses given by touch and pressure being transmitted faster than pain in the dorsal root of the medulla spinalis that block the transmission of pain (Derbyshire 2000). Other theories of the mechanism of action of reflexology include the positive effects of therapeutic touch, the activation and altering of fascial structures and placebo effects (Whatley et al 2022).

While the mechanism of action remains a topic of debate (Whatley et al 2022), reflexology is commonly used in cancer care settings as a complementary therapy (Gholamzadeh et al 2019, Blackburn et al 2021). In general, reflexology services in NHS cancer settings are funded and delivered by external providers who monitor the safety, efficacy and quality of such services through service evaluation or audit. Annual reports are produced to inform funders about service uptake and patient experience to provide evidence of value for money. This article reports the findings of a service evaluation of the clinical foot reflexology service delivered in the cancer service at Dorset County Hospital NHS Foundation Trust (DCHFT).

Clinical foot reflexology service

The clinical foot reflexology service at DCHFT cancer service was introduced in November 2014, initially for three hours per week, and is funded by the charity Fortuneswell Cancer Trust. Findings from an internal trust audit in 2015 concluded that for patients receiving cancer treatment, reflexology was a useful therapeutic intervention in relation to reducing patient-perceived levels of stress and anxiety. Additionally, a feasibility study of the service reported beneficial patient-perceived outcomes regarding symptoms, including reduced swelling, improved sensation and increased flexibility in the lower limb (Langstone-Wring and Machin 2018).

By 2019 the service had expanded to provide 20 hours of foot reflexology sessions delivered five mornings per week (Monday-Friday) by two reflexologists with DCHFT honorary contracts. In the first author's (AL-W) experience, and from informal feedback from staff engagement events at which reflexology was offered to staff as a 'taster', service development has been driven by increased patient demand assisted by promotion of its benefits by nursing staff.

The foot reflexology service has been offered to adult oncology patients (aged over 18 years) receiving cancer treatment on Fortuneswell cancer ward and those attending the trust's chemotherapy outpatient unit since its inception. In 2019, the service was expanded to patients receiving outpatient radiotherapy during a three-month pilot project.

To identify patients who may benefit from foot reflexology, the reflexologists visit the ward and outpatient units daily and discuss with a senior member of staff which patients might be suitable for treatment. Patients with the following issues are generally considered unsuitable for foot reflexology treatment:

- Patients with open wounds, ulcers or sores on the lower legs or feet.
- Patients with a recent diagnosis of deep vein thrombosis and who are not receiving associated medicine.
- Patients with a skin rash or allergy of unknown origin.
- Patients in isolation.
- Patients with cognitive impairment.
- Patients with suspected spinal fractures.
- Patients who are excluded from receiving reflexology treatment on clinical or medical advice.

The reflexologists talk to the patients identified as suitable for foot reflexology and explain what the treatment entails. Patients are also offered an information leaflet.

Combined consent/evaluation form

Patients who agree to have a foot reflexology treatment session are given a combined consent/evaluation form which provides evidence of consent and is used as a data collection tool. Patients fill out a new consent/evaluation form for each reflexology treatment as their symptoms often change throughout their cancer treatment.

The consent part of the form states that by completing the form patients are consenting to their information being stored and used for research purposes, staff training and service development. To ensure anonymity, patients are asked to initial rather than sign the form and neither their NHS number nor hospital number is recorded.

The evaluation part of the form is adapted from the Measure Yourself Concerns and Wellbeing (MYCaW) tool (Paterson et al 2007). Patients fill out the evaluation section of the form before and after each reflexology treatment and the data are entered at a later point onto a software spreadsheet by one of the reflexologists. The data are used in annual reports that are prepared for the funding charity, the DCHFT chief executive, cancer service management and staff to inform them about service quality, service uptake and patient satisfaction and to provide evidence of value for money.

Foot reflexology treatment method

The ethos of foot reflexology is to encourage a deep sense of relaxation. The length of each treatment is adjusted to meet individual patients' needs, but usually the maximum time per session is 20 minutes. Footwear is removed and the patient's feet are refreshed with disposable wet wipes. Grapeseed oil is then applied to the patient's feet to facilitate smooth delivery of the reflexology treatment.

An adapted sequence of reflexology massage movements is carried out, starting with the right foot then moving on to the left. The adapted sequence follows the Federation of Holistic Therapists Vocational Training Charitable Trust Reflexology Manual level 3 guidelines (Cressy 2006). Due to the complexities and frailty of some patients in this condition-specific group, a more even pressure is applied over the feet rather than organ-specific pressure. The sequence was standardised by the reflexologists to ensure continuity of treatment delivery for all patients across all sites.

Aim

The aim of the service evaluation was to evaluate the foot reflexology service offered

Accepted
7 March 2023

Published online
May 2023

at DCHFT from the patients' perspectives. The objectives were to:

- Identify patients' main concerns (symptoms) and measure their level of concern before and after a reflexology treatment session.
- Capture patients' experience of:
  - The clinical foot reflexology service.
  - The beneficial effect of reflexology treatment on symptoms.
  - The therapeutic effect of reflexology treatment.
- Ascertain the effectiveness of the combined consent/evaluation form as a method of data collection.

Method

A retrospective review of combined consent/evaluation forms completed between 1 January 2019 and 1 January 2020 was undertaken by the first author. These forms included those completed during a pilot project (12 August 2019 to 31 December 2019) that trialled delivery of the foot reflexology service to patients receiving outpatient radiotherapy treatment.

Data collection tool

DCHFT guidance on the foot reflexology service states that all patients should be able to measure symptom improvement following reflexology based on a comparison of level of concern scores before and after treatment. As previously mentioned, the form used to obtain consent and capture evaluation data relating to the reflexology treatment is an adapted version of the MYCaW tool. The MYCaW tool was originally developed by Paterson et al (2007) as an individualised method of evaluating outcomes in cancer support care, including complementary therapies. It is a validated and reliable patient-centred questionnaire that allows patients with cancer to identify and quantify the severity of their 'concerns' and 'well-being' (Paterson et al 2007, Jolliffe et al 2015).

The combined consent/evaluation form used by the DCHFT foot reflexology service has undergone a number of revisions since initial implementation of the service, based on patient feedback. The version of the form used during this service evaluation period provided space for consent (patient and reflexologist initials) and identification of the delivery site (Fortuneswell ward, chemotherapy unit, radiotherapy outpatient department).

On the reverse side of the form patients are requested to indicate their age and gender and whether they would recommend the service to others. They are also asked to identify their concern(s) (symptoms), physiological or psychological or both, and to rate their level of concern on a ten-point scale, ranging from one (low) to ten (high), before and after their reflexology treatment. If a patient enters more than one concern, the first concern and its score is recorded on the software spreadsheet. Additional space is provided for comments about the patient's experience of the reflexology service, the beneficial effects of the reflexology treatment on symptoms and the overall therapeutic effect of the treatment.

Findings

A total of 2,078 consent/evaluation forms were reviewed. This equates to the number of reflexology treatments delivered during the service evaluation period and not the number of individual patients, as patients are asked to fill out a new form each time they have a reflexology session. Of the 2,078 reflexology treatments 1,041 (50%) were delivered in chemotherapy outpatients, 875 (42%) were delivered on Fortuneswell cancer ward and 162 (8%) were delivered in radiotherapy outpatients.

Patient-reported concerns

Patients reported a range of concerns. The most frequently cited was anxiety, followed by pain and swelling (see Figure 1).

Patient-reported level of concern before and after reflexology treatment

Figure 2 illustrates patient-reported level of concern before and after reflexology treatment sessions. The findings show that before the reflexology treatment, levels of concern were rated at the higher end of the scale (6-10) (1,543 [74%] forms) and that after the reflexology treatment levels of concern were rated towards the lower end of the scale (1-5) (1,923 [93%] forms). Only 155 (7%) consent/evaluation forms contained post-treatment levels of concern rated between six and ten. These findings suggest that patients' level of concern reduced following a foot reflexology treatment session.

Patient experience

A total of 1,839 (88%) of the 2,078 consent/evaluation forms contained patient comments, of which 638 (35%) were about patients' experience of the foot reflexology service (Figure 3), 247 (13%) were about the beneficial effects of the reflexology

treatment on their symptoms (Figure 4) and 954 (52%) were about the therapeutic effect of the reflexology treatment (Figure 5).

Patients' experience of the foot reflexology service

There were no negative comments about the foot reflexology service. Some patient comments were complimentary about the professionalism, care, compassion and personal approach of the reflexologists. Other comments included the words 'excellent', 'wonderful' and 'helpful' to describe the patient's experience of the service (Figure 3).

Some comments suggested improvements regarding where the reflexology sessions were delivered. For example, some patients

Figure 1. Patient-reported concerns

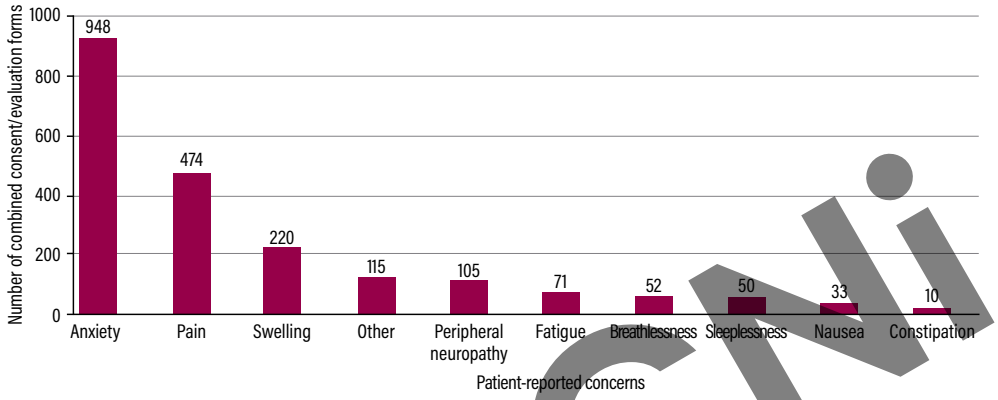


Figure 2. Patient-reported level of concern before and after reflexology treatment session

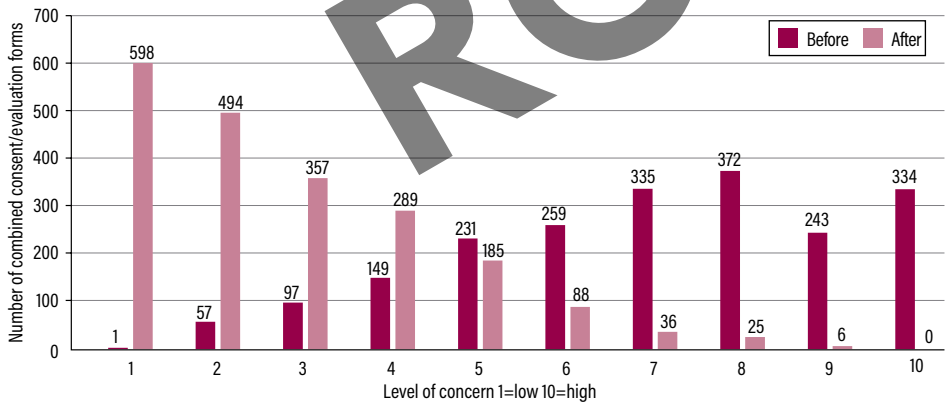
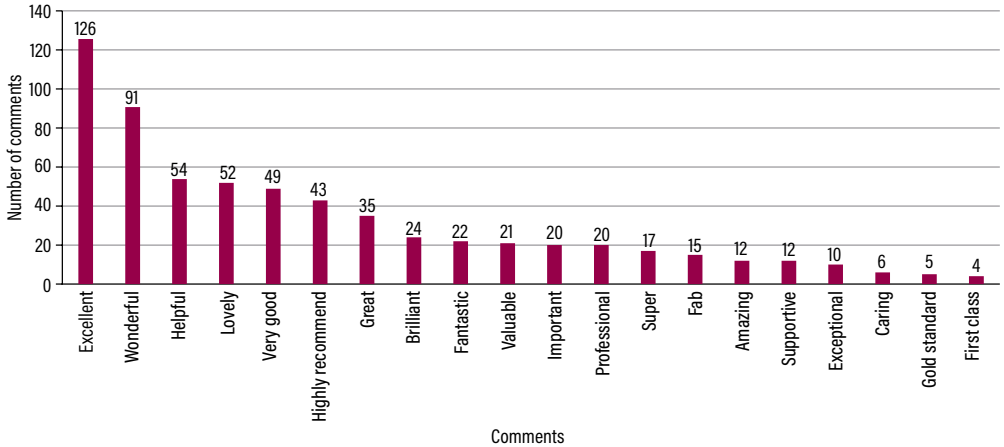


Figure 3. Patient comments on the foot reflexology service



Key points

- Patients with cancer may experience physical and emotional benefits and improved quality of life following reflexology treatment
- Complementary therapies such as reflexology for patients with cancer can provide a unique therapeutic space for relaxation, address patients' physical concerns and offer an opportunity for emotional support
- In this service evaluation, patients' level of concern reduced overall following foot reflexology treatment
- Patients in this service evaluation reported beneficial effects of foot reflexology treatment on a range of symptoms, including pain, swelling and those related to peripheral neuropathy

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commented on the need for more privacy, particularly in the chemotherapy outpatient unit. In the first author's experience, being able to talk privately to the reflexologist can enhance the patient's experience, but clinical space for delivering reflexology treatment in the chemotherapy outpatient unit is limited. Other comments, particularly from patients undergoing chemotherapy, were about the challenge of accessing the reflexology service, for example when demand outstripped availability of appointments or where those who required hospital transport could not match this to the timing of a reflexology treatment appointment.

Beneficial effects of reflexology treatment on symptoms

Of the 247 (13%) comments on this aspect, 36 (15%) were about the beneficial effects of the reflexology treatment on pain, 32 (13%) on swelling and 24 (10%) on symptoms related to peripheral neuropathy (see Figure 4). There were no comments about worsening of symptoms following reflexology treatment. Although these findings are based on subjective comments rather than empirical evidence, they have value as patient-reported outcome measures (Nelson et al 2015).

Therapeutic effect of reflexology treatment

Of the 954 (52%) comments on this aspect, 517 (54%) were about the relaxing effect of reflexology (Figure 5).

Effectiveness of the combined consent/evaluation form

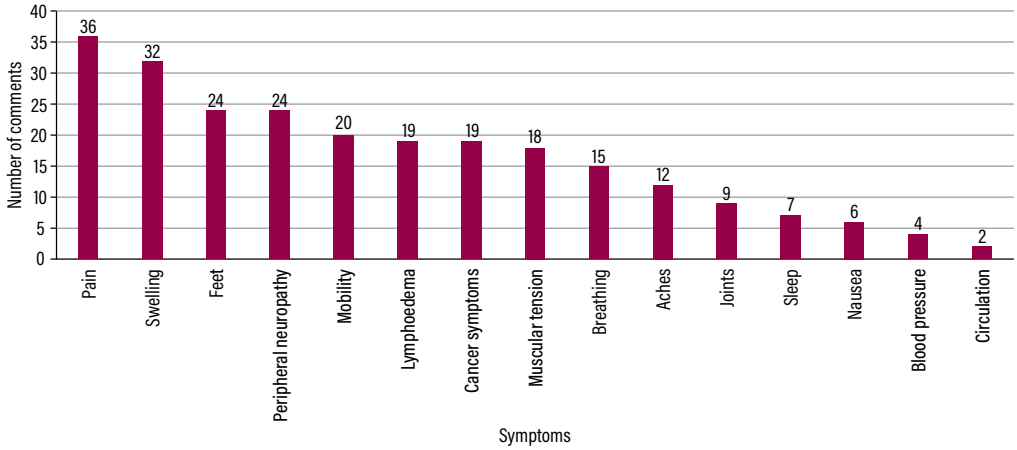
The combined consent/evaluation form was considered by the first author to be an effective method of collecting data, based on the number of completed forms available for review (2,078). However, the number of forms does not correlate with the total number of treatments delivered during the review period, as some forms were incomplete or unreadable and could not therefore be used in this service evaluation.

In the first author's experience, some patients can find it challenging to complete the consent/evaluation form due to physical issues, such as suboptimal eyesight or grip or cannulation, therefore rendering the form unreadable, while others can find the terminology confusing, particularly the word 'optional' applied to physiological or psychological concerns and the terms 'high/low' in relation to the level of concern scale.

Discussion and recommendations for service improvement

Evidence suggests that patients with cancer may experience physical and emotional benefits and improved quality of life following reflexology treatment (Tsay et al 2008, Wilkinson et al 2008, Wyatt et al 2012). Physiological symptom relief in this patient group is believed to be achieved through reducing symptoms of chemotherapy-induced peripheral neuropathy (Noh and Park 2019), decreasing pain and alleviating anxiety (Grealish et al 2000, Yang 2005, Quattrin et al 2006, Ghazavi et al 2016, Jahani et al 2018, Blackburn et al 2021) and improving sleep and digestive functioning (Elbasan and Bezgin 2018, Rambod et al 2019, Azari et al 2021). Patients in this service evaluation reported beneficial effects of the reflexology treatment on pain, swelling and symptoms of peripheral neuropathy, which supports the findings of previous research.

Figure 4. Patient comments on the beneficial effects of foot reflexology treatment on symptoms



A systematic review of the use of complementary and alternative medicine in oncology reported positive and significant findings regarding symptom improvement following reflexology (Calcagni et al 2019). Meanwhile, a service evaluation of a complementary therapy outpatient service offering aromatherapy, massage, reflexology and Reiki for patients with cancer found that such therapies provided a unique therapeutic space for relaxation, addressed patients' physical concerns and offered an opportunity for emotional support (Charlesworth et al 2018). In this service evaluation, patients commented on the relaxing effects of the reflexology and used words such as 'soothing' and 'comforting' to describe these effects.

Overall, the findings of this service evaluation suggested that the foot reflexology service was received well by patients. The findings were included in the annual report to the funder with a recommendation that the service should continue at the two original sites and should be implemented at the third site (radiotherapy outpatients). This was agreed and funding was secured for the service to be delivered in all three sites.

The service evaluation also identified some areas for improvement, which are discussed below.

Designated therapeutic space

Fortuneswell cancer ward comprises 17 beds, three isolation rooms and two specialist rooms for patients with neutropenia. Reflexology is delivered to patients who are confined to bed and to those who are able to sit out of bed, but there are few options for providing these patients with a private space for this treatment.

The outpatient chemotherapy unit consists of one large room with eight recliner chairs and two small rooms with three recliner chairs, one room with a bed for patients who are unable to sit and one room with a bed and recliner chair for clinical tasks such as wound dressing. Although a large chemotherapy room can provide patients with companionship and an opportunity to share experiences, some people prefer a more private space for reflexology treatment. At the time of writing, the chemotherapy outpatient unit was about to undergo remodelling which may include space for a complementary therapy room or a shared consultation room.

Meeting demand for appointments

Meeting demand for reflexology appointments is challenging, due in part to the limited funded hours and the number of reflexologists.

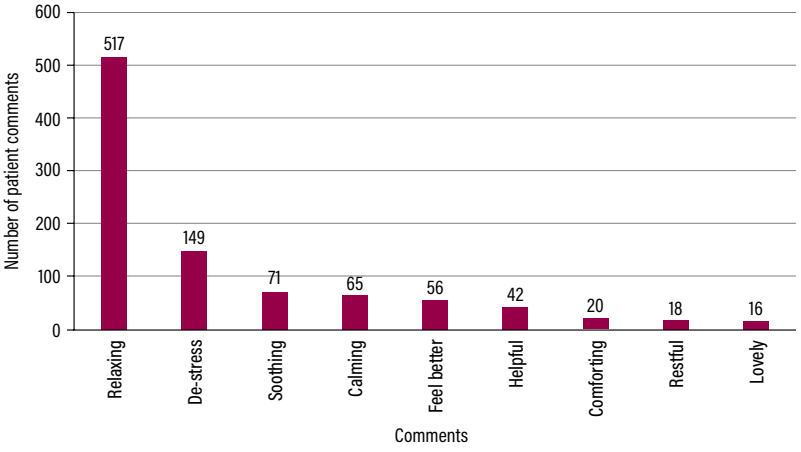
It may be possible for oncology staff to prioritise patients for referral to the reflexologists; for example, patients on Fortuneswell cancer ward who are in acute pain or who are receiving end of life care, or patients attending outpatients who may have a needle phobia or acute symptoms related to chemotherapy or radiotherapy treatment.

Consent/evaluation form

It is important to use a validated data collection tool when conducting a service evaluation but such tools must also meet the needs of the intended patient group. In the first author's experience, patients who receive foot reflexology treatment at DCHFT are often extremely unwell or extremely fatigued, therefore the data collection tool must be short, easy to understand and simple and quick to complete. Consequently, the combined consent/evaluation form has undergone numerous revisions based on patient feedback since the foot reflexology service was first implemented.

Based on the first author's experience of the process of reviewing the consent/evaluation forms for this service evaluation, suggested improvements include simplifying the level of concern scale by using the words 'better/worse' rather than 'low/high' and removing the word 'optional' in relation to physiological or psychological concerns. Additionally, the reflexologist could write patients' verbal scoring and comments on the form on their behalf and add their initials to acknowledge this. These changes could result in fewer incomplete forms and therefore provide a larger amount of data to inform future funding applications and potentially increase funded treatment hours.

Figure 5. Patient comments on therapeutic effect of the foot reflexology treatment



Conclusion

Clinical foot reflexology can offer patients with cancer relief from symptoms associated with their condition or cancer treatment, for example pain, swelling or those related to peripheral neuropathy, reduce their anxiety levels and provide therapeutic effects such as relaxation and comfort. Reflexology and other complementary therapies are generally funded and delivered by external providers, therefore it is essential to be able to evidence patient outcomes and capture patients' experiences, not only to secure funding but also to learn from patients' experience to continually improve the delivery of such interventions to meet patients' needs.

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Why you should read this article:

- To improve your knowledge of systemic anticancer therapy (SACT) and its administration
- To increase your awareness of the need for thorough systematic safety checks before SACT administration
- To read about a project at a haematology unit designed to help nurses conduct pre-SACT safety checks

Developing a standardised pre-SACT safety checklist for nurses on a haematology unit

Danielle Casey, Joanne Conway and Elaine Tomlins

Citation
Casey D, Conway J, Tomlins E (2023) Developing a standardised pre-SACT safety checklist for nurses on a haematology unit. Cancer Nursing Practice. doi: 10.7748/cnp.2023.e1840

Peer review
This article has been subject to external double-blind peer review and checked for plagiarism using automated software

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Conflict of interest
None declared

Accepted
17 February 2023

Published online
April 2023

Abstract

Systemic anticancer therapy (SACT) is a high-risk procedure with the potential for medication errors at every stage, from prescribing and dispensing to administration. Pre-administration checks carried out by nurses are the last opportunity to detect any discrepancies or potential errors before the patient receives their planned treatment. It is therefore crucial that nurses use a consistent, comprehensive and systematic method of conducing pre-SACT administration checks. In 2020-2l, the practice education team on the haematology unit at a specialist cancer hospital in London developed, trialled and evaluated a pre-SACT administration checklist. The checklist has provided nurses with a consistent and systematic order of checks to follow before SACT administration and practice educators with a tool for training nurses and assessing their competence in administering SACT.

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Keywords

cancer, cancer treatments, chemotherapy, clinical, drug errors, medicines, medicines management, never events, patients, patient safety, professional

EDUCATING CANCER nurses about systemic anticancer therapy (SACT) is crucial to ensure that they deliver high-quality cancer care and treatment (Challinor et al 2020). SACT is an overarching term for systemic anticancer treatments including chemotherapy, targeted therapy and immunotherapy. These different treatments can be administered via the oral, intravenous, subcutaneous or intramuscular route. For chemotherapy agents, recent advances have led to the development of further administration routes including the intravesical route, the intraperitoneal route and isolated limb perfusion (Lister et al 2020). SACT administration is a high-risk procedure and nurses have several responsibilities in relation to the handling and administration of SACT agents (Sim et al 2020). The timing and carefulness of administration are crucial.

Nurses who administer SACT assume the responsibility of being the last link in a chain of healthcare professionals involved in providing anticancer treatment. Pre-administration checks carried out by nurses are the last opportunity to detect any errors or discrepancies. Depending on the agent and on local policy, the administration of SACT agents usually requires pre-administration checks involving at least one nurse and the administration of high-dose SACT agents usually requires two nurses to do all the pre-administration safety checks independently of each other (Goldspiel et al 2015).

This article outlines a service improvement project aimed at developing a standardised pre-SACT administration checklist for nurses to ensure all required safety checks are completed before treatment. The checklist was

developed, trialled and evaluated for all SACT administration routes on the haematology unit at a specialist cancer hospital in London.

Project background

Customarily, every healthcare organisation in the UK with an oncology service requires cancer nurses to complete some form of SACT competency training (Lavender 2019). This may include theory and practice elements, an academic module and/or various formal and informal in-house training programmes. Only after completing these is a nurse deemed able to competently administer SACT (Lavender 2019).

In September 2017, a London-wide SACT passport was developed to address variations in the skills and competence of clinicians involved in providing SACT, such as nurses, pharmacists and radiographers (UKONS 2019). Previously, there was no London-wide standardised competency document for clinicians involved in providing SACT, so when staff changed jobs trusts did not recognise their previous qualification. The SACT passport was implemented across London's NHS trusts to address this issue.

The SACT passport provides a record of nurses' theoretical and practical competence in administering SACT. It has been adopted nationally by the UK Oncology Nursing Society (UKONS) as a recognised approach to the training and assessment of nurses involved in administering SACT (Lavender 2019). The passport details the pre-administration checks required before each treatment, including patient identity, consent, fitness to treat, agent, dose, venous access and follow-up arrangements. However, it does not explicitly provide a standardised step-by-step checklist for nurses to follow. There is therefore a gap between theory and practice and some checks can be missed, particularly when SACT is administered by less experienced nurses.

Service improvement project

The practice education team on the authors' haematology unit – which comprised the three authors of this article and junior educators – decided to conduct a service improvement project to develop, trial and evaluate a pre-SACT administration checklist at their unit.

The team held initial informal discussions with 25 nurses on the unit who were either new to, or experienced in, SACT administration. In their feedback, the nurses emphasised that there were inconsistencies in how they were taught to conduct SACT administration and which checks were mandatory, and that there were points regarding the checking process that they were still uncertain about after having passed the SACT passport theory. From the nurses' feedback it was also identified that while the unit's policy was to have two SACT-competent nurses undertaking checks independently of each other before each treatment, the process was neither methodical nor consistent. For the dual purpose of reducing the risk of errors and ensuring consistency in practice, the team therefore suggested that nurses could use a checklist.

The team determined two objectives for their service improvement project:

- To provide nurses with a practical and systematic method of ensuring that all required safety checks have been completed before SACT administration and of identifying potential errors or discrepancies. If nurses identified potential errors or discrepancies or if there were checks they could not complete, the checklist would instruct them not to proceed to SACT administration; to challenge the planned treatment, the prescription or the patient's fitness for treatment; and to lead discussions with colleagues from the multidisciplinary team, for example from the prescriber or the pharmacy team, to seek advice or clarification.
- To use the checklist in conjunction with the UKONS SACT passport as a benchmark for the competence of nurses new to SACT administration. This was aimed at staff nurses training in SACT administration at the unit, who would be expected to complete all required checks with minimal or no prompting and to be aware of the escalation processes if a check could not be completed before being signed off as competent. The checklist would provide a structure for nurses' practical SACT administration competency training.

The Plan, Do, Study, Act (PDSA) tool (NHS England and NHS Improvement 2013) was used to develop, trial, evaluate, and embed and disseminate the checklist.

Plan – Developing the checklist

Mnemonics are used as educational tools in many healthcare settings to assist staff to recall fundamental and/or large amounts of information (Linnard-Palmer and Ganley 2014, Putnam 2015). Traditionally, when teaching nurses how to administer SACT and assessing their competence, the practice education team on the authors' haematology unit used an ABCDEF mnemonic standing for 'access', 'bloods and baseline', 'consent', 'drug

and dose', 'education' and 'fit for treatment and follow-up'. However, that mnemonic did not outline every step required under each heading and was mostly referred to when staff were being assessed, rather than being consistently implemented in practice. The team therefore reviewed and expanded the mnemonic so that each heading would correspond to a comprehensive list of all checks required before SACT administration. This revised mnemonic became the basis for the pre-SACT administration checklist, which is detailed in Table 1.

Do – Trialling the checklist

The mnemonic-based checklist was trialled on the haematology unit over a 12-month period between July 2020 and July 2021. The checklist was printed on A3 posters displayed in treatment rooms. It was also printed on one side of a small card, with the other side listing information on cell cycle-specific and cell cycle-non-specific SACT agents and on vesicant, irritant or neutral SACT agents (see notes in Table 1). All nurses involved in administering SACT were asked to attach one of these cards to their ID badge so that they had immediate, permanent and easy access to the checklist. The practice educators introduced the use of the checklist on the unit with support from the unit's managers to ensure all nurses would refer to the checklist when completing their pre-SACT administration checks.

All nurses who were due to undergo their annual SACT re-accreditation during the 12-month trial period had to use the checklist to be re-accredited. Nurses new to SACT administration were introduced to the checklist when they started their practical SACT administration competency training at the unit. For their practical assessment, these novice nurses were asked to verbally 'run through' the checklist to demonstrate their knowledge to the supervisor. The checklist also became an essential tool when teaching and assessing nurses who were completing their UKONS SACT passport.

Nurses were deemed competent in SACT administration if they had been assessed as being able to:

- Complete, with minimal or no prompting, every check on the checklist for the specific SACT agent they were administering.
- Lead discussions with the multidisciplinary team when they identified a potential error or discrepancy and/or when they could not complete a check.

Prescribers and the pharmacy team on the unit were also introduced to the checklist so that they would be familiar with it if nurses had questions about a prescription.

Study – Evaluating the checklist

To evaluate the checklist, nurses on the unit who had been using the checklist were asked to give feedback in one-to-one discussions with the authors. Over the trial period, discussions took place with 77 nurses, 55 experienced in SACT administration and 22 new to it.

Almost all nurses (n=76, 99%) thought the checklist provided them with a consistent and systematic order of checks to follow. All nurses (n=77, 100%) thought that using the checklist promoted consistency and trust between the two nurse checkers. Many indicated that, since they had begun using the checklist, they felt more confident in identifying and clarifying discrepancies and in avoiding potential errors. Some nurses explained that they had assessed certain patients for peripheral neuropathy between SACT doses given as part of a multi-day regimen – peripheral neuropathy can be a side effect of SACT agents such as vincristine sulfate and bortezomib (Zajączkowska et al 2019). These assessments had led to dose reductions or exclusion of these agents.

All nurses experienced in SACT administration (n=55, 71%) said that since they had begun using the checklist, they felt more confident in leading discussions with colleagues, for example with the other nurse checker, with prescribers or with the pharmacy team. All nurses new to SACT administration (n=22, 29%) reported that their confidence in the checking process and in leading discussions with the prescriber or the pharmacy team had improved because the checklist gave them a structure to frame their checks and their discussions with colleagues. These often resulted in further assessments before SACT administration and/or in dose reductions.

Nurses on the unit were encouraged to informally reflect, during the trial period, on how the checklist could have assisted them when issues around SACT administration had arisen in the past. One nurse described a scenario involving the administration of a second cycle of high-dose methotrexate as part of a multi-day SACT regimen. The patient's prescription had been verified by the medical and pharmacy teams, but the patient's glomerular filtration rate (GFR) had not been checked before the start of the second cycle and the patient's renal function had deteriorated, resulting in acute kidney injury. The nurse felt that if they had been using

Key points

- Nurses are the last 'link' in a chain of healthcare professionals involved in providing systemic anticancer therapy (SACT)
- Pre-SACT administration checks are the last opportunity to detect any error and avoid potential patient harm
- Educating nurses about SACT is crucial to ensure that they deliver high-quality cancer care
- The SACT passport used for training and assessing nurses does not provide a standardised step-by-step checklist
- The practice education team on a haematology unit has developed a pre-SACT administration checklist for nurses
- The checklist provides a systematic order of checks to follow before SACT administration as well as a tool for training and assessing nurses

the checklist they would have been able to identify which checks had not been completed and challenge the proposed treatment, therefore possibly preventing the patient from developing acute kidney injury.

Table 1. Pre-SACT administration checklist based on the ABCDEF mnemonic

Heading	Checks required
A = Access	» Does the patient have a central venous access device (CVAD) or a peripheral intravenous cannula (PIVC) in place? » Can the SACT agent be infused through the device? Is the CVAD or PIVC patent? Does the CVAD have blood return? » Is the SACT agent a vesicant, an irritant or a neutral medicine?*
B = Bloods and baseline	» Has the patient recently had a blood test (full blood count, urea and electrolytes and liver function)? » Have the patient's height and weight been recently measured and recorded? » Check whether the patient requires: — EDTA or DTPA to measure GFR† — ECHO or MUGA scan to measure EF‡ — PFT to measure DL_{CO} or TL_{CO}¶ — An assessment of pregnancy status
C = Consent	» Has the patient consent form been completed and signed by the patient and the medical team? » Has the patient received a copy of the consent form?
D = Drug and dose	» Check the 'five rights' (right patient, right drug, right dose, right route, right time) » What SACT agent is being given? » Is the SACT agent cell cycle-specific or cell cycle-non-specific?§ » Check the patient's body surface area (the square root of their height multiplied by their weight divided by 3,600)** » Check the SACT agent's dose banding†† » Check the SACT agent's expiry date and time
E = Education	» Has the patient been taken through the prescription? » Has the patient been informed of any potential infusion reactions and side effects? » Has the patient taken their prescribed supportive medicines?‡‡ » Has the patient stopped taking any medicine that may interact with the SACT agent?¶¶
F = Fit for treatment and follow-up	» Is the patient fit for treatment? » Have any concerns been discussed with the medical and/or pharmacy team? » Are you, as a SACT-competent nurse, happy to proceed with SACT administration? » What are the follow-up arrangements? Does the patient have the necessary contact details?

SACT = systemic anticancer therapy; *Based on their properties and the risk of necrosis if they leak from a vein into surrounding tissue, SACT agents given via the intravenous route can be classed as vesicants (medicines that can cause severe tissue injury or necrosis), irritants (medicines that can irritate the vein) or neutral medicines (Lister et al 2020); †Measuring the clearance of a radioactive tracer, such as ethylenediaminetetraacetic acid (EDTA) or diethylenetriaminepentaacetic acid (DTPA), enables measurement of the glomerular filtration rate (GFR), giving an indication of renal function; ‡An echocardiogram (ECHO) or a multigated acquisition (MUGA) scan can be performed to measure the ejection fraction (the amount of blood pumped by the heart's left ventricle), giving an indication of cardiac function; ¶Pulmonary function tests (PFTs) are performed to check pulmonary function, for example by measuring the lungs' diffusing capacity for carbon monoxide (DL_{CO}) or transfer factor for carbon monoxide (TL_{CO}); §Chemotherapy agents act either at a specific phase of the cell cycle when cancer cells are dividing (cell cycle-specific agents) or at all phases of the cell cycle including the resting phase (cell cycle-non-specific agents). Cell cycle-specific agents are usually given multiple times during one treatment course and should be given at approximately the same time every day, whereas cell cycle-non-specific agents can be given at any time (Lister et al 2020); **Most SACT agents are dosed according to the patient's body surface area; ††In dose banding, drug doses are rounded to a predefined standard dose according to the patient's body surface area; ‡‡Some patients may have been prescribed supportive medicines to take before, during or after receiving certain SACT agents; for example, an antiepileptic such as levetiracetam before the administration of the SACT agent busulfan; ¶¶Some patients may be taking medicines with known potential interactions with SACT agents; for example penicillins and co-trimoxazole, which can interact with the SACT agent methotrexate, or azole antifungals, which can interact with the SACT agent vincristine sulfate

Examples of near misses that nurses identified during the pre-SACT administration checklist trial period were documented by the authors and are detailed in Table 2.

Patients can deteriorate before they arrive at the unit for treatment, but also between cycles or doses delivered as part of a multi-day SACT regimen, either haemodynamically or because of multi-organ compromise. Nurses therefore need to ensure that patients are fit for treatment not only before the start of treatment but also between doses or cycles. If they find that a patient has deteriorated, they should question whether the patient is still fit for treatment and request a medical review.

Patients who develop acute kidney injury during multi-day regimens may require a dose reduction or the discontinuation of treatment. In patients who show signs and symptoms of acute kidney injury during a multi-day regimen, nurses should check creatinine clearance using the Cockcroft-Gault formula (Cockcroft and Gault 1976) to assess the patient's kidney function and, depending on the result, request a medical review to check whether dose reduction or treatment discontinuation is warranted.

Act – Embedding and disseminating the checklist

The nurses' feedback showed that the checklist had provided them with a succinct and thorough resource on which to base their pre-SACT administration checks. The checklist has therefore been implemented in clinical practice at the unit. The checklist has also been embedded at the unit as a mandatory component of practical assessments for nurses new to SACT administration and for nurses seeking SACT re-accreditation. It has become a tool that practice educators use to provide a consistent framework for assessing nurses' competence and to frame discussions about nurses' knowledge gaps and areas for improvement. For example, if a nurse needs significant prompting to satisfy the checks under the 'Education' heading of the checklist, this demonstrates to the educator that this is an area for improvement and they can consequently plan to enhance the nurse's education in that area.

After the 12-month trial period, some areas were highlighted for further development, including presenting the service improvement project at the trust's clinical forum for wider feedback and implementing the checklist across the hospital. It was decided to consult the hospital's lead chemotherapy nurse consultant, as a result of which the checklist was further developed to include an

'assessment of toxicities' under the 'Access' heading (which was therefore changed to 'Access and assessment'). Furthermore, it was decided to design a digital version of the checklist that would become part of the trust's digital programme. Outside of the authors' trust, further developments would include disseminating the checklist through networking at events such as the UKONS annual conference. An abstract entitled 'Implementation of a SACT Pre-Administration ABCDEF Safety Checklist for Nurses' was subsequently submitted to the 2021 UKONS conference and was placed second in the 'best poster' category.

Discussion

Administering SACT is a high-risk clinical activity that requires evolving education, resources and procedures to reduce risk and enhance patient safety (Goldspiel et al 2015). In the past, safety procedures for SACT have included electronic prescribing, the use of aseptic facilities for preparation, vinca alkaloids being prepared in intravenous mini bags (due to historic fatalities that had occurred after these agents had been inadvertently dispensed intrathecally), dose banding (whereby drug doses are rounded to a predefined standard dose according to the patient's body surface area), closed-system devices, and two nurses checks independent of each other before administration (Goldspiel et al 2015, Neuss et al 2016). Designed as an adjunct to these existing safety procedures, the pre-SACT administration checklist described in this article has been shown to assist nurses in ensuring that all the checks required have been completed before treatment. The checklist acts as a methodical tool that can assist nurses in identifying discrepancies and avoiding potential errors that could lead to patient harm.

There is an accepted increased risk of medication errors with medicines such as SACT agents, with errors potentially occurring at every stage, from prescribing and dispensing to administration (Comerford and Galligan 2021). The incidence of medication errors in oncology settings is described as low in the literature, but it is also deemed challenging to measure because of suboptimal detection and recording (Comerford and Galligan 2021). Preventable medication errors in oncology may occur for many reasons, including inconsistent checking methods during prescribing and administration, interruptions during administration and lack of staff (Pfeiffer et al 2018). Fully eliminating the risk of medication errors in SACT is not feasible because of the possibility of interruptions during administration and of human error. The pre-SACT administration checklist aims to provide a standardised method of mitigating that risk.

The policy of having two nurses undertaking checks independently of each other before medicine administration is common in healthcare organisations. However, in a systematic review of the effectiveness of double checking for reducing medication errors, Koyama et al (2020) found that there was insufficient evidence that double checking is associated with lower rates of medication errors or reduced harm compared with single

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Table 2. Examples of near misses identified by nurses during the pre-SACT administration checklist trial period

Heading	Examples
A = Access	Patient admitted with inappropriate venous access for the SACT regimen prescribed – for example: » Patient who had been prescribed a DT-PACE regimen (a chemotherapy regimen for multiple myeloma comprising five agents), which requires a triple-lumen central venous access device (CVAD), admitted with a single-lumen CVAD » Patient who had been prescribed a MATRIX regimen (standard chemoimmunotherapy treatment for primary central nervous system lymphoma comprising methotrexate, cytarabine, thiotepa and rituximab), which requires a peripherally inserted central catheter (PICC), admitted without a PICC
B = Bloods and baseline	» Patient's blood test results not within safe ranges, with potential implications for SACT agent dosing – for example: — Haemoglobin, platelet and/or neutrophil levels too low — Bilirubin and alanine transaminase levels too high » Patient's glomerular filtration rate not checked between treatment cycles* » Patient's weight had increased by more than 10% since previously recorded, which had changed their body surface area and therefore changed SACT agent dosing* » Patient's pregnancy status not clearly documented
C = Consent	Inaccurate or incomplete consent form – for example: » Form not signed by the medical team » Medical team had changed the patient's treatment regimen but used the consent form for the previous regimen
D = Drug and dose	» SACT agents inaccurately listed » SACT agents expired » Inaccurate timings for the planned administration of cell cycle-specific SACT agents* » SACT agent dosed according to adjusted body weight instead of body surface area, requiring a different calculation to follow » Lack of clear documentation of how dosing had been calculated
E = Education	» Patient had not taken their prescribed supportive medicines* » Patient had not stopped taking medicines known to interact with the SACT agent*
F = Fit for treatment and follow-up	Patient no longer fit for treatment – for example: » Patient had deteriorated between SACT doses or cycles » Patient had developed acute kidney injury during a multi-day SACT regimen » Patient had developed peripheral neuropathy following treatment with vincristine sulfate and bortezomib

SACT = systemic anticancer therapy; *See notes in Table 1

checking. Conversely, the use of standardised checklists is well researched and has been proven to assist with the prevention and reduction of errors (Goldspiel et al 2015).

Conclusion

The pre-SACT administration checklist developed for this service improvement project at a specialist cancer hospital in London contains all the safety checks required of nurses before they administer SACT agents to patients. The feedback gathered from 77 nurses after the checklist had been trialled on their haematology unit indicates that it provides a consistent and systematic order of checks to follow before SACT administration. Nurses felt the checklist had brought structure to the checking process and had enhanced their confidence in challenging the planned treatment, the prescription and the patient's fitness for treatment as well as in leading discussions with nurse colleagues, prescribers and the pharmacy team. The checklist also provides the practice education team with a tool for training nurses and assessing their competence in SACT administration. The risk of medication errors in SACT cannot be fully eliminated, but the authors believe that the checklist represents a standardised method of reducing that risk.

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Why you should read this article:

- To understand why some nursing students may be anxious about working with people with cancer
- To learn how to support nursing students' learning needs on specialist cancer practice placements
- To consider your own role in supporting nursing students on specialist cancer practice placements

Supporting preregistration nursing students on specialist cancer practice placements

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Citation
Kerr H, Porter S (2023) Supporting preregistration nursing students on specialist cancer practice placements. Cancer Nursing Practice. doi: 10.7748/cnp.2023.e1845

Peer review
This article has been subject to external double-blind peer review and checked for plagiarism using automated software

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Conflict of interest
None declared

Accepted
08 June 2023

Published online
August 2023

Abstract

Practice placements in specialist cancer services can provide preregistration nursing students with a range of valuable learning opportunities and a meaningful placement experience. However, some nursing students may have a negative attitude towards working in cancer services and may be anxious about working with people with cancer and their families. All nurses, including those acting as practice assessors and practice supervisors, have an important role in supporting students to overcome these issues and contribute to a positive learning experience. This article explores different ways in which nurses can support nursing students' learning needs in specialist cancer practice placement areas. The authors also challenge nurses to reflect on how they support nursing students in such placement areas and to consider how they might develop this important component of their role.

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Keywords

cancer, career pathways, clinical placements, education, experiential learning, learning outcomes, practice learning, preregistration education, professionals, students

Aims and intended learning outcomes

The aim of this article is to explore ways in which nurses can support preregistration nursing students' learning in specialist cancer practice placement areas. After reading this article and completing the time out activities, you should be able to:

- Discuss the potential benefits and challenges of specialist cancer practice placements for preregistration nursing students.
- Recognise the benefits and potential challenges for nurses in supporting preregistration nursing students on specialist cancer practice placements.
- Identify some of the learning opportunities for preregistration nursing students in your clinical area, aligned to the core cancer capabilities in practice set out by Health Education England (HEE) (2023).
- Describe the steps involved in designing a simulation scenario for preregistration nursing students on practice placement in specialist cancer services.
- Use a simple framework to structure delivery of informal feedback for preregistration nursing students in your clinical area.

In the UK, the Nursing and Midwifery Council (NMC) sets out the legal and entry requirements, recognition of prior learning, length of programme, requirements for supervision and assessment and information on the award required for all preregistration nursing education programmes (NMC 2023a, 2023b). Management of preregistration education programmes lies with the approved educational institution in partnership with practice learning partners (NMC 2023a), which emphasises the responsibility of both systems to provide supportive learning environments for nursing students.

The NMC (2023b) Standards for Student Supervision and Assessment sets out the expectations for the learning, support and supervision of students in the practice environment and describes three main roles for registered nurses – academic assessor, practice assessor and practice supervisor. The role of the practice assessor is to assess and confirm the student's achievement of practice learning for a placement, the practice supervisor role is to support and supervise the student in the practice placement area, while the academic assessor is responsible for collating and confirming the student's achievement of proficiencies and programme outcomes in the academic environment (NMC 2018a). However, the NMC (2018b) expects that all nurses, at the point of registration, will be able to 'support and supervise students in the delivery of nursing care, promoting reflection and providing constructive feedback, and evaluating and documenting their performance'.

Practice placements for nursing students can be in generalist or specialist areas. This article focuses on practice placements in the specialist cancer setting, although it is important that preregistration nursing students recognise that people may access cancer care and support in primary, secondary and/or tertiary services. Specialist cancer services are delivered to people with cancer and their families by multi-professional teams in various settings, such as cancer units, cancer centres and supra-regional centres, which may include outpatient, day hospital or inpatient settings, or via specialist cancer services in the community (HEE 2023). Practice placements in the specialist cancer context can, therefore, provide a range of valuable and meaningful learning opportunities and experiences for nursing students. There have been few studies on nursing students' experiences of caring for people with cancer so there is limited information on how nurses can best support nursing students in specialist cancer practice placement areas (Cunningham et al 2006, Sanford et al 2011, King-Okoye and Arber 2014).

This article describes some of the benefits and challenges for nursing students on specialist cancer service practice placements and explores how nurses can support student learning in this environment.

Specialist cancer practice placements

Potential benefits for students

Specialist cancer practice placements can provide nursing students with a range of learning opportunities. Alongside transferable skills, such as effective communication, delivery of person-centred and family-centred care and safe administration of medicines, such settings can offer nursing students the opportunity to develop skills and knowledge specifically related to specialist cancer care. Examples of such skills and knowledge, based on the authors' experience as clinicians and as practice assessors in specialist cancer settings, include:

- Recognition of side effects associated with cancer and cancer treatment.
- Observation of the safe administration of treatments such as systematic anti-cancer therapy (SACT).
- Care of people receiving radiotherapy.
- Observation of the management of symptoms and/or toxicities related to cancer treatment.
- Observation of the management of oncological emergencies such as neutropenic sepsis, malignant spinal cord compression or superior vena cava obstruction.
- Observation of complex communication scenarios such as sharing information with a patient and family related to a new cancer diagnosis, cancer recurrence or metastases or end of life care.

To take full advantage of these unique and challenging learning opportunities, however, nursing students require support from nurses to ensure that they achieve positive learning outcomes.

Potential challenges for nursing students

Due to the limited number of specialist cancer clinical areas, not all nursing students will experience a practice placement in this environment, which may explain the lack of literature on their experiences of such settings and on how nurses can best support them. The limited information that is available suggests that the nurse should consider a number of factors when supporting nursing students.

One important factor is students' personal and professional life experience and how these may affect their approach to caring for people affected by cancer (Sanford et al 2011). For example, in a survey of nursing students' (n=134) experiences of caring for patients with cancer, 69% (92) indicated they had at least one personal experience of cancer among close family, friends or themselves (Cunningham et al 2006). Additionally, in the authors' experience, nursing students enter their programme of study with different professional experience, ranging from no relevant experience to many years working as nursing assistants or nursing associates.

Another factor to consider is the variation in nursing students' knowledge about cancer and potential lack of skills related to cancer care.

Despite the inclusion of care of people with cancer and their significant others in preregistration nursing programmes, students have reported a lack of knowledge of this subject (Charalambous and Kaite 2013, Hedenstrom et al 2021) and suggested that they require more education and support (King-Okoye and Arber 2014). This lack of knowledge can lead to students feeling out of their depth (Cunningham et al 2006) and emphasises the importance of assessing their knowledge of cancer at the start of, and throughout, their practice placement. Nursing students have also reported that they lack the skills required to care for people with cancer and their families and reported feeling anxious when caring for people with cancer, mainly related to inadequate classroom teaching of communication skills (Cunningham et al 2006). It is important, therefore, that nurses engage in supportive conversations with nursing stTabledents about their preparedness for engaging in complex or challenging communication scenarios.

Even experienced nurses can find the emotional aspect of caring for people with cancer challenging (Tay et al 2011, Moghadam et al 2021); caring for such patients may also cause them to reflect on their own losses and/or death (Jones 2017). This is no different for nursing students. Although there is a lack of literature on the topic, King-Okoye and Arber (2014) reported that nursing students may experience challenges in managing their emotions when caring for people with cancer and their families and that some have found the experience emotionally distressing and draining. Additionally, evidence suggests that nurses caring for people with cancer and their families are at high risk of burnout and compassion fatigue (Jones 2017, Kohli and Padmakumari 2020) and are encouraged to engage in self-care activities, such as aromatherapy, exercise, meditation and massage (Grafton and Coyne 2012). It is important, therefore, that nurses encourage nursing students to care for themselves while on placement and to share how caring for people with cancer is affecting them, if they wish to do so.

Some nursing students may have a negative attitude towards cancer and caring for people with cancer (Komprood 2013, Hedenstrom et al 2021), for example they may regard all cancers as incurable and fatal (Sanford et al 2011, King-Okoye and Arber 2014). Students may therefore require support from a nurse to address and overcome feelings of fear, hopelessness or uncertainty and the association of cancer with death (Kav et al 2013).

Despite the challenges described above, nursing students have emphasised the importance of having their mentor's support when caring for people affected by cancer (Cunningham et al 2006) and the important role of the nurse in ensuring the quality of their clinical cancer care experience (Sanford et al 2011). This reinforces the importance and potential effectiveness of the support provided by nurses.

Potential benefits and challenges for nurses

Clinical education is an essential part of nursing student education and all nurses have a crucial role in this learning process (Aghamohammadi-Kalkhoran et al 2011). Supervising and assessing nursing students on placement has many benefits for nurses, including a sense of personal satisfaction in supporting another person's learning (Casey and Clark 2013) and supporting their own professional development, for example through searching for evidence in response to nursing students' questions about practice decisions (Casey and Clark 2013). Additionally, supporting students can expand nurses' skills, such as teaching and providing feedback (Casey and Clark 2013).

Although nurses have reported that they enjoy supporting nursing students they have also identified challenges such as: lack of preparedness for teaching (Anderson et al 2016); limited time to fulfil the requirements of this aspect of their role (Cusack et al 2020); increased workload, a factor that is often not recognised by management (Anderson et al 2016, Cusack et al 2020); and feeling that supporting students impedes their ability to complete their own work (Coyne and Needham 2012).

TIME OUT 1

Consider some of the challenges you have experienced when supervising or assessing nursing students on placement. How did you address these challenges? Reflect on how supporting students has enhanced your own professional development

Supporting nursing students' learning

The following sections provide some suggestions for encouraging experienced nurses to reflect on the approaches they might have used to support nursing students on practice placements and to support more recently registered nurses to consider which approaches they might use in the future.

Developing learning opportunities

In the UK, practice placement learning is guided by the proficiencies set out by the NMC

Key points

- Specialist cancer practice placements can provide nursing students with a range of learning opportunities
- Some nursing students may have a negative attitude towards cancer and caring for people with cancer, for example they may regard cancer as incurable and fatal
- Each nursing student brings unique values, knowledge and skills to a placement setting, so it is vital to adopt an individualised approach to student learning
- Nursing students require formal feedback such as summative assessments at certain points in their preregistration programme, but they also require informal feedback while on placement

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(2023a) and related to the stage the nursing student has reached in their preregistration programme. Learning in cancer care is guided by the Career Pathway, Core Cancer Capabilities in Practice (CiP) and Education Framework for the Nursing and Allied Health Professions Workforce (the framework) (HEE 2023), developed as part of the Aspirant Cancer Career and Education Development programme (NHS England 2023). The framework details core cancer CiP under seven domains (HEE 2023):

- Domain A: person-centred collaborative working.
- Domain B: assessment, investigation and diagnosis.
- Domain C: condition management, treatment and planning.
- Domain D: leadership and management.
- Domain E: evidence-based practice.
- Domain F: quality improvement.
- Domain G: education.

Rather than focusing on roles, the framework focuses on seven levels of practice – supportive, assistive, preregistration, registered, enhanced, advanced and consultant – and provides details of the core cancer CiP within each domain for each level of practice (HEE 2023). The specialist cancer setting can provide nursing students with the opportunity to achieve many of the core cancer CiP listed within the preregistration level of practice (HEE 2023).

When developing learning opportunities for nursing students on specialist cancer placements it is useful to focus on transferable skills – for example effective communication and person-centred care (related to domain A) – and on those that may be limited in other settings, such as knowledge of the side effects associated with cancer or cancer treatments (related to domain C) and/or observation of different routes of medicine administration (related to domain B), for example subcutaneous infusion or peripherally inserted central catheter (PICC) lines and intrathecal routes.

TIME OUT 2

Access the Career Pathway, Core Cancer Capabilities in Practice (CiP) and Education Framework for the Nursing and Allied Health Professions Workforce at: **www.hee.nhs.uk/sites/default/files/documents/ACCEND%20Career%20Pathway%2C%20Core%20Cancer%20Capabilities%20and%20Education%20Framework.pdf**

- Read the core cancer CiP related to the preregistration level of practice (from p40-p69)
- Think about potential learning opportunities for nursing students in your clinical area that align with the preregistration CiP detailed under each domain

Learning approaches

It is important to recognise that each nursing student brings unique values, knowledge and skills to a placement setting (Sanford et al 2011), so it is vital to adopt an individualised approach to student learning. Such an approach recognises, respects and values individuality and aims to provide an environment that 'fosters empathy, trust, patience and respect toward nursing students' (Aghamohammadi-Kalkhoran et al 2011).

Adopting an individualised approach requires an initial discussion with the student about what they hope to learn, then assisting them to align these goals with realistic outcomes and experiences, depending on what stage of the programme they are at and the opportunities available in the placement area. During this discussion it may also be appropriate to explore any concerns the student may have about the placement, such as feelings of inadequacy, fear or anxiety about caring for people with cancer and their families.

Aghamohammadi-Kalkhoran et al (2011) suggested that the quality and quantity of interactions between the nursing student and the nurse can either facilitate or act as a barrier to the student's learning. This emphasises the importance of spending time supporting the student's development and tailoring approaches to their individual learning needs. Although students learn through using a range of learning models and styles – for example theorist, pragmatist, reflector or activist (Honey and Mumford 1986) – each will have a preferred learning style. Often, students are asked to explore their preferred learning style in their higher education institution, so the nurse could ask the student about this and attempt to tailor their teaching approach to align with the student's preference, where possible.

Reflective observation

Reflective observation is an essential element of nursing students' learning (Bagweneza et al 2021) and has been identified as a method valued by nursing students (O'Regan et al 2016) because it provides them with an opportunity to identify gaps in their knowledge (Dieckmann et al 2012). Examples of learning through reflective observation in the specialist cancer context may include wound management, complex conversations with patients and families and administration of SACT.

Students are encouraged to use a reflective framework to support their observations – for example, Kolb's (1984) Learning Cycle Stage or Gibbs' (1988) reflective cycle – to identify their learning needs for their professional

development and future application in practice. Since students are required to provide evidence of their progress in practice placements, written reflective accounts of their experiences are a useful way of capturing their learning and can provide the basis for discussions with the practice assessor or practice supervisor.

Experiential learning – simulation

Experiential learning is another essential part of nursing students' learning (Bagweneza et al 2021). Innovative developments in clinical education, including the use of problem-based learning and simulation, provide opportunities for experiential learning in practice (Allert et al 2022, Silva et al 2023). Simulation has been found to be an effective method of education for nurses working in cancer care (Silva et al 2023).

Simulation can be time-consuming and expensive due, for example, to the use of resources such as mannequins and technology. However, there are ways in which students can be supported to take part in simulation experiences in specialist cancer placements without the need for such equipment. For example, the student can work through a real-life clinical scenario, developed by the nurse and involving other ward staff and/or other students, to practise skills such as communication and decision-making (Silva et al 2023).

Simulation supports problem-based learning, in that the nurse can use the gaps they have previously identified in the student's knowledge or skills to inform the clinical scenario. The nurse should provide an opportunity for debriefing following the simulation to enable the student to reflect on their learning (Luctkar-Flude et al 2021).

Table 1 describes a step-by-step approach to designing a simulation scenario in the specialist cancer placement setting.

TIME OUT 3

How might you organise a simulation session in your clinical area? Reflect on a real-life patient scenario you could adapt for use in a placement-based simulation. Using the process shown in Table 1, jot down some ideas for each step based on the patient scenario you have adapted

Providing feedback

Nursing students require formal feedback such as summative assessments at certain points in their preregistration programme, but they also require and value informal feedback while on placement (Casey and Clark 2013). Providing informal feedback in the clinical setting can be challenging for nurses due, for example, to time constraints or lack of training (Helminen et al 2016). Using a simple framework may therefore support them to engage effectively in this process.

Russell (2019) suggested that Bloom's (1956) domains of learning – cognitive (knowledge), psychomotor (skills) and affective (attitude) – can offer a straightforward framework for providing nursing students with feedback.

Table 1. Step-by-step approach to designing a simulation scenario in the specialist cancer placement setting

Step	Description
1	Identify learning objectives: » Clearly define the knowledge, skills or attitudes the student should display throughout the simulation (this can be informed by previously identified gaps in the student's knowledge)
2	Choose a clinical scenario: » Select a scenario based on an actual patient situation encountered in the clinical environment » Consider the setting, patient population and specific healthcare issues
3	Develop a patient profile: » Create a detailed profile for the simulated patient » Include relevant past medical history, main current healthcare complaint, physical assessment and observations findings
4	Determine the scenario timeline: » Detail the progression of events and any changes in the patient's condition throughout the simulation
5	Define roles and responsibilities: » Assign roles to participants, including the student undertaking the simulation, the facilitator, the simulated patient and any additional healthcare professionals
6	Design supporting materials: » Prepare materials such as medical records, diagnostic results, medicine prescriptions and any equipment that may be required
7	Write the scenario: » This should include progression of the patient's condition and cues or events that will prompt the nursing student, and any other participants, to initiate appropriate interventions or actions
8	Prepare the simulation environment: » Arrange the physical space to resemble a realistic clinical setting
9	Prepare the person acting as the patient (if applicable): » Explain the person's role and their expected behaviours and responses to the student's actions or interventions
10	Conduct a pre-briefing session with participants: » Provide an overview of the scenario, set expectations of each participant and describe any theoretical concepts or procedures related to the scenario
11	Facilitate the simulation: » Observe the student's actions, providing feedback and intervening where necessary to ensure a safe and effective learning experience
12	Debrief: » Engage in a structured debriefing session with the student to enable them to reflect on the experience, to discuss their performance, including any gaps in their knowledge or skills, and to address any questions or concerns the student may have

(Adapted from International Nursing Association for Clinical Simulation and Learning 2016)

This framework works well in relation to experiential, problem-based and simulation-based learning within the clinical setting because it can be used to structure immediate feedback, for example during a supervised procedure. An example of how this framework can be used in practice is shown in Table 2.

TIME OUT 4

Practise using the framework shown in Table 2 to give informal feedback to a nursing student. Once you have done this, reflect on the effectiveness of this approach in terms of giving feedback and how the student received and acted on the feedback

Widening the learning experience

According to Casey and Clark (2013), nursing students like to feel a sense of belonging as they move into different practice placement areas, so it is important to introduce the student to other members of the multidisciplinary team and support them to engage in discussions with and/or arrange for them to spend time with wider team members.

Table 2. Using a simple framework to provide informal feedback to the nursing student

This example details how Bloom's (1956) domains of learning may be used as a framework for assessment and provision of feedback during a clinical procedure (changing a peripherally inserted central catheter (PICC) line dressing)

Domain	Assessment	Feedback
Knowledge	Ask the student questions to determine their understanding of the procedure, for example: » What do you know about central venous access devices? » When changing a PICC line dressing, what else should you assess? » What are specific risks of central venous access devices for patients in cancer services?	Reflect the information gained from the responses to these questions back to the student, pointing out any gaps in their knowledge
Skill	Observe the student changing a PICC line dressing and ask clarifying questions, for example: » Why is effective infection control crucial when changing a PICC line dressing? » What are you observing for at the site of entry and surrounding area when changing a PICC line dressing? Offer the student opportunities to undertake the procedure in various situations, for example with patients at different stages of treatment	Provide the student with details about how they undertook the procedure, for example the steps they completed and/or the steps they missed or did not complete
Attitude	Consider whether the student demonstrates an appreciation of the importance of applying their knowledge in practice. Becoming proficient in a skill may require multiple attempts and the student should be assessed on their ability to apply what they have previously learned to specific skills and to their wider practice. For example, consider whether the student incorporates infection control principles appropriately	Provide details about how the student is applying their knowledge in practice, in relation to this specific procedure and to their wider practice

(Adapted from Russell 2019)

The 'hub and spoke' model of practice learning involves allocating students to a placement (hub) from which they are supported by their practice assessor or practice supervisor to work in other settings with different clinicians (spoke experiences), for example advanced nurse practitioners or nurse consultants (Harrison-White and King 2014). This hub and spoke model supports students to meet the NMC (2023a) standards for preregistration education by exposing them to a wide variety of experiences to enable them to appreciate the complexity of the patient journey in the cancer services context. Following a spoke experience, the nurse should encourage and support the student to reflect on their learning.

TIME OUT 5

A nursing student, Ibrahim, is starting the first placement of year two of a three-year preregistration nursing programme in an inpatient specialist cancer ward. Ibrahim has had three six-week placements in year one – a dermatology outpatient clinic, a nursing home and a community public health service. How might you support Ibrahim's learning during this placement? Think about how you might identify how Ibrahim feels about a placement in a specialist cancer service, his learning expectations and his preferred method of learning. Consider how you could monitor his well-being throughout the placement. Which of the learning opportunities that you identified from completing Time out 2 might you include in Ibrahim's learning plan?

Conclusion

A practice placement in a specialist cancer setting can offer nursing students an opportunity to develop a range of transferable skills and to observe specialist care and treatments and may encourage them to consider this field of nursing as a career option. Nurses can support nursing students to maximise their practice placement experience by considering their individual learning styles, developing learning opportunities linked to relevant core cancer CiP, providing simulation scenarios, offering regular, informal feedback and supporting engagement with other members of the multidisciplinary team. The nurse should also consider the potential emotional effects of caring for people with cancer and their families on students and should encourage them to self-care and to share any concerns. Supporting nursing students can also be beneficial for nurses through, for example, enhancing their professional development and teaching skills and from the sense of satisfaction gained from preparing the next generation of nurses.

CPD CONTINUING PROFESSIONAL DEVELOPMENT

TIME OUT 6

Identify how supporting preregistration nursing students in specialist cancer practice placements applies to your practice and the requirements of your regulatory body

TIME OUT 7

Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account. See: **rcni.com/reflective-account**

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Supporting students in specialist cancer practice placements

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. The requirements for supervision and assessment of preregistration nursing students in the UK is set out by:

a) The Royal College of Nursing ☐
b) The Nursing and Midwifery Council ☐
c) The Florence Nightingale Association ☐
d) The Queen's Nursing Institute ☐

2. Specialist cancer practice placements can offer students an opportunity to develop skills in and expand their knowledge and experience of:

a) Recognition of side effects associated with cancer and cancer treatment ☐
b) Care of people receiving radiotherapy ☐
c) Management of oncological emergencies ☐
d) All of the above ☐

3. Factors to consider when supporting students in specialist cancer practice placement settings do not include:

a) Whether students are willing to work overtime ☐
b) Students' personal and professional life experiences ☐
c) The variation in students' knowledge about cancer ☐
d) Students' potential lack of skills related to cancer care ☐

4. Which of these are described as benefits of supervising and assessing students?

a) Having an 'extra pair of hands' ☐
b) Gaining a sense of personal satisfaction in supporting the learning of another person ☐
c) Increased workload ☐
d) Reduced workload ☐

5. Reflective observation can provide students with an opportunity to:

a) Take part in simulation experiences ☐
b) Watch other students undertake procedures ☐
c) Identify gaps in their knowledge ☐
d) Take part in challenging conversations ☐

6. Which of the following is a reflective framework that can support students' observations?

a) Framework for Effective Cancer Management ☐
b) The Transdisciplinary Framework ☐
c) The Plan-Do-Study-Act (PDSA) Cycle ☐
d) Kolb's Learning Cycle ☐

7. Which of these steps forms part of designing a simulation scenario?

a) Identify learning objectives ☐
b) Develop a patient profile ☐
c) Debrief ☐
d) All of the above ☐

8. Writing a scenario for a placement-based simulation should include:

a) Cues or events that will prompt the student to initiate appropriate interventions or actions ☐
b) A detailed description of the clinical environment ☐
c) A detailed description of the props required ☐
d) A detailed description of gaps in the student's knowledge ☐

9. Bloom's (1956) domains of learning can offer a straightforward framework for:

a) Assessing the patient's condition in a simulation ☐
b) Understanding how systemic anti-cancer therapies work ☐
c) Providing nursing students with feedback ☐
d) Calculating medicine dosage ☐

10. Which statement is inaccurate? A 'hub and spoke' model of clinical practice placement can:

a) Support students to meet the NMC standards for preregistration education ☐
b) Save students money by reducing travel costs ☐
c) Expose students to a wide variety of experiences ☐
d) Enable students to appreciate the complexity of the patient journey in the cancer services context ☐

How to complete this assessment

This multiple-choice quiz will help you test your knowledge. It comprises ten multiple choice questions broadly linked to the previous article. There is one correct answer to each question.

You can read the article before answering the questions or attempt the questions first, then read the article and see if you would answer them differently.

You may want to write a reflective account. Visit rcni.com/reflective-account

Go online to complete this multiple-choice quiz and you can save it to your RCNi portfolio to help meet your revalidation requirements. Go to **rcni.com/cpd/test-your-knowledge**

This multiple-choice quiz was compiled by **Ruth Williams**

The answers to this quiz are:

1. b 2. d 3. a 4. b 5. c 6. d
7. d 8. a 9. c 10. b

This activity has taken me ___ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor ☐

As a result of this I intend to: _____

_____

_____

_____

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