



ISNCC president receives nursing excellence award

Professor Sanchia Aranda, President of ISNCC, was announced as the inaugural recipient of the Excellence in Cancer Nursing Award from the Cancer Nurses Society of Australia (CNSA) at their recent national conference. The award acknowledges an outstanding commitment by a cancer nurse to leadership, research, clinical practice or education.

In presenting the award, Gabrielle Prest, Chairperson of CNSA, said that Professor Aranda had made an impressive national and international contribution to cancer nursing and cancer control through her many and varied cancer nursing education, research and leadership roles.

Professor Aranda has worked in the area of cancer and palliative care nursing for the past 30 years. She has been pivotal in the development of tertiary post-



Professor Sanchia Aranda receiving her excellence award from Gabrielle Prest, Chairperson of the CNSA

graduate cancer and palliative care nursing courses in Australia and has led numerous rigorous research studies to explore,

control and support the symptoms experienced by people with cancer and their families. She has attracted over \$3 million in research funding and \$5 million in development grants.

In addition Professor Aranda has co-lead a team awarded \$4 million by the Australian Government to develop a national cancer nursing education project to ensure competent and educationally prepared nurses are available to meet the needs of people with cancer and their families across the country.

Her contribution to key professional organisations and policy bodies has ensured the recognition of nurses' contributions to the improved care of people with cancer. Her excellence in

leadership was recognised in 2001 when she received the ONS award for International Contributions to Cancer Care.

Find out more about the 16th ICNN

Get a taste of what will be on offer at the 16th International Conference on Cancer Nursing (ICCN), the premier international educational opportunity for cancer nurses, to be held in Atlanta, Georgia, USA, from 7–11 March 2010. Go to http://www.isncc.org/conference/16th_ICCN/Preliminary_Program.asp to consult the preliminary programme.

The ICCN is a unique educational and networking opportunity that highlights the essential role that nurses play in the prevention, treatment and care for cancer patients worldwide. The ICCN brings

together leaders in cancer nursing from all over the world and is the longest running international conference in the field.

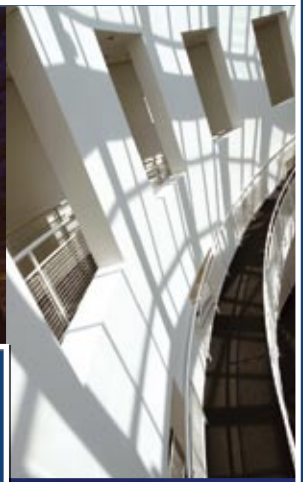
There is an exciting selection of educational pre-conference workshops which will take place on Sunday 7 March, 2010:

- *Models of cancer survivorship care and patient navigation, utilization of a care plan and engaging the primary care community: perspective from the Lance Armstrong Foundation*, hosted by the Lance Armstrong Foundation,
- *Evidence-based practice*, hosted by the International Society of Nurses

in Cancer Care (ISNCC) and the Oncology Nursing Society (ONS),

- *Advancing palliative care for cancer patients internationally*, hosted by the End-of-Life Nursing Education Consortium (ELNEC),
- *Writing for publication masterclass*, hosted by the European Journal of Oncology Nursing (EJON).

Early booking offers are still available. For information about the conference including registration and pre-conference workshops go to http://www.isncc.org/conference/16th_ICCN/



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For further information on the 16th ICCN please visit our website at www.isncc.org



The International Society for Nurses in Cancer Care sincerely thank Emory Healthcare, Atlanta, Georgia, USA, for their support of the 16th ICCN by being the sponsoring agency for the Georgia Nurses Association Continuing Nursing Education application. EMORY HEALTHCARE is an approved provider of continuing nursing education by the Georgia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. CNE credits pending.



Join up with Livestrong

During August 24th to 26th 2009 I, along with ISNCC Executive Director Sarah McCarthy, attended the Livestrong Global Cancer Summit in Dublin, Ireland.

Livestrong is the programme initiated by the Lance Armstrong Foundation aimed at generating a global movement with the goal of reducing the cancer burden.

The summit featured more than 300 world leaders, corporations, non-governmental organisations and advocates together in a common forum with the unique opportunity of committing to working together to change the course of cancer history.

Lance Armstrong, a cancer survivor and seven times winner of the Tour de France, is using his name to attract funds and commitment to this work.

The campaign features 3 key targets:

- to end the stigma of cancer and turn cancer victims into cancer survivors,
- to build an international grassroots movement that will take cancer from isolation to collaboration,
- to transform cancer from obscurity to priority.

One of the key lessons for Sarah and I was the relative silence of the nursing voice at the summit.

We were the only representatives of a nursing organisation and managed to find only one other nurse amongst the delegates, an educator from Texas involved in some local Livestrong activities.

Our goal is to challenge this silence and to continue to raise the nursing voice in the international arena.

You can help. First, you can sign the world cancer declaration on the UICC website as discussed in a previous newsletter (www.uicc.org).

Second you can visit the Livestrong website and consider how you might make a personal commitment to join this global movement (www.livestrongaction.org).

Make sure the nursing voice is heard as we make it known that the global cancer effort requires a strong nursing engagement to make a difference to people affected by cancer everywhere.

*Sanchia Aranda,
ISNCC president*

Chemotherapy course

A two-day chemotherapy and biotherapy course will be run by ONS as part of the preconference programme for the 16th ICNN in Atlanta.

This accredited course provides nurses with a comprehensive overview of chemotherapy and biotherapy and includes information on new drugs to keep nurses up to date with the latest developments. It is based on the *ONS Chemotherapy and Biotherapy Guidelines and Recommendations for Practice* (3rd edition). Recognised as the leading programme for nurses administering chemotherapy, it will take place on 6th to 7th March 2010. For more information and to register go to www.isncc.org.

Advertise in the ISNCC newsletter

International Cancer Nursing News is distributed to over 11,000 cancer nurses worldwide. Advertising in ICNN will allow you to market directly to your target demographic. For further information on this exciting opportunity, please contact the ISNCC Head Office at info@isncc.org or by phone on +1 604 630 5516.

EU Partnership launch

Over 300 cancer organisations, patients and cancer survivors, health professionals, researchers, health authorities and health ministers gathered to mark the official launch of the European Partnership for Action against Cancer in September 2009.

The Partnership aims to draw together relevant organisations to share expertise, to identify challenges in order to reduce the number of new cancer cases in the EU by 15% by 2020. Preparatory meetings for the Partnership are planned for later in the autumn.

Global inequality

An annual investment of \$217bn is needed to address the shortfall in global spending on cancer care and treatment, according to a report from the Economist Intelligence Unit.

The report, commissioned by the Lance Armstrong Foundation, estimates that of the predicted 12.9 million new cancer cases in 2009, almost two thirds (61%) will occur in low or middle income countries. However only 5% of the resources allocated to cancer globally are spent in the developing world.

Spotting cancer

One in seven people cannot name a single symptom of cancer, according to a UK survey. The poll of almost 4000 people found that 19% of men and 10% of women did not know any symptoms that could be a sign of cancer.

The lack of awareness was more marked for people from ethnic minority backgrounds. However 22% of women and 16% of men did identify weight loss as a possible sign of cancer, and one in five identified bowel or urinary problems in the Cancer Research UK survey.

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Strengthening hope and self-esteem in cancer patients

This presentation from the 15th ICNN details a programme to alleviate depression

Introduction

People who face a diagnosis of cancer will experience different levels of stress (Kubler-Ross, 1972). The uncertainty of different treatment choices causes anxiety and emotional strain to patients and their relatives (Frojd & Von Essen, 2006).

Cancer patients receiving treatment encounter anxiety, fear of death, feelings of weakness, depression, hopelessness, changes in social role, lifestyle, body image and self-esteem (Rosenberg, 1965). These can impede successful outcomes from a variety of treatment modalities.

Previous studies have acknowledged that one of the most crucial variables affecting self-motivation is positive thinking — positive thinking is related to hope and self-esteem (Herth, 1992; Miller & Powers, 1988). Hope is definitely correlated with social and family support, spiritual well-being, responsive action, health promotion behaviour and quality of life. Currently there is evidence supporting the efficacy of various training interventions which incorporate cognitive, affective and behavioural components (Fallowfield, 2003).

The instruments used in this programme has been shown to increase hope and self-esteem so that depression can be effectively reduced. The aim of the study was to report the effect of a hope and self-esteem strengthening programme compared to a control group.

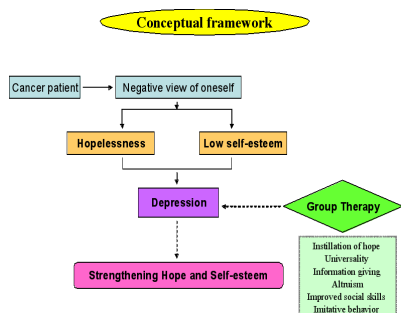


Figure 1

Method

The study sample was 22 cancer patients having radiation therapy at Ubon Ratchathani Cancer Center, Thailand during May to June 2007. All the were over 20 years old and had symptoms of depression. Patients were assigned to two groups, the experimental (13) and the control (9).

Permission to conduct this study was approved by the ethics committee at the

hospital. In addition, written informed consent was obtained from the patients.

The conceptual framework and strengthening programme are shown in Figure 1 and 2. The Cronbach's reliability of the instrument to measure hope, self esteem and depression using internal consistency alpha coefficient were 0.89, 0.91 and 0.86 respectively (Cronbach, 1951).

The control group received conventional nursing care whereas the experimental group received eight sessions of therapy plus conventional nursing care. The process in each group was recorded and analysed by observation. The data was statistically analysed using descriptive statistics, Wilcoxon Signed Ranks Test, and Mann-Whitney Test.

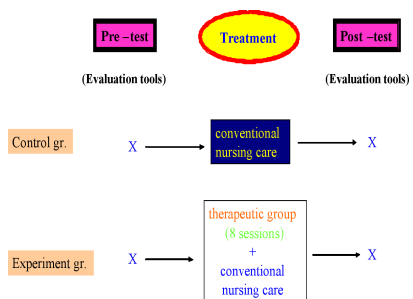


Figure 2

Results

The result revealed that there was significant increase in hope and self-esteem (p-value <0.01) and significant decrease in depression in the experimental group whereas there was no significant differences in the control group.

Moreover, self-esteem found in the experimental group was significantly higher than in the control group (p-value <0.05).

Discussion

Patients with cancer can live longer as a result of multi-modal interventions (Leydon, 2000; Yalom, 1995). The proficiency of care providers dealing with difficult issues has been shown to be improved through skill training (Fallowfield, 2003; Korstjens, 2008).

Improving physical condition and psychosocial function should be simultaneously provided through rehabilitation programmes. In accordance with the literatures (Frojd & Von Essen, 2006; Herth, 1992; Miller & Powers, 1988; Fallowfield, 2003; Korstjens, 2008) the current study

demonstrated that the strengthening programme can restore confidence and hope.

By sharing and caring for each other, the group intervention helped patients to integrate their experiences and knowledge so that they felt stronger, more assertive and with a more positive view on life. Family support should be incorporated into care because cancer affects the whole family, not just the patient. Nurses, as part of a multidisciplinary team, have been recognised as playing an active role throughout the intervention. Knowledge, skill and empathy are key success factors for those who provide care to cancer patients. The main limitation of the study was the small number of the participants.

Conclusion

In conclusion, the study presented a useful instrument to be used in groups of cancer patients receiving radiation therapy. The programme is an essential step for ongoing recovery process.

Chaliya Wamaloon, Deputy director of Nursing; Patchanee Thepa-apiruk, Oncology nurse; Sililak Ngeoywijit, Oncology nurse. All at Department of Nursing, Ubon Ratchathani Cancer Center, Ubon Ratchathani, Thailand. Jirungkoon Nattharungsri, Psychology nurse, Department of Nursing, Prasrimahabodi Hospital, Ubon Ratchathani, Thailand.

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Improving pain management by promoting knowledge transfer

Evaluation of a pain resource nurse programme shows improving clinical practice

Introduction

Nurses have a responsibility for assessing and managing patients' pain (Watt-Watson, 2003). Lack of nursing knowledge related to pain management may lead to inappropriate clinical decisions for patients (Brockopp, et al, 2004). Pain is a multi-dimensional experience involving both physiological and psychological factors (Watt-Watson et al, 2000).

There are many benefits to effective pain management including earlier patient mobilisation, decreased morbidity, shortened length of hospital stay, and reduced health care costs (RNAO, 2007). This article describes the processes used for implementing and evaluating a Pain Resource Nurse (PRN) programme on two oncology inpatient units in a large academic health science hospital.

Background

Several external and internal factors at our hospital provided the catalyst for improvement in pain management. These included:

- sub-optimal provincial patient satisfaction data related to pain management,
- 2004 hospital-wide nursing survey results using the Nurses' Knowledge and Attitudes Survey Regarding Pain (NKAS) by Ferrell and McCaffery (1997),
- Canadian Council on Health Services Accreditation (CCHSA) requirements,

- Canadian Pain Society standards (2006),
- our status as a Registered Nurses Association of Ontario (RNAO) Best Practice Spotlight Organization Candidate,
- the adoption of the RNAO Best Practice Guideline (BPG): Assessment and Management of Pain as a corporate standard.

Other components that were key enablers of change included our professional practice infrastructure (Model of Nursing Clinical Practice 2002) that supports the use of Clinical Nurse Experts on each unit to promote evidence informed practice; and the formation of a BPG Pain Work Group to facilitate the implementation and evaluation of the pain BPG.

Intervention

Dobbins and colleagues (2005) conducted a synthesis of the evidence-based literature regarding the effectiveness or ineffectiveness of knowledge transfer strategies. They found that a combination of strategies such as interactive face-to-face and involvement of stakeholders in the process improves uptake (Dobbins et al, 2005).

One successful approach identified is a Pain Resource Nurse (PRN) programme (Ferrell and McCaffery, 1997) developed at the City of Hope (CoH 2005) to address nurses' pain management educational gaps. Therefore, a PRN programme, incorporating multiple knowledge transfer strategies was

developed by our pain BPG-Workgroup.

The PRN programme was based on the CCHSA pain standards as well as recommendations from the RNAO BPG: Assessment and Management of Pain. It was conducted by the APN-Palliative Care and other clinical experts in pain management.

A logic model guided the programme design and evaluation (Porteous et al, 1997). Funds for staff replacement for the PRN workshop and programme resources were secured through our Centre for Patient Safety Grants Programme. Research ethics approval was also obtained prior to programme implementation.

Purpose

The purpose of our pilot PRN programme was to implement and evaluate:

- knowledge transfer of pain management assessment and intervention strategies,
- inter-professional collaboration,
- safe and effective pharmacological pain management interventions,
- the role of unit clinical pain experts,
- patient satisfaction.

Methods

The setting included two in-patient oncology units: (36 beds and 34 beds) with a total of 70 and 67 full and part time RNs respectively. The sample for the pilot PRN programme consisted of 6 nurses from each unit. Nurses were recruited by their clinical

Table 1: key components of best practices in pain management

Indicator	Pre (N=44)	6 months post (N=45)	12 months post (N=38)
Initial screen for pain completed	50%	64%	100%
Documented pain assessment (rating, descriptors, location & time)	36%	80%	100%
Orders for pain medication around the clock (ATC) on chart	41%	58%	69%
Orders for pain medication (PRN)	73%	71%	100%
Med documentation of ATC	94%	94%	96%
Med documentation of PRN	36%	71%	100%
Follow up assessment	Not assessed	Not assessed	69%
Bowel regimen ordered	32%	39%	90%
Bowel regime documented	0%	27%	73%
Patient education documented	5%	17%	65%
Consults to pain management experts	9%	20%	100%
Pain management plan documented	0%	1.5%	70%

practice and virtual cancer care

managers based on experience and interest in pain management and competency in critical thinking, problem-solving and inter-professional collaboration.

The nurses were seconded for two days. Programme content included pain pathophysiology, pain management principles, pain assessment strategies and tools, pharmacological and non-pharmacological interventions, neuraxial interventional techniques, equi-analgesic dosing and titrations.

Educational strategies included didactic presentations, interactive discussions, quizzes and case studies.

Workshop outcomes

The PRN workshop was evaluated highly by the nurses and was effective in increasing participants' knowledge about pain management as supported by the results of the Nurses' Knowledge and Attitude Survey Regarding Pain (NKAS).

Scores indicated an overall 11% increase in knowledge following the PRN workshop. Attendees enjoyed the practical applications and were impressed with the realistic case studies. They also valued group work and the open interactive approach to learning.

Programme outcomes

Chart audits conducted on each unit pre intervention and at 6 and 12 months post intervention indicated that key components of best practices in pain management

improved significantly over the study period. See Table 1 for details.

Patient satisfaction with pain management was chosen as an outcome measure of the PRN programme. NRC-Picker patient satisfaction data regarding pain management for these two oncology units was reviewed for the periods both pre and post the intervention and have shown a consistent increase since implementation of the PRN role.

Focus groups with PRNs identified issues arising from the implementation of the role. Specifically, conflicts arose with other nurses on the unit as they were not chosen to attend the workshop. PRNs identified that time constraints impacted their ability to function as a resource for others.

They also required time to understand the PRN role and feel confident in assessing pain, reviewing orders for pain management and making recommendations. They struggled in adopting the 'expert' role in pain management and often did not realise that they had achieved this expert level. They recognised improvement in pain management but acknowledged the need for ongoing support to effectively fulfil their roles.

Conclusion

As evidenced by our results, the PRN programme was an effective intervention to promote knowledge transfer and improve both clinical practice and patient satisfaction. The PRN role built upon our

Model of Clinical Nursing Practice, recognising clinical nurse experts as a key component in providing excellent patient care. Therefore the PRN role is likely to be sustained as it is embedded within this supportive structure.

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VIRTUAL CANCER CARE

The role of humour in aiding recovery and promoting hope

The very idea of cancer and humour being linked is to some an insensitive contradiction. However, those of us who work with cancer patients know only too well how useful the shared warmth, compassion and humanity that comes from humour can help a person deal with a potentially life-threatening treatment and prognosis.

There is an increasing body of evidence that the use of humour can aid recovery and foster and promote hope. There are also clear physiological benefits including promoting relaxation, pain relief and stimulating the immune system and circulation.

The internet has a number of useful resources in this area and this edition will guide you to a few of the best.

Cancergiggles

http://www.cancergiggles.blog-city.com/live_with_cancer_1.htm

This interesting site is essentially a collection of anecdotes and blogs from cancer patients put together by Cass Brown who also has a

book of the same name. The stories are easily accessible from a menu on the left of the screen and there are some real gems of wit, pathos and self-deprecating humour.

Support 4 Change

<http://www.support4change.com/health/living/humor/sense-humor.html>

This well written and sensitive article is well worth a read, not only for the sense of perspective it gives to the use of humour with cancer, but also the links to the useful resources within the article.

Youtube

<http://www.youtube.com/watch?v=j4lzD9oFN8Y>

This link to youtube will take you to the video diary of an American woman called Ali who has been diagnosed with breast cancer. Her offbeat, humorous and realistic attitude makes this compulsive and at times inspirational viewing. There are a series of short video clips to follow on

from this one which are all linked from this page. Both patients and professionals will get some benefit from viewing these.

American Cancer Society

http://www.cancer.org/docroot/ETO/content/ETO_5_3X_Humor_Therapy.asp

For those of you who wish to review the evidence base in support of humour in cancer care this article is a good start.

Worth a look

Troop C: prostate cancer humour

<http://www.yananow.net/troopc.htm#doc>

There are a wealth of stories, jokes, poems and sometimes pictures here all on one page to scroll down, or via the menu at the beginning. Very creative, sometimes funny, and always supportive *Robert Becker, Macmillan Senior Lecturer in Palliative Care, Staffordshire University Faculty of Health and Sciences and Severn Hospice, UK*

New initiatives in oncology APN research and education

Introduction

April 28, 2009 marked the launch of the Canadian Centre of Excellence in Oncology Advanced Practice Nursing (OAPN) at the Juravinski Cancer Program at Hamilton Health Sciences in Ontario, Canada. OAPN represents the first research unit in Canada dedicated to improving the use of nursing roles in cancer control.

The goal of the centre is to promote the accessible, cost-efficient, and sustainable delivery of cancer control services in Canada through the effective development and utilisation of innovative oncology advanced practice nursing (APN) roles.

The centre uses a three-pronged approach to achieve this goal including research, education and mentorship, and knowledge translation activities.

Role of oncology APNs

In Canada, oncology advanced practice nurses (APNs) are clinical experts involved in the specialised care of patients and families affected by cancer. Two APN roles are recognized in Canada: the clinical nurse specialist and nurse practitioner.

APNs are registered nurses with a master's degree who have increased autonomy and expertise in the care of specific populations (DiCenso et al, 2009).

Oncology APNs work to improve patient health through innovation in nursing practice and in the delivery of cancer services. They work in community, ambulatory and inpatient settings and provide nursing services across the cancer journey from cancer prevention, early detection and screening, treatment, recovery and palliative and end-of-life care (Cancer Care Ontario, 2009).

In addition to their clinical expertise, APNs require competencies in education, research, organisational leadership and professional development (Canadian Association of Nurses in Oncology, 2001).

Impact of APN roles

Research has shown that well designed APN roles in oncology and other specialties have a significant impact on patient and health system outcomes including:

- improved access, coordination and continuity of care,
- improved patient and health provider satisfaction,
- reduction of side effects and complications,
- improved health, functional capacity, quality of life and survival rates especially for high risk populations,
- lower acute care costs due to reduced lengths of hospital stay and re-admissions, improved patient

and health care provider uptake of evidence-based practices.

(DiCenso et al, 2009; Cancer Care Ontario, 2009; Canadian Association of Nurses in Oncology, 2001; Bredin et al, 1999; Brooten et al, 2002; Corner et al, 1996; Faithfull et al, 2001; Moore et al, 2002; Ritz et al, 2000; McCorkle R, et al 2000; Fulton and Baldwin, 2004).

Global perspective

From a global perspective, there is significant demand for APN roles due to:

- increased complexity of therapies and health care services,
- increased patient acuity,
- the need to contain health care costs;
- provider shortages,
- greater emphasis on evidence-based practice, quality, accountability and patient safety,
- the need for highly skilled and flexible roles that are responsive to changing patient and health systems needs.

(DiCenso et al, 2009; Bryant-Lukosius et al, 2004).

Bridging the gap

Cancer control refers to services and activities focused on preventing or curing cancer, reducing the suffering associated with cancer, and increasing survival and quality of life for those who develop cancer (Health Canada, 2004).

There is currently a significant need for innovation in Canadian cancer control. More effective models of care are required to improve access, equity and the quality of cancer services particularly for cancer prevention, screening and supportive and palliative care (Health Canada, 2004; Canadian Strategy for Cancer Control, 2002).

Improved human resource planning and new models of care to maximise the use of health provider roles, expertise and scopes of practice, including the expanded introduction of APNs are identified as important strategies to address the increasing demand for cancer services. The expansion of APN roles in cancer control will require further research to:

- 1 evaluate new APN clinical interventions,
- 2 determine the most effective models of APN care,
- 3 evaluate the impact of non-clinical APN activities,
- 4 to evaluate interventions for improving the recruitment, retention, and use of APN roles in cancer control.

(DiCenso et al, 2009; Bryant-Lukosius et al, 2004; 2007).

Ultimate goal

The ultimate goal of OAPN is to improve the health of Canadians at risk for, or affected by, cancer through the effective use of APN roles. Specific objectives of OAPN are to:

- 1 establish a national and international hub of APNs, clinicians, educators, researchers, managers and policy makers with expertise relevant to oncology APN,
- 2 increase capacity to conduct oncology APN related research,
- 3 conduct integrated streams of research in three priority areas:
 - therapeutics or clinical APN interventions,
 - new models of cancer control that include APN and/or other advanced health provider roles,
 - interventions to promote effective oncology APN role development, implementation and utilisation,
- 4 provide education and mentorship to promote the development, recruitment and retention of highly qualified APNs,
- 5 promote evidence-based oncology nursing practice through the development of practice guidelines and other knowledge transfer/uptake activities,
- 6 increase stakeholder (patients, health providers, administrators, policy makers, educators, and researchers) awareness and understanding of oncology APN roles and therapies through knowledge translation activities.

Advisory & scientific committees

A national advisory committee, composed of key provincial and national stakeholders with expertise in oncology, advanced practice nursing, human resource planning, management, research and programme evaluation, policy development and knowledge transfer provides strategic leadership, expert guidance, and recommendations necessary to ensure the achievement of planned goals and objectives of OAPN.

A scientific committee has been established to provide research expertise, guidance and leadership to ensure the conduct of high quality research that is relevant to oncology APN stakeholders both nationally and internationally. In addition to its director, Denise Bryant-Lukosius, OAPN is fortunate to have the following members

on its scientific committee:

- Sanchia Aranda, Director of Cancer Nursing Research, Peter MacCallum Cancer Centre, and Professor and Head, School of Nursing, University of Melbourne, Australia,
- Jessica Corner, Professor of Cancer and Palliative Care and Head of Health Sciences, University of Southampton, UK, Chief Clinician, MacMillan Cancer Relief Services,
- Greta Cummings, Associate Professor, Faculty of Nursing at the University of Alberta, Canada and principal investigator of the Connecting Leadership Education & Research (CLEAR) Outcomes Program,
- Debra Bakker, Professor, School of Nursing at Laurentian University, Sudbury, Canada.

The future of APN and OAPN

As clinical experts, leaders and change agents, APNs are recognised as an important within the strategy for improving access to high quality, cost-effective and sustainable models of cancer care.

Studies conducted in Ontario, Canada indicate that by 2012 this province alone will require a minimum of 150 new oncology APN positions to meet rising demands for cancer services.

The extent to which other national and international jurisdictions will have similar needs for oncology APNs has not yet been systematically examined. There are also substantial barriers to role implementation and the retention of oncology APN

roles due to poor job satisfaction (DiCenso et al, 2009; Bryant-Lukosius et al. 2007).

Studies have shown that most barriers to the effective APN role implementation could be avoided through improved planning and better understanding of the roles (DiCenso et al, 2009; Bryant-Lukosius et al, 2004; 2007). It is at this juncture where OAPN will make significant contributions.

While there is substantive international evidence about the benefits of APN roles, the full contribution of these roles for improving the health of Canadians through their effective development, deployment and integration within the health system has yet to be fully realised. Collaboration with national and international research is a key strength of OAPN. Through these partnerships, OAPN will build on international experiences and best practices for APN role implementation and create opportunities to conduct large scale and comprehensive studies in different jurisdictions.

Beyond the scope of oncology APNs, lessons learned from this programme will also inform the development of APNs and other advanced health care providers in various specialities.

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Future practice, education and research partnerships will be established to address national priorities for enhancing the contribution of APNs in cancer control.

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