A report on Palliative Care and Cancer Nurses’ Educational Needs

Prepared for the Ministry of Health

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Disclaimer
Unless otherwise indicated, views expressed in this report are personal to the authors and are not necessarily the views of the New Zealand Ministry of Health. The New Zealand Ministry of Health accepts no responsibility or liability in respect of the contents of this report.
Executive Summary

This report provides comprehensive information on the cancer and palliative care nursing workforce in New Zealand, with particular emphasis on education. National, regional and local data have been presented, which will serve as baselines against which future evaluations of the workforce can be made. The report arose from an initial stock take undertaken as part of the Implementation Programme for the New Zealand Cancer Control Strategy Action Plan 2005 – 2010. The specific remit was to determine the educational needs of nurses working in New Zealand with patients receiving either palliative or cancer care.

Many nurses, in many different settings, work with patients who have cancer or palliative care needs, and with their families and whanau. Some of these nurses work in specialist services, others encounter these patients in general clinical settings. Core knowledge and skills are needed for all nurses, which are supplemented by, for the advanced nurses, their possession of specialist skills and knowledge. This review of the cancer and palliative care nursing workforce and its education needs captures levels of practice (actual and perceived), activities undertaken (clinical, educational and research), academic levels, and education provision, as well as the key issues facing nurses across the country in relation to life-long learning. However, this is just a snapshot picture of the cancer and palliative care workforce, their existing skills and knowledge, and their educational needs and intentions at the current time. Limitations with the data collected include the low availability of data nationally, and a lower than expected response rate to the survey, and different response rates in different locations and services. The fact that further information collected during key informant consultations agreed with survey results did, however, ameliorate the low response rate to some extent.

Methodology

Four interrelated research approaches were utilised within an overall framework involving:

- A national stock take of available nursing workforce data on numbers, roles and education levels for those working with cancer and palliative care patients, and education availability.
- A case study of four DHBs that involved surveys of nurses and interviews with key informants regarding nurses and their educational needs working in cancer and palliative care services in DHB regions.
• A review of New Zealand and international literature on recommended benchmarks for numbers and skill mix in cancer and palliative care nursing.

• A gap analysis in which study findings were benchmarked against international practices and national key informants were consulted.

**Educational Preparation of Nurses**

• Nursing curricula preparing students for registration as nurses were described as integrated in nature, and very crowded. The programmes did not intend to, nor could be expected, to prepare nurses for specialty practice in pre-registration studies. In addition there is variation across the country on availability of clinical placements in cancer and palliative care.

• Coherent educational programmes at postgraduate certificate and diploma levels are offered by 2 universities in both cancer and palliative care, and by a polytechnic in palliative care. In addition a few institutions offer a course relevant to the specialties, many offer generic postgraduate programmes and courses relevant to advanced nursing in the specialties, and nurses can build on these using specialty courses, and continue on to Masters and Doctoral studies.

• Graduate study that is not articulated with postgraduate study is also offered, at the time of the study by a South Island polytechnic and by other organisations; such advanced education in the specialties is attractive particularly to older nurses wanting to upskill.

**National Stocktake of Cancer and Palliative Care Nursing Workforces**

• In the absence of accurate, current national data availability, multiple approaches and sources were used to provide a picture of the nursing workforces in cancer and in palliative care. The main sources were: the Nursing Council, Directors of Nursing, specialty organisations employing nurses and associations to which nurses in the specialties belonged.

• In spite of these efforts, the national nursing workforce data is partial, for reasons that include Nursing Council data describing only the palliative care and not cancer nursing workforce, not all DHBs supplied data, and that its accuracy, therefore, has to be questioned.
There are three main explanations for the latter: 1) because nurses are not classified according to specialisation; 2) because of differences in how nurses providing cancer and palliative care services were defined and counted; and 3) the state of flux affecting nursing services as services are developed and changed.

**District Health Board Case Studies-Surveys**

- Surveys were completed by 649 nurses working in four district health board regions, including the DHBs themselves and NGOs with contracts with the DHBs.
- Demographic profile indicated the nurses were older, predominantly European, and less than half worked full-time. The larger proportion had been educated as nurses in hospital based programmes. Many reported very long periods of service in the specialty area.
- A key finding was that less than 20% overall described themselves as ‘beginner’ nurses; a high 44% described themselves as ‘competent (i.e. experienced practitioner without specialist qualifications), nearly 30% as ‘proficient (i.e. experienced practitioner with specialist qualifications) and 7% as ‘advanced’ (highly competent) practitioners.
- Many nurses reported an overall low uptake of graduate and especially postgraduate education. Only 19% of all participants reported they held a postgraduate qualification; the remainder with post-registration qualifications had graduate qualifications. Many had prepared through informal education for the role including in-house sessions and short (not-for-credit) courses. An exception was those nurses who worked in palliative care who overall had a higher uptake of postgraduate education.
- About a quarter of participants said they were currently studying for a postgraduate qualification. A close examination of subjects revealed that while some study was in the specialty area, others were not, reflecting general clinical nursing subjects and non-clinical study such as in management.
- Paradoxically, in spite of nurses’ extensive experience and high ratings of their competence and proficiency, it was the specialised activities they felt less confident in performing, and were more confident in generic nursing activities.
- Between 50% and 64% of nurses indicated that they intended to engage in further study in cancer or palliative care nursing in the future, and a further third indicated they may do so.
• Barriers to such study were identified, and the main barriers affecting all nurses were release from clinical duties to participate in education, and nurses’ lack of time (noting the multiple responsibilities including family responsibilities of the largely female, mid-aged workforce). Lack of available, relevant courses was not a major barrier, and nor was funding now that CTA funding is administered by DHBs. However there were differences across the specific groups and regions: available courses, access and travel were greater barriers for nurses away from main population centres; cost was also greater when nurses had to travel; differential access to funding by DHB and NGO employees, and; differences in course availability in cancer and palliative care.

District Health Board Case Studies-Interviews

• Interviews with 40 senior nurses in the four DHBs. complemented and extended survey results. These interviews involved clinical nurse educators, clinical nurse specialists, nurse managers and leaders.

• Interviews indicated that service development and models of care have not kept pace with the treatment advances for the patient populations that have transformed cancer from an acute, often terminal, disease to a chronic condition. They felt that services need to shift from being episodic and biomedically based in character, and nursing workforce development to change accordingly.

• Increasingly treatment interventions are now being carried out by nurses as overall demand for services has grown. Nursing skill levels and nursing team skill mix need to be redesigned to reflect these developments. Advanced educational preparation to meet these identified needs is agreed, but there is less agreement on the levels and modes of delivery of advanced education.

• Cross-cultural communication and cultural health-related beliefs and practices were seen as subjects of nurses’ education to care for increasingly diverse patient populations. On the other hand, overseas-trained nurses, particularly from non-English speaking backgrounds, need further education to prepare them to meet the needs of Māori and Pacific patients.

• The importance of employer and organisational recognition and support for advanced nurse education, including clinical release and equitable access to available courses, was highlighted.
Consumer Perspectives

- A series of focus group interviews were held with consumers to complement nurses’ perspectives with those of individuals and communities they work with.
- Consumers emphasised the importance of nurses with the specialised skills working with them in partnership. A related theme was the importance of good communication skills, and also reflecting person-centred care was cultural skills.
- Consumers also reflected on the greater confidence they had in those nurses working in specialised services compared with the general services.
- Where consumers needed to interface with many services and personnel, nurses’ management and case management skills were valued.
- While much of what consumers valued in nurses reflected interpersonal and relational skills, technical skills including assessment and screening skills were also raised.

Consultation with Key Stakeholder Groups

The consultation process confirmed many of the results of the survey of nurses and interviews in four DHBs and expanded on issues identified.

- The demographic profile of the nursing workforces in cancer and palliative care services attracted comment, in particular the rising median age. A largely New Zealand European nursing workforce caring for an ethnically diverse population of patients and their families and whānau has significant implications for both nurse recruitment and for advanced education. The increasing representation of overseas trained nurses in the nursing workforce highlights the need to be educated on New Zealand and Māori culture, including the Treaty of Waitangi and cultural safety.
- There was a wide range of views on the topics, types of programmes and mode of delivery of educational courses. Overall it was agreed that a range of opportunities was needed, including postgraduate, graduate, continuing education and in-house, to meet the diversity of nurses’ circumstances and preferences. There was also agreement that flexible learning, including technology-assisted learning, needed to be further developed.
- The success of decentralizing CTA funding to DHBs to administer, in addressing many previous barriers to postgraduate education, was widely confirmed. Despite the funding of release time, finding nurses to fill in remains a barrier.
Many stakeholders confirmed the importance of general nurses, working in hospital, primary health and community settings where they are caring for patients with cancer and palliative care needs, also having the education needed to give them the skills and confidence needed to work with these patients. Increasingly, unregulated nurses such as health care assistants are also involved in patients’ care and have educational needs.

There is a need for the coherent development of career pathways for cancer and palliative care specialties, involving standards and competencies, the educational pathways to support specialty practice and the employment recognition of specialty practice.

Arising from this, collaboration among the professional, employer and educational stakeholders was identified as of key importance, along with open engagement and improved understanding of each others’ contributions and constraints.

Some, but not all, stakeholders believed nursing leadership in both cancer and palliative care had suffered due to an emphasis on clinical competence and needed further development.

There were different views on how to achieve improved nursing workforce data. Some were opposed to following the medically specialisation model as this could limit nursing workforce flexibility. Another perspective was that nursing practice categories, developed historically, had become incoherent over time and needed review. A suggestion is that Nursing Council workforce categories are reviewed and changed to articulate with the Australia-New Zealand Classification of Occupations, as used by Statistics New Zealand and the Department of Labour in their labour surveys.

Gap Analysis
Findings from the survey of nurses in the four DHBs, interviews with nurse leaders in those four DHBs and consultations with national key informants were then examined in the light of international benchmarks on nursing workforce development and educational preparation of nurses based on the literature review. Caution is needed as differences between New Zealand society and its health system with those of other countries, even those fairly similar, mean that other countries’ experiences and guidelines need to be adapted to New Zealand’s environment.
Recommendations Arising from the Report

Arising out of the study and its findings, the following recommendations have been prepared by the Ministry of Health in consultation with the project steering group.

1. Competency frameworks are produced for each specialty, defining levels of nursing knowledge and skill to create a professional development pathway.

2. Educational requirements are outlined to support professional development within these competency frameworks for each specialty.

3. Collaboration between nursing leaders and educationalists (from DHBs, NGOs and education providers) aligns education programmes, from undergraduate to specialty post graduate, to support the professional development pathway.

4. DHB senior nursing management work with the Ministry of Health to develop strategies to address ongoing constraints (in particular release time) to nurses participating in specialty education.

5. Specialty education programmes are oriented to respond to the range of different needs of those working in the two specialties.

6. Nurses working in general clinical settings (ie not specialised cancer and palliative care services) have access to appropriate specialty educational opportunities (resources, courses and/or elements of specialist education programmes).

7. Different cultural needs of clients are addressed through appropriate cultural safety education for nurses in these specialties.

8. Leadership within each specialty is promoted through support for networking, education and national and international collaboration.

9. A strategic approach to specialty workforce nursing development, based on skill mix requirements, is adopted by the DHBs, Ministry of Health and NGOs.

10. Specialty nursing workforce data is improved by the relevant agencies to enable better forecasting.
1. Introduction

This report arose from an initial stock take undertaken as part of the Implementation Programme for the New Zealand Cancer Control Strategy Action Plan 2005 – 2010. This identified several issues for nurses working with palliative care and cancer patients; in particular, skill mix and access to training and education. Its specific remit was to determine the educational needs of nurses working in New Zealand with patients receiving either palliative or cancer care.

1.1 Background

The Minister of Health articulated the Government’s vision for cancer and palliative care in New Zealand in “The New Zealand Cancer Control Strategy” (2003), the ‘Cancer Control Action Plan’ (2005) and “The New Zealand Palliative Care Strategy” (2001). Two aims of each of the above strategies are to improve timely access to cancer and palliative care services for all people of New Zealand who may require end of life care, and their family/whanau, and to reduce inequalities that exist among different population groups in these areas of care. Key components of the Strategies are to raise awareness of cancer and palliative care services, to improve quality of life for those with cancer, and other chronic conditions who would benefit from palliative care, and to improve the coordination and delivery of essential local and specialist palliative care services across the country. Community involvement in the planning and management of such services, coordination across services, the development of a well-prepared multi-disciplinary work force, and greater awareness of the needs of people who are close to the end of their life are considered to be vital for the success of these Strategies.

Improving outcomes for cancer and palliative care patients requires appropriately educated nursing workforces in all settings where care is provided, from patients’ homes and private nursing facilities, to hospices and cancer centres. For strategic planning purposes, accurate information about that workforce is needed. Acute services for people with cancer are provided by public hospitals throughout New Zealand. Currently in New Zealand, tertiary cancer treatment services including therapeutic radiology, chemotherapy and haematology are located in six centres, with outpatient follow-up services delivered regionally. Palliative care is provided by generalist and specialist teams that work together to address physical, psychological, spiritual and cultural needs in all types of care settings (e.g. home, rest-home, hospice, inpatient unit). Generalist care is often provided as part of standard clinical practice by GP
teams, Maori health providers, district nurses and residential care staff, general ward teams, allied health teams and disease specific teams. Specialist care is that provided by expert teams of interdisciplinary health professionals who have undertaken advanced education in this field of care. This builds on generalist care provision to assist with complex symptom management as well as psychosocial, grief and bereavement support.

To date, the actual numbers of nurses working in such settings are unknown. Therefore, in order for effective actions to be put in place to address any shortfalls in current education and training programmes for nurses in these specialties, documented evidence of the current palliative care and cancer nursing workforces is required. This report has been commissioned by the New Zealand Ministry of Health to capture further evidence that will help define this need, and which can then be used to influence or shape future plans associated with the Cancer Control and Palliative Care Strategies.

There is a clear relationship between cancer and palliative care, in that historically palliative care developed to support those suffering from cancer who reached the stage where not further treatment would be effective and therefore they were preparing for the end of their life. However, today a clear distinction can also be made between the two types of nursing. Cancer nursing tends to be seen as a specialist area of practice, where care is provided for a specific population all of whom have a diagnosis of cancer. Palliative care, on the other hand, is required by a much broader population, all of whom have reached the latter stages of their life but who have varying clinical diagnoses, one of which may be cancer. The greater proportion of patients requiring palliative care have non-cancer diagnoses, which include heart failure, end stage respiratory disease such as chronic pulmonary disease, neurological disorders such as multiple sclerosis and many other chronic, life-threatening conditions. Palliative care nursing, therefore, is delivered by many nurses working in general, rather than specialist services, to assist patients with non-cancer conditions.

1.2 Terms used
Terms used in this report reflect those used in policy and other documents as cited below. (See also 8.2.2 for further discussion on use of terms.) Given the absence of a New Zealand definition for cancer care, for the purpose of this report, cancer care is defined as:
“The provision of the necessary services, as determined by those living with or affected by cancer, to meet their physical, social, emotional, nutritional, informational, sexual, spiritual and practical needs throughout the spectrum of the cancer experience” (Canadian Strategy for Cancer Control, 2002).

_Palliative care_ is defined as:

“The care of people of all ages with a life-limiting illness which aims to: optimise an individual’s quality of life until death by addressing the person’s physical, psychosocial, spiritual and cultural needs; support the individual’s family, whanau and other caregivers where needed, through the illness and after death (Palliative Care Subcommittee, NZ Cancer Treatment Working Party, 2007).

_Generalist nurses_ are, for the purposes of this report, those nurses who work in general clinical areas where patients with cancer and palliative care needs are treated, but are not part of a specialist team. They provide “palliative (or cancer) care for those patients affected by life-limiting illness (or cancer) as an integral part of standard clinical practice.” (Palliative Care Sub Committee 2007). Such care is provided in a variety of clinical settings, such as general medical or surgical wards, rest homes, and in primary care and community settings. The Nursing Council (2001) regards all nurses – including those referred to as “generalist nurses” in this report - as practising in specialty areas, and they are expected to maintain competence through in-house and graduate education.

_Specialist nurses_ are those who have “undergone specific training and/or accreditation in palliative care (or cancer)” (Palliative Care Sub Committee 2007) and who work within an expert interdisciplinary team of specialist health professionals. Specialist nursing practice builds on the practice delivered by generalist nurses and reflects a higher level of expertise, skill and experience; the term ‘advanced nursing practice’ includes the specialist nurses who have advanced skills and knowledge and is associated with higher degree education, usually at a minimum of Master’s level (see Nursing Council, 2001).

### 1.3 The Report

This report includes details of the nursing workforce in New Zealand, working with either palliative care or cancer patients, and their educational needs. The following data are reported:
• Available New Zealand and international literature on recommended benchmarks for numbers and skill mix in cancer and palliative care nursing

• Available national-level data (from DHBs, NGO providers, and professional and registering bodies) on numbers, roles and education levels for those working with cancer and palliative care patients

• Detailed data from four DHB areas about nurses providing cancer and palliative care.

The data collected as part of the DHB cases are comprehensive in nature and include: education levels; modes of working (full or part-time); age, gender ethnicity; length of service; current level of practice; education/training for current roles; formal and informal training/education they have received for their current nursing role (from undergraduate, orientation in the area, speciality skills, speciality training, including ongoing education requirements); attitude and intentions regarding undertaking further education; and perceived limitations to access to training/education for role requirements or for career in speciality (e.g. lack of availability of courses, lack of funding to meet costs, distance to travel to courses, inability to get work release).

Further feedback is provided from interviews with selected key stakeholders including national and DHB nursing leadership and management personnel, the Ministry of Health, other provider organisations, and personnel in educational institutions, about their views of nursing numbers, roles, education levels and access to specialty education.

A gap analysis using international workforce benchmarks captured differences in the structure of the New Zealand nursing workforces, limitations on training/education of the nursing workforces, and possible ways to resolve the identified shortfalls.

Recommendations have been made, based on the findings of this study, in relation to the future educational needs of specialist nurses working in these two areas of practice, and those of generalist nurses working with palliative care and cancer clients.
1.4 Overview of Methodology

Each of the following strategies have been considered within the study: The New Zealand Cancer Control Strategy (2003) and associated New Zealand Cancer Control Strategy Action Plan 2005-2010; and The New Zealand Palliative Care Strategy (2001).

Four interrelated research approaches were utilised within an overall framework, which is shown in Figure 1.1.

![Figure 1.1 Overall framework](image)

1.4 Research Process

The nationally available data were searched to generate information on the number and demographics of nurses within New Zealand who are currently providing palliative and/or cancer care. At the same time, a review of international best practices in relation to palliative care and cancer nursing was conducted. Searches of the following databases were conducted:
PsychInfo, Web of Science, Medline, and CINAHL; articles were also accessed through on-line searches using internet search engine ‘Google’ (www.google.co.nz) and manually on the Ministry of Health (www.moh.govt.nz), District Health Board New Zealand (www.dhbnz.org.nz), Te Puna and World Health Organisation web pages.

In addition, personal contacts were maximised to identify grey literature such as conference presentations and other unpublished or draft material relevant to the project.

Information related to leading educational programmes in cancer and palliative care nursing was sought and reviewed, as were details of various international nursing associations’ web-based career pathways for specialist nurses in cancer or palliative care.

In order to generate more detailed information on the number and demographics of nurses within four of New Zealand’s DHBs that are providing palliative and/or cancer care, a survey was undertaken. The associated data were descriptively analysed and comparisons made against international benchmarks, such as those from the workforce survey in England dated 2007. Telephone and face to face interviews with key nurses and other stakeholders in each of the DHBs were also carried out to complement the data gained from the postal survey.

The DHBs that took part in the survey were selected for the following reasons:

Auckland: This DHB is the largest district health board in the country with annual revenue of approximately $1.3 billion, arising in part from the national and regional services that it provides for some specialties. It serves 10% of the total population of New Zealand (approximately 445,000 people) making it the fourth largest DHB in the country in terms of population size. Its boundaries are captured in figure 1.2. Its population is predominantly European (67%) although almost 19% are Asian and almost 14% Pacific in ethnicity. Maori people represent approximately 5% of the Auckland city’s population.

Auckland City Hospital is a large tertiary hospital with over 900 beds including Women’s Health. The Northern Regional Blood and Cancer Service is based at Auckland City Hospital and provide care for people with cancer living in the Northland, Waitemata, Auckland and Counties Manukau districts health board areas. Treatments such as radiotherapy, chemotherapy and haematology treatments are provided. A number of outpatient clinics are provided by visiting cancer specialists in Northland, Waitemata and Counties Manukau District Health Boards areas. Outpatient services for Auckland district residents are provided at the Green Lane Clinical Centre. Community nursing care for patients with cancer is provided by District
Nursing Teams in partnership with General Practitioners. In addition this care is supplemented by a specialist oncology district nursing team who support general district nurses in caring for those with cancer and become directly involved with those requiring more complex care.

Specialist Palliative Care at Auckland City Hospital is provided by a hospital based palliative care team. In view of the regional approach to Cancer Services, many non ADHB people are admitted to Auckland City Hospital. As a result hospital services such as the hospital palliative care team, who have a significant role in the care of patients with cancer, provide consultation and specialist advice for not only ADHB patients but also for those from neighbouring DHB’s accessing the regional cancer services.

For people residing in the Auckland district health board area, community specialist palliative care is provided by the Mercy Hospice Auckland team. This service has a 13 bed inpatient unit which accommodates short admissions for respite care, symptom control and end of life care. In addition they offer a day stay programme, family support service and a volunteer programme. The hospice community nursing team care for up to approximately 200 patients and families at any one time and work closely with General Practitioners and District Nursing Teams.

Starship Children’s Hospital (200 beds) provides a regional paediatric oncology service covering the same regional area as described previously. The specialist paediatric palliative care team provides direct care in collaboration with community nursing services for children within the district in addition to national advice and leadership.

Figure 1.2 ADHB boundaries
Counties Manukau: This DHB provides health services for 450,000 residents of Manukau City, Franklin and Papakura districts. It is located in the south of the Auckland region, with Auckland DHB to the north, and Waikato DHB to the south. This region has wide ethnic diversity with high numbers of Maori and Pacific peoples; 17% and 28% of the Counties Manukau population. Asian people account for a further 16% of the DHB’s population.

Counties Manukau has seen rapid population growth in the last five years and a further expansion is predicted, with the estimated population growth of 2-3% per year. The community is relatively youthful, in that approximately 25% are aged 15 or under and 13% of New Zealand children live in the Counties Manukau DHB catchment area. However, the older population is also increasing here and numbers are expected to rise significantly. A further issue for this region is deprivation since a high proportion (37%) of the Counties Manukau population live in areas that are very deprived. Each of these factors place demands on health services, including palliative care. Counties Manukau has a high rate of illness related to overcrowded housing and Maori and Pacific residents living here have relatively higher rates of hospitalisation than the NZ average; Asian and Europeans have a lower rate than the NZ average.

Middlemore Hospital is the secondary level provider of health care services for the Counties Manukau District and has over 700 inpatient beds. Residents of Counties Manukau area requiring cancer care are referred to the Northern Regional Blood and Cancer Service at Auckland City Hospital. Specialist oncology and haematology outpatient clinics are provided at the Manukau Super Clinic and Botany Downs. In addition to Middlemore Hospital, there are two small rural hospitals in the Franklin area. Pukekohe Hospital has 30 beds, 26 long stay (primarily aged care) and 4 beds used for rehabilitation, palliative care and respite. Franklin Memorial Hospital in Waiuku has 18 beds, 12 beds for long stay admissions (primarily aged care) and 6 beds used for rehabilitation and palliative care.

The Middlemore Hospital Palliative Care Team provides specialist consultation and advice for patients with complex palliative care needs. In addition they provide outpatient palliative care clinics in Pukekohe for those living in the Franklin area.

Community specialist palliative care is provided by Hospice South Auckland. However this service does not provide care for people living in the Franklin District. They have an 11 bed
inpatient unit which is used for respite, symptom control and end of life care. The community hospice nursing service provides care in people’s homes in partnership with the District Nursing Team and General Practitioners. Hospice South Auckland offers an extensive specialist service which includes day stay, bereavement support and a volunteer programme. Palliative Care medical specialist consultation is also available.

Franklin Hospice provides palliative care to residents of the Franklin district which number almost 60,000. They do not have an inpatient unit or palliative care medical specialists. They provide a community nursing service with two visiting nurses who work in partnership with the District Nursing Team and General Practitioners. Franklin Hospice provides an extensive volunteer service which enables them to provide assistance to patients with bereavement, transport, home visiting, day stay sessions and a biography service.

Figure 1.3 Counties Manukau DHB boundaries

**West Coast:** This rural DHB serves the population of the West Coast of the South Island, approximately 30,000 people who live along a 600km strip of land bounded by the Tasman Sea and the Southern Alps which are in places barely 20km apart – figure 1.4. Many of the
population are engaged in primary industries such as mining, timber production and farming. There is less ethnic diversity in this region than in the other DHBs identified with approximately 9% of the population identifying as Maori and 1% as Pacific.

People living in the West Coast district travel to the Regional Cancer Centre at Christchurch Hospital where they may receive treatment such as radiotherapy and chemotherapy. If hospital care is required during this time they will be admitted to Christchurch Hospital. The hospital palliative care team may be involved in the care of patients from the West Coast district while an inpatient at Christchurch Hospital providing specialist advice and consultation. In partnership with the District Nursing Service community care for people with cancer is provided by a community oncology nurse specialist.

Specialist community palliative care on the West Coast is provided by a clinical nurse specialist. Remote support and advice is provided by specialists in oncology and palliative care via the Regional Cancer Service or Hospital Palliative Care Team at Christchurch Hospital or Nurse Maude Hospice in Christchurch. There are no hospice inpatient beds available on the West Coast however Reefton, Greymouth and Westport Hospitals have one bed each for patients with palliative care needs requiring inpatient care. There are no medical specialists in palliative care on the West Coast however medical and nursing advice is provided by the specialist teams in Christchurch by telephone.
Bay of Plenty: A provincial DHB which also has a large geographic spread, Bay of Plenty serves approximately 200,000 people living in the Bay of Plenty district, on the east coast of New Zealand’s North Island, taking in the major population centres of Tauranga, Katikati, Te Puke, Whakatane, Kawerau and Opotoki – figure 1.5. It currently has the second fastest population growth rate of all New Zealand’s district health boards. This population includes a high proportion of Maori, who make up 15% of the region’s population. A much smaller proportion identify as Pacific people, at 2.8%.

Tauranga Hospital (346 beds) and Whakatane Hospital (119 beds) are the providers of acute medical and surgical services for the residents of the Bay of Plenty region. The Regional Cancer Centre based at Waikato Hospital provides the Bay of Plenty population with oncology and haematology services including treatments such as chemotherapy and radiotherapy. Visiting oncology and haematology specialists provide outpatient clinics at Tauranga Hospital. Support in the community for people with cancer is provided by the District Nursing teams. If people with cancer require hospital inpatient care during their treatment this is provided at Waikato Hospital and as a result the hospital palliative care team will provide input during the admission to people from the Bay of Plenty district. At the time of discharge the community palliative care is handed over to one of the two hospice services in the Bay of Plenty district.

Waipuna Hospice provide specialist palliative care to people living in the Western Bay of Plenty area. The community hospice nursing service provides care for people from Waihi Beach to Paengoroa allowing patients to remain in their own home when appropriate. In addition Waipuna Hospice provides inpatient care, in their six bedded inpatient unit. These beds are used for short term admission for pain and symptom control, respite care and end of life care. A medical palliative care specialist is a member of the multidisciplinary team and is available for consultation on referral by General Practitioners.

Hospice Eastern Bay of Plenty, based in Whakatane, provides community based palliative care services throughout the Whakatane, Opotiki and Kawerau districts. This service provides community based palliative care nursing in people’s homes. It does not have an inpatient unit or medical specialist support. The service works in partnership with the General Practitioners and District Nursing Services in the area to provide community based palliative care.
The involvement of these DHBs provided a good regional spread, captured the diversity of population needs around the country, and ensured that both North and South Islands are involved.

The workforce in each of the DHBs was described and a typology constructed of nurses’ demographic characteristics, current working roles, actual levels of education for these roles, attitudes and intentions for further education, and perceived ability to access this education.

A gap analysis of New Zealand cancer and palliative care nurses’ educational needs was also undertaken using the information collected for this report. In addition, consultation was undertaken with national and other key stakeholders, with significant funding and provider responsibilities, who commented on the needs of the cancer and palliative care nursing workforce. Consumer feedback was also obtained.

1.6 Ethics Approval

Ethics committee approval was sought, and given, from the Multi-Region National Health and Disability Ethics Committee (see Appendix 1). Ethical principles of informed consent to participation in surveys and interviews, confidentiality, the right to withdraw, and feedback to participants were observed throughout the study. The data collected will be stored securely and access restricted to the named researchers only for a period of 10 years.
2. International Literature Review

This literature review considers cancer and palliative care nursing skills and educational requirements, career pathways for nurses in the speciality areas of cancer and palliative care and any recommended benchmarks for numbers and skill mix in cancer and palliative care nursing. The review draws largely on international work; European literature predominates, of which the United Kingdom (UK) provides the largest contribution.

The impact of the support that nurses and other health professionals provide for patients and their families before, during or after a diagnosis of cancer, or when palliative care services are required, is emphasised in the available literature as being significant. Consequently, attitudes, knowledge, skill, behaviour, and capabilities all need to be optimised to ensure that care is provided within a sensitive, holistic approach (NHS ES, 2006). Nursing roles are diverse, ranging from specialist care to that of generalist provision and it is clear from the review that nurses must have confidence in their knowledge and skills since this facilitates the development of services that truly meet the clients’ needs across all settings.

2.1 Summary of Cancer Education, Pathways and Competencies

Nurses play a vital role in meeting the needs of those who suffer from cancer, their families and their carers and a sound knowledge base has been recognised as being essential to the provision of quality cancer care. The development of cancer nursing as a specialty area appears to be closely linked to changes to government health policies, as evidenced in the countries that make up the UK. In these, widespread changes have been occurring in Politics and the National Health Service, with the Labour government’s agenda being to ‘modernise’ the health service. These have led to the introduction of the National Cancer Plan (2000), which then was the impetus for many of the subsequent developments in cancer care within the UK. Unfortunately, this association with government changes in the UK complicates comparisons with other European countries, as evidenced by the European Oncology Nursing Society survey (EONS 2004) that reviewed cancer nursing across 22 countries in 2001 to identify key indicators of status and characteristics of nursing working conditions, education and nursing development issues.
Clearly, there are differences in the types of advanced and specialist cancer nursing roles internationally, with work ongoing in a number of countries in an attempt to develop workforce capacity models to determine workforce numbers and roles. The relevant cancer nursing literature is summarised in Table 2.1 and a detailed overview from each of the countries is contained in Appendix 3.

Table 2.1 Summary of cancer nursing literature – education, pathways and competencies

<table>
<thead>
<tr>
<th>Country</th>
<th>Key points</th>
<th>Paediatric and adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Europe</td>
<td>• European Oncology Nursing Society identifies competencies for practice, linked to education.</td>
<td>• Adult focused</td>
</tr>
</tbody>
</table>
| UK      | • Based on RCN Framework for adult cancer nursing  
• Pathways developed – linked to education level  
• Pre-registration inclusion of cancer-related content in curriculum being considered by NMC | • Sub speciality of children’s nursing  
• On-line PG cert in cancer care for teenagers and Young adults  
• Similar developments in advanced nursing roles in paediatric oncology as adults |
| Canada  | • Based on Canadian Association of Nurses in Oncology standards of care  
• Canadian Oncology Nursing Certification is competency based all of which must be met.  
• Aims to introduce cancer education into undergrad curriculum  
• Currently some registration exam competencies pertinent to oncology nursing | |
| USA     | • Oncology Nursing Society standards for nursing education  
• Two levels of practice – generalist and advanced  
• 5 oncology nursing credentials from basic to specialist  
• Linked to education level | |
| Australian | • No specific competency standards for cancer nursing  
• Ongoing work EdCaN – 3 year project to develop these  
• Draft competencies currently published on web for RNs, advanced RNs and specialist breast nurses  
• Cancer Nurses Society of Australia have developed standards for practice | • Joint venture with UK and NZ: on-line PG cert in cancer care for teenagers and Young adults |

The changing demographic profile of the western world’s population means that there will be increasing numbers of older people surviving cancer related illnesses and this has implications for the types of nursing roles developed. Within the UK, the health care support worker role is regarded as a legitimate role within the cancer nursing team but little research has been undertaken exploring the educational needs of this workforce, or the impact that they have on
cancer nursing services. This role is not evident in non-UK literature however this is an area for attention in New Zealand given the potential for increase in the employment of similar types of health support workers. Health Care Assistants and Nurse Assistants are evident in the New Zealand workforce, although the numbers working in cancer services are currently unclear and need to be clarified to determine the extent of any educational development and support.

Within the literature there is a consistent view that having levels of practice, or roles, that are linked to competencies is a useful framework to support the educational development of nursing roles in cancer care. An example of such a framework is included in Table 2.2. Formal university based programmes of study are being delivered in flexible ways and there is some evidence to support the growth of interdisciplinary learning. There is also recognition of the need for lifelong learning principles to be embraced by organisations and by the workforce, as well as acknowledging the value of short courses e.g. chemotherapy administration. However, national standards are needed to ensure a level of consistency across educational providers.

### Table 2.2 Nursing roles in Cancer Care (modified from the RCN 2003 p21)

<table>
<thead>
<tr>
<th>Generic and Specialist areas</th>
<th>Specialist nursing</th>
<th>Senior Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General services with cancer patients; needs supervision and learning from experienced cancer nurses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cancer-related care area, provided by generic nurses supported by specialists in cancer nursing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- These nurses should have proven development in experiential and academic learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist cancer nurses with higher and advanced specialist practice skills; developing autonomy in expert specialist practice.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- These nurses have substantial specialist learning at a minimum level of (cancer) Diploma or Bachelor Degree.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Senior cancer nurses with at least 2 years clinical experience.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Able to plan care needs for clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cancer-related Bachelor or taught Masters degree.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The Nurse Consultant role builds on experience, education and skills gained from a number of years of senior practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- A tripartite role of clinician (50%), management and education.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Academic level</th>
<th>Diploma/Degree</th>
<th>Pg Dip-MA/MSc</th>
<th>MA/MSc-MPhil/PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diploma/Degree</strong></td>
<td>Diploma/Degree</td>
<td>Pg Dip-MA/MSc</td>
<td>MA/MSc-MPhil/PhD</td>
</tr>
</tbody>
</table>

Cancer and Palliative Care Nurses’ Education Needs Report Final April 2008
There is widespread support for cancer care being seen as an essential component of the undergraduate pre-registration curriculum with the identified need to prepare nurses for cancer care during pre-registration programmes being a consistent theme internationally. In 2003, the Royal College of Nursing in the UK put forward suggestions for core content for such programmes, which included prevention and screening of cancer through to treatments, rehabilitation and palliative care (see Table 2.3). It is unclear to what extent Schools of Nursing in the UK have addressed these recommendations, although the RCN do comment that a few changes have already been made. The UK’s registering body for Nursing, the Nursing and Midwifery Council, is also considering making these subjects compulsory within the pre-registration curriculum, although no other countries appear to be directing the pre-registration curriculum content in this way.

Table 2.3 The pre-registration cancer-related nursing curriculum (RCN 2003 pp 25)

<table>
<thead>
<tr>
<th>Generic</th>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Initial awareness in common foundation programmes building to more targeted knowledge in branch pathways.</td>
<td>Primary focus</td>
</tr>
<tr>
<td></td>
<td>Health promotion; primary prevention initiatives; screening; self-examination techniques; skills and abilities to improve personal poor self-health; cancer awareness in primary care, school nursing, community health, genetic counselling.</td>
</tr>
<tr>
<td>- Cancers related to demographics: age, gender, sexual health, ethnicity, poor socio-economic indicators etc.</td>
<td>Secondary focus</td>
</tr>
<tr>
<td></td>
<td>Primary and acute care settings: e.g. investigations for cancer; the patient's complete experience of cancer care service and support.</td>
</tr>
<tr>
<td>- Mental health implications of: bad news, chronic illness, the worried well, coping with serious life changes.</td>
<td>Tertiary focus</td>
</tr>
<tr>
<td></td>
<td>Managing difficult therapies; coping with chronic illness; body image changes; sexual and reproductive health problems; disability; rehabilitation; communication and counselling in loss and bereavement; supporting colleagues.</td>
</tr>
<tr>
<td>- Counselling and communication skills: breaking bad news, listening and supporting people; reflective practice, mentorship support, psychological boundaries; multi-professional collaboration etc.</td>
<td></td>
</tr>
</tbody>
</table>

Much of the literature takes an adult focus and concern has been identified with regard to the educational needs of nurses working in the areas of paediatric and adolescent oncology. These are accepted sub-specialities of children’s nursing and smaller numbers of participants and issues of local access can impact on the viability of educational courses (Langton 2007). Advanced nursing roles within paediatric oncology have tended to develop along similar pathways to that of adults, with a tumour specific focus. Other issues, such as the push to
reduce length of stay in hospitals and the move to more outpatient/day care facilities, have also meant the need for more specialist education for nurses working in these areas. For both adult and children’s nursing, there is significant potential for development in the Nurse Practitioner and nurse specialist roles involving advanced assessment, decision-making and prescribing, and more emphasis on community roles and outreach (Fallon and Sanderson 2007).

### 2.2 Summary of Palliative Care Education, Pathways and Competencies

The literature review revealed that some aspects of palliative care education are more advanced than that of cancer nursing, while for others it is less so. Full details of the literature reviewed are appended in Appendix 4, but a summary of the key issues is presented in Table 2.4.

#### 2.2.1 Workforce Projections

Various documents have been developed to guide workforce development in this aspect of nursing. In relation to service provision, the UK’s National Institute for Clinical Effectiveness (NICE) reported in 2004 that there should be sufficient specialist palliative care staff to provide 24-hour care, 7 days per week. However, there is little or no detail on numbers of staff needed per head of population served, or on the mix of staff within the teams. NICE singles out specialist palliative care teams, which it says should consist of palliative medical consultants, and palliative care nurse specialists, but again specific guidance or benchmarks are provided beyond the following statement about the minimum level of service:

“The team should be staffed to a level sufficient to undertake face-to-face assessments of all people with cancer at home or in hospital, 0900-1700, seven days a week. In addition, there should be access to telephone advice at all times (24 hours, seven days a week). Provision for bed-side consultations in exceptional cases outside the hours of 0900-1700, seven days a week is also desirable” (NICE 2004 pp 129).

In 2005, Tebbit completed a population-based palliative care needs assessments for the three Cancer Networks in Wales, which he contended would provide useful contextual data to guide national palliative care policy and service development in the short-term. Through reference to the mortality data and benchmarking these with England, the needs for palliative care resources were able to be estimated. An exercise of this nature, if carried out in New Zealand,
would assist future resource planning but identifying the appropriate benchmark could be problematic. Since there are clear differences in care provision, using England as the comparator, in the same way that Tebbit did, may lead to unrealistic expectations being created.

Table 2.4 Summary of palliative care nursing literature – education, pathways and competencies

<table>
<thead>
<tr>
<th>Country</th>
<th>Key points</th>
<th>Paediatric and adolescent specific issues</th>
</tr>
</thead>
</table>
| Europe  | • European Association for Palliative Care produced guidance for palliative education – 4 levels  
• Linked to academic levels  
• Aim to be interdisciplinary  
• Makes recommendations for undergraduate pre-registration curricula | • Includes paediatrics |
| UK      | • Specialist roles in palliative care well developed  
• NICE guidance used to develop teams  
• Education developed aimed at upskilling primary care teams  
• NICE guidance identified core skills and knowledge  
• Additional requirements for best practices e.g. Gold Standards Framework  
• RCN identifies competencies in 7 domains for specialist palliative care nursing | • Sub speciality of children’s nursing  
• On-line PG cert in cancer care for teenagers and Young adults includes some palliative care topics  
• Reflective model proposed |
| Canada  | • Canadian Hospice Palliative Care Nursing Certification developed competencies for palliative care nurses – linked to education.  
• Canadian Registered Nurse Exam assesses competencies, some of which are pertinent to palliative care | |
| USA     | • End of Life Nursing Education Consortium developed specialist nurse educator competencies for end of life care  
• Extended to new graduates  
• 5 oncology nursing credentials from basic to specialist  
• Linked to education level | • Initiative for Paediatric Palliative Care developed web-based educational material specific to children’s palliative care needs.  
• 5 specialist modules developed |
| Australia | • Federal and State initiatives evident  
• Workforce planning taking place – provides projected workforce requirements  
• Roles delineated by Palliative Care Australia  
• Palliative Care Curriculum for Undergraduates introduced in 2003.  
• Competencies for Palliative Care Nursing now published (2007)  
• National competencies for ANMC registration do not include ones specific to palliative care  
• Residential Aged care Palliative Approach Network developed guidelines for this sector. | • National Palliative Care Strategy (2000) identified specific needs for children and adolescents  
• Paediatric Palliative Care Service Model Review (2004) identified need for greater education and training and new model of care  
• National Paediatric Palliative Care reference group formed  
• Flinders Graduate Certificate in Paediatric Palliative Care |
| Israel  | • All general nursing courses including undergraduate, deliver one unit or module on palliative care | • Nothing specific to paediatrics stated |
The need to estimate future palliative care workforce projections led the Victorian State Government in Australia to undertake the Palliative Care Workforce Supply and Demand Study (Victorian Government 2006). The study found that 45% of the palliative care workforce was community based and the remaining 55% located in in-patient settings. Workforce capacity measures were developed to estimate the number of nurses needed for each of these settings based on the level of input that palliative care nurses have in relation to care delivery. Based on these calculations the projected workforce requirements were determined for 2006-2011. Although the clarity of divisions between urban and rural areas, and in-patient and community are less pronounced in New Zealand than appears to be the case in Victoria, modelling using these workforce measure might be of value, with Victoria used as the comparator or benchmark, although it would be easier for DHBs to use the modelling devised by Tebbett to determine future resource needs.

### 2.2.2 Education Development

In 2004, the European Association for Palliative Care produced a guide for the development of palliative care education for nurses and other health professionals (see Table 2.5). The levels are determined by the degree to which the health care professional is involved in palliative care.

<table>
<thead>
<tr>
<th>Level name</th>
<th>Type of preparation</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level A</td>
<td>Basic (undergraduate)</td>
<td>Future health care professionals during their initial training</td>
</tr>
<tr>
<td>Level A</td>
<td>Basic (postgraduate)</td>
<td>Qualified health care professionals working in a general health care setting who may be confronted with situations requiring a palliative care approach.</td>
</tr>
<tr>
<td>Level B</td>
<td>Advanced (postgraduate)</td>
<td>Qualified health care professionals who either work in specialist palliative care or in a general setting where they fulfil the role of resource person. Qualified health care professionals who are frequently confronted by palliative care situations (e.g. oncology, community care, paediatrics and elderly care)</td>
</tr>
<tr>
<td>Level C</td>
<td>Specialist (postgraduate)</td>
<td>Qualified health care professionals who are responsible for palliative care units, or who offer a consultancy service and/or who actively contribute to palliative education and research</td>
</tr>
</tbody>
</table>

### 2.3 Paediatric and Adolescents’ Palliative Care Needs

As with cancer nursing, both paediatric and adolescent palliative care are sub-specialities of children’s nursing and again, the same issues such as small numbers of participants impact on
the viability of any speciality specific educational courses (Langton 2007). There is variability internationally in relation to the development of this specialist field of practice. The UK, Australia and Canada are considered leaders in this development, whilst the US is seen to be lagging behind. New Zealand appears to be up with the main field, although in 2002 Jones et al. identified the growing need for more services dedicated to paediatric palliative care.

The World Health Organisation affirmed that palliative care should be incorporated into the care of all children with cancer, irrespective of geographic location. It also stated that paediatric palliative care is most successfully delivered using a flexible, coordinated multidisciplinary approach, and that activities should be introduced to try to meet families preferences that their child be cared for at home (WHO 1998). Five years on from the publication of this statement, data from England revealed the extent to which this goal is being achieved; 52% of children and adolescents were able to receive palliative care enabling them to die at home. These figures suggest that primary care and community services are critical to the provision of paediatric palliative care services (Higginson & Thompson 2003).

Despite being seen as a place where development is needed, the United States is making progress. The Initiative for Paediatric Palliative Care (IPPC) developed web based educational material to support health practitioners working with children in palliative care (Solomon et al 2002). Three distinct groups of children were identified:

- Those who are born without an expectation of survival to adulthood but who may live a long time with substantial suffering
- Those who acquire illnesses such as cancer
- Those who suffer relatively sudden death due to trauma.

In responding to their differing needs, five curriculum models were developed:

- Engaging with children and families
- Relieving pain and other symptoms
- Analysing ethical challenges in Paediatric End of Life Decision Making
- Responding to suffering and bereavement
- Improving communication and strengthening relationships.
As well as providing educational materials, the IPPC set goals for hospitals and other institutions involved in paediatric palliative care, such as developing strategies for enhancing the palliative care clinical competence of staff (Solomon et al 2002). Unfortunately there is no evidence to determine the uptake of these by organisations in the USA or further afield.

In Australia, the National Palliative Care Strategy (2000) also identified specific needs for children and adolescents and this led to a Paediatric Palliative Care Service Model Review (2004). Arising from this was an identified need for greater education and training and the development of a new model of care. In response, a National Paediatric Palliative Care reference group was formed to address many of the issues pertinent to paediatric palliative care including the variability in palliative care services, in models of service delivery, as well as in the lack of tertiary training in paediatric palliative care. Flinders University in South Australia delivers the Flinders Graduate Certificate in Paediatric Palliative Care, which is one of just a few programmes of this nature located internationally.

Another programme located was that developed in Northern Ireland. Here the paediatric palliative care programme arose out of a review of opportunities for this sector of the workforce (Price et al, 2005). The reflective model of paediatric palliative care (Price & McNeilly 2006) is intended to be used formally within education settings as well as informally in the clinical arena to tease out the complexities of caring for the child and family.

Interestingly, few formal standards or competencies have yet been identified for the paediatric and adolescent palliative care nursing workforce in New Zealand or internationally, although some may arise from the review of educational needs project taking place in Australia. It may be possible to utilise some of those that have been developed for the adult care arena since these appear to be sufficiently flexible to be adapted for addressing knowledge and skills related to caring for children.

### 2.4 Summary

Clearly there have been significant investments by a variety of organisations and governments to estimate the resources needed to meet the needs of the future cancer and palliative care population. Workforce measures have been identified, predominantly for estimating palliative care needs, some of which could be of value to New Zealand. Care must be taken, however, to
determine an appropriate country for benchmarking purposes since New Zealand’s health care system differs from that in other countries. In general, however, in relation to the ideal numbers and the skill mix of the cancer and palliative care nursing workforces, the review of the literature has identified a paucity of data. Some data are provided but details are minimal.

The relationship between education and workforce development is clearly apparent in the literature reviewed. There is consensus that, for cancer nursing, levels of practice or roles should be linked to competencies, and the high quality work that has been undertaken by organisations such as the RCN should not be ignored when considering the approach to be adopted for workforce development in New Zealand. Pathways for the specialty have also been developed which would require minimal modification if adopted. It is the area of education provision where comparisons internationally can be made since New Zealand has many similarities with the provision of nursing education internationally. The graduate nature of the workforce must be acknowledged but, when linked to competencies, the models developed particularly in the UK and Australia should be considered as having good transferability. Further details will be provided in the gap analysis presented in Chapter 8.

The next chapter builds on this information to provide a picture of the educational provision for cancer and palliative care nursing in New Zealand.

Recommendations arising from this review include the following:

- Further clarification of the measures used to estimate workforce predictive measures in relation to numbers and skill mix is needed. Cancer or oncology nursing numbers relative to population size are particularly hard to determine at present and attention should be paid to developing workforce measures for this speciality.

- In relation to educational programmes and associated competencies, clearly a great deal of work has been undertaken world-wide and this can, and should, be used to inform developments in New Zealand. Efforts have been made in a number of countries to include cancer and palliative care content in the undergraduate pre-registration curricula. However more work still needs to be done in the area of competencies to ensure that the necessary skills and knowledge, appropriate for the beginner level of proficiency, are gained at an early stage of a nurse’s career.
A clear educational framework for nurses is developed and that this is related to specialty services development and the core and advanced competencies required. The framework will need to reflect: generalist and specialist nurses’ competencies and educational needs; skill development to meet the expected growth in community-based service delivery; future service development; articulation from pre-registration nursing education right through to research degrees where new knowledge is generated; and continuing education to update and improve competencies. An ideal framework to prepare the nursing workforce for future service development is proposed. This framework does not emphasise the preferences of nurses approaching their retirement, but is future oriented. Working groups work with and refine such a framework for their respective specialty areas.
3. Educational Preparation of Nurses in Cancer and Palliative Care Nursing in New Zealand

The educational preparation of nurses to work with clients with cancer and palliative care needs takes place in a range of institutions, including tertiary educational institutes and health service providers where nurses are employed. It also reflects a variety of levels including undergraduate, graduate and postgraduate, and different approaches including assessed for-credit academic programmes, formal not-for-credit courses and continuing education approaches. There are various levels of education available for registered nurses in New Zealand and overseas: short in-service courses provided by employers, graduate level (level 700 on the NZQA framework), postgraduate level (level 800 NZQA) and doctoral studies. And within the tertiary educational sector there are a range of educational institutions providing advanced education to nurses: polytechnics offering graduate and postgraduate courses (levels 700 and 800 on the NZQA system), and universities offering postgraduate courses.

To place this discussion in context, the Nursing Council (2001) sets out a post-registration educational framework related to entry to practice through to advanced practice. Newly registered nurses entering practice and generalist nurses working in specialty areas (but who are not part of a specialist team) maintain and advance their knowledge and competence through a range of continuing education, in-house employer provided and graduate or postgraduate courses (p.12). Having thereby established a defined scope of practice (p. 9) experienced nurses would engage in advanced nursing programmes at postgraduate level and potentially be recognised as a specialist (p.12).

The emphasis of this chapter is on formal for-credit academic educational programmes offered by tertiary educational institutes. The process followed is outlined:

- Information on opportunities for nursing education in New Zealand was sourced initially from an internet search. Two websites were accessed: the Nursing Council of New Zealand’s website, that lists Postgraduate courses and programmes, and the National Association of Nurse Education in the Tertiary Sector (NETS) website, which provides lists of entry level and postgraduate programmes in nursing within the ‘Programmes and Institutions’ link. Each institution in the table was then investigated directly through its website for the courses it provides. Investigations were limited to those with content relevant to palliative and cancer care and focused on details including course level;
timing, frequency, location and method of delivery; entry criteria; role within a qualification; and student numbers. Other relevant features were noted as necessary (e.g., method of funding, student demography, courses which could be applied to palliative and cancer care such as Masters and Doctoral level theses). Where such details were not available, or further information was required, the institution was contacted directly via telephone or email.

- All providers of nursing undergraduate educational programmes were contacted. Educational institutions offering specialty programmes to nurses at advanced levels, identified through searching the internet, were also contacted for further information. The data generated are reported separately for each educational level; each section being introduced with a description of the method used.

3.1 Undergraduate Nursing Education

Initial consultation with a Director of a Bachelor of Nursing programme indicated that, in general, the curricula for 3-year Bachelor of Nursing and Bachelor of Health Sciences programmes tended to be integrated in nature, and were crowded. All 16 Directors of undergraduate nursing programmes in New Zealand Schools of Nursing were asked how, in their curriculum, did they ensure that on graduation a nurse is prepared to work with patients receiving cancer and palliative care services? In response to concerns expressed regarding confidentiality, Directors were assured that the resulting description would be general and no individual School curriculum identifiable. Although only six responses were received (37.5 percent response rate), those schools included technical institute and university programmes, urban and rural locations in both North and south Islands, and both smaller and larger schools. Further consultation confirmed that these provided a fair reflection of undergraduate educational preparation. Responses are reported under the main issues raised.

Learning was integrated with students being introduced to the theory that applied to a topic at the same time as they were taught skills and techniques. Programmes were described as integrated, which makes it very difficult to isolate a relevant section specific to cancer and palliative care nursing. At the same time, however, topics were reflected at many points in the 3-year programme, resulting in students being exposed to cancer and palliative care in a number of ways. Therefore, reporting on how cancer and palliative care subjects are included
in undergraduate nursing programmes, firstly the approaches used in theoretical aspect of programmes, are described, followed by the clinical placements.

**Theory in Nursing Curricula**

Examples of conceptual organisation of the curricula and how the topics of cancer and palliative care are reflected are presented and these illustrate the wide range of approaches used to introduce concepts related to cancer and palliative care nursing.

**Developmental approach:** Health and illness are introduced over the life cycle and its developmental stages. One example provided related to recognition of age-related interruptions to health such as those that occur with cancers of childhood and ageing related malignancy. A second example referred to care of the dying and the deceased as part of the normal progression through life, with students learning about grief and loss; family support; cultural practices; staff support; bereavement support and services.

**Pathophysiology:** At a generic level, neoplasms were introduced as part of a course on processes and effects of altered anatomy and physiology and included the associated assessment skills. In some programmes the subject of cancer was introduced as part of a course on altered physical health, covering pathophysiology, assessment skills, family and community contexts. Others included an approach that captures the acute presentation of cancer in a course on responses to acute illness and trauma. Palliative care was used in another example to illustrate concepts in physiology, pathophysiology, chemotherapy and pharmacology.

**Acute or episodic illness:** Some programmes included cancer as an example of in acute presentations of illness. Others had an integrated one-week theory block teaching and learning in acute nursing practice based on cancer and palliative care; lectures, student self-directed learning, and group research focused on topics including specific cancers.

**Chronic illness:** Examples provided included a specific module dealing with chronicity and rehabilitation included cancer (from new diagnosis through to exacerbation and remission of chronic health problems and rehabilitation); and oncological and haematological disorders included in a course on adaptation to long-term altered health. One response stated that, while
cancer is introduced in the context of chronic illness, there is no section in the curriculum named ‘oncology’.

**Nursing theory and leadership:** In one programme cancer care is taught as part of a module on leadership in nursing across a range of nursing roles and environment.

**Palliative care subjects:** In addition to the broad topics, there were some examples of subjects in nursing curricula specific to palliative care nursing. These included pain management, grief, dying and support of family/whanau of the dying patient. Other curricula include such topics as: Palliative Care, Chronic Pain and Symptom Management, Intimacy and Self-concept in Palliative Care. One response described covering “society’s’ attitudes and beliefs related to dying and death within the hospital or community that influence the nurse’s response to these very personal and difficult times for individuals and whanau/family/significant others; the nurse’s role in supporting the whanau/family and staff when caring for a terminally ill person; the care of the body following the person’s death”.

**Special Topics** and electives were sometimes available for students to explore further the subjects at greater depth.

An example was given to show how content on cancer and palliative care nursing is included in the theory block:

1. **Review the terminologies related to carcinogenesis.**
2. **Identify the epidemiologic trends in the incidence of cancer in New Zealand context and the significances to the New Zealand Cancer Control Strategy.**
3. **Describe the process of carcinogenesis as well as the risk factors.**
4. **Familiarise the methods of classifying degrees of malignancy.**
5. **Identify nursing management and responsibilities in the client receiving chemotherapy and or radiotherapy.**
6. **Assess the psychosocial impact of cancer on both the client and the family. Identify the nursing actions that promote effective coping for both the client and family.**
7. **Familiarise the roles of palliative care teams and discuss factors that affect quality of life for the individual and family during the dying process.**
8. **Describe self-care strategies for nurses in managing the demands of caring for the dying client and grieving family.**
9. **Complete group presentation of library assignment on the selected cancer topics as per instruction.**
Clinical placements and field visits

The application of knowledge through clinical placements and field visits also reflected the integrated nature of curricula, since students experienced cancer and palliative care environments as part of their integrated practice clinical practice. Opportunities such as field visits reflected the availability of services in any given location and included: visiting the Cancer Society; participating in a loss and grief workshop; visiting a funeral home or a hospice visit.

Students in larger centres with specialised oncology and hospice services had more opportunities for placements than their counterparts in regional areas. Only a few, however, could be accepted to do electives in a hospice of oncology clinic/ward. Students, therefore, were more likely to encounter patients with cancer and palliative care needs, and develop specific clinical skills, in general clinical contexts. Examples of specific clinical contexts included: general medical, surgical and children’s wards; palliative care settings in the community and in institutions including rest homes.

An example of how students develop applied knowledge in general contexts was given:

Students placed in the acute surgical ward…have opportunities to look after the client undergoing the surgical treatment for neoplasm and develop practical knowledge of facilitating the client with cancer to access to cancer support services. They are expected to understand the applications of adjuvant treatment modalities, such as chemotherapy and radiotherapy, in cancer control.

3.2 Postgraduate Academic Programmes

In view of the generic and integrated nature of undergraduate nursing programmes, formal for-credit education to advance nurses’ skills specifically in cancer and palliative care takes place at postgraduate levels. In addition to the programmes in New Zealand, flexible postgraduate programme offered by Australian institutions may also be selected.

A search for courses/papers and programmes in cancer and palliative care was undertaken using the websites of tertiary educational institutes offering postgraduate programmes for nurses and those offering specialised course/papers in these subjects. Information available on the websites was downloaded and a summary of this is reported below. In addition, contact persons in each institution were identified and asked to provide further information on such issues as numbers of students, modes and locations of delivery and
observations on matters such as student access and demand. Opportunities to study cancer and palliative care nursing as specialties at the postgraduate levels of Certificate, Diploma, Masters and Doctorates are outlined briefly. Noting that course and programme availability changes from year to year, the emphasis here is to provide indicative information on the nature of programmes and location that was true at the time of the study, rather than go into detail.

A number of NZ Universities and other tertiary education facilities provide post registration education for nurses in palliative care and cancer nursing. At the postgraduate Masters level there are five institutions that offer specialty based courses/papers and programmes (postgraduate certificate and diploma) focusing on palliative or cancer nursing. Currently there are no named Masters programmes in cancer or palliative care nursing available in NZ; however it should be noted that no other specialties in nursing have dedicated Masters pathways either. All the institutions mentioned below have clinically based Masters programmes in advanced nursing which have been approved by Nursing Council of New Zealand as being suitable for advanced nursing, including Nurse Practitioner preparation.

**Postgraduate Certificate and Diploma**

At the postgraduate certificate and diploma level there are some programmes which are endorsed in the specialities - cancer or palliative care. The programmes are stepped and students may progress from postgraduate Certificate to Diploma and then on to a Masters programme as long as their grade average reaches the level specified by the institution. Two years post registration experience is required as entry criteria for all institutes except in the case of a university programme where the programme is aligned with a District Health Board (DHB) that requires only that nurses are working in the specialty area.

Using a systematic approach, it was identified that specialist Certificate and Diploma programmes were offered at the following educational institutes: The University of Auckland; Victoria University of Wellington; and Whitireia Community Polytechnic in association with Hospice NZ. In addition a single course/paper at the same level was offered by WINTEC at Waikato and Otago University’s Christchurch School of Medicine and Health Sciences. Details are summarised below.
The University of Auckland

The School of Nursing in the Faculty of Medical and Health Sciences has three courses focused on cancer nursing:

- Specialty Based Knowledge and Practice (Cancer Nursing) (average 20 students per year)
- Nursing the Client with Breast Cancer (average 15 students)
- Health Promotion & Early Detection of Cancer (new for 2008).

These specialty courses are taken along with other applicable generic nursing courses, for example students are advised to take a course on Patient Assessment and Clinical reasoning in order to complete a specialty focused Postgraduate Certificate. Other cancer courses may then be taken or other more generic courses such as evidence based practice, or a clinical practicum in pharmacology to complete a Postgraduate Diploma in Health Sciences (Advanced Nursing). Students who gain a B grade average or better may progress to the Master of Nursing programme.

The courses are offered annually. They involve a combination of classroom based and CD or web based teaching and, while most of the students come from Auckland, at least 25% would come from wider New Zealand, although mainly the North Island. Students work in a range of clinical areas including oncology and haematology as well as more generic areas such as district nursing, surgical areas, primary health care. Students are attracted by the specialty focus of the courses and the clinical relevance of the various programmes.

This school also offers a postgraduate Certificate focused on chronic care which includes some palliative care content. This course was funded by the Ministry of Health (MoH) in 2007 as a pilot with 35 students, and will be offered in 2008 nationally to primary health care nurses. Nurses may then choose other courses to suit their specialty pathway including the cancer or palliative care courses.

The School of Population Health, also in the Faculty of Medical and Health Sciences at the University of Auckland, offers six courses in palliative care. All these courses are multidisciplinary targeting social workers, counsellors and GPs as well as nurses, but the majority are nurses. An increasing number of generalist nurses (acute care, aged care, district nurses) are enrolling in the courses while the core student population remains nurses from
hospice areas. Nurse teachers also coordinate and teach on the courses. The courses are offered annually, are considered distance courses and include classroom block time and involve CD or web based delivery. The students may progress to a Master of Nursing as previously described and it is estimated that at least a third continue on the Masters pathway. Again the students are attracted to the courses by their specialty focus. The majority of nurses come from the wider Auckland area but approximately one third come from outside the Auckland region.

The palliative care courses are:

- Ethics, Culture and Societal Approaches to Death (average 15 students per year)
- Psychosocial Issues in Palliative Care (average 20 per year)
- Reflective Practice in Palliative care (average 17 per year)
- Foundations of Symptom Management in Palliative care
- Clinical Symptom Management in Palliative care 11 (average 19 per year)
- Child and Adolescent Palliative Care (average 7 per year).

In addition there are other courses that complement the six palliative care courses that some nurses select.

**Victoria University, Wellington**

The Graduate School of Nursing, Midwifery and Health offers specialty based programmes and courses in cancer nursing and palliative care nursing. Postgraduate Certificates in Clinical Nursing endorsed in Palliative Care and Cancer Nursing are available to nurses. These qualifications consist of 2 integrated courses:

- Advancing Nursing Practice – Palliative Care, or
- Advancing Nursing Practice – Cancer, plus
- Practicum.

The programmes are open to nurses with two years of clinical experience in the relevant specialty area. The qualification is delivered over two semesters and consists of classroom block courses in Wellington and self directed learning activities.
The cancer focused courses were offered, for the first time, two years ago and to date have had 12 students participate; they come from a range of clinical areas including in-patient, ambulatory care and primary care settings, as well as tertiary and general hospitals. Most are from the wider local area with a few from the upper South Island and lower North Island (Nelson/Marlborough and MidCentral DHBs). Most students plan to continue with their studies.

At the postgraduate Diploma level another course is available called Complex Assessment and Diagnostic Reasoning in cancer care or palliative care. To complete the postgraduate Diploma this course is combined with one of three research papers that allow the student to focus on their own clinical area for assignment work.

Students may then progress to a Masters programme including the Master of Nursing (MN) and the Master of Arts (MA)–Applied programme. A future paper is planned in pain management for nurses and another in long term conditions management.

**Whitireia Community Polytechnic and Hospice NZ**

The nursing department based in the Faculty of Health, Education and Social Services at Whitireia Community Polytechnic offers a postgraduate Certificate in Hospice Palliative Care in partnership with Hospice NZ.

This programme has a long history and began in the 1980s as a work based Certificate for allied health professionals and nurses offered by TeOmanga Hospice in Lower Hutt. In 2000 the Certificate was offered collaboratively through Whitireia as a graduate course, level 700 NZQA, and a couple of years later it was approved as a postgraduate qualification.

The postgraduate Certificate consists of four modules, each with a one week block course and some on-line learning. The modules are generally delivered across 3 sites, however, the first module has been delivered in other more distant sites to increase access for students. The courses are open to nurses and other allied health professionals, and attract students predominantly from South Island, Wellington and lower North Island. The nurses come from hospice care, long term care, acute services, and the community. Students may continue on to complete the generic postgraduate diploma offered by Whitireia. Whitireia Polytechnic has an agreement with Victoria University to admit students who reach the entry requirements to the MN programme.
WINTEC

The Nursing Department based in the School of Health, Waikato Institute of Technology, offers one postgraduate cancer focused course: Advanced Nursing Practice in Breast Care. The course was developed collaboratively with Breast Screen Aotearoa and is a combination of on-campus course days at Waikato and on-line delivery.

This specialty course was offered for the first time in 2006 (8 students) and again in 2007 (7 students). Students come mainly from the central North Island and are attracted by the specialty nature of the course content. This course is one of a number of other specialty practice courses that may be credited toward either the postgraduate Certificate or Diploma and combined with core courses to complete the qualification. There is then a clear pathway of generic courses to complete the Master of Nursing.

Otago University's Christchurch School of Medicine and Health Sciences

The School of Psychological Medicine delivers a course in Psycho-Oncology. The course is multidisciplinary for health professionals and nurses are eligible for entry as long as they meet the University’s entry requirements. Numbers vary each year but the average would be approximately 30 and half of these would be nurses. The course attracts students from DHBs, community settings and palliative care and they are usually completing degrees such as Masters or postgraduate Diplomas. The course is delivered in four 2-day blocks across one semester which allows access for those outside of the Christchurch area.

Table 3.1 summarises the specialty postgraduate programmes delivered including mode of delivery and the potential for access by nurses outside the location of the institution.

<table>
<thead>
<tr>
<th>Location of institution</th>
<th>Other sites</th>
<th>Other flexible delivery</th>
<th>Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>The University of Auckland</td>
<td>Auckland</td>
<td>No</td>
<td>Study days CD supported Web-supported</td>
</tr>
<tr>
<td>Victoria University</td>
<td>Wellington</td>
<td>No</td>
<td>Study blocks</td>
</tr>
<tr>
<td>Whitereia</td>
<td>Porirua</td>
<td>Wellington Christchurch</td>
<td>Study blocks Web-supported</td>
</tr>
<tr>
<td>WINTEC</td>
<td>Hamilton</td>
<td>No</td>
<td>Study days Web-supported</td>
</tr>
<tr>
<td>Otago University</td>
<td>Christchurch School of Medicine &amp; Health Sciences</td>
<td>No</td>
<td>Study days</td>
</tr>
</tbody>
</table>

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3.2.1 Funding for Postgraduate Study

The Clinical Training Agency (CTA) is the principal source of financial support to nurses undertaking advanced postgraduate study in the cancer and palliative care specialty areas. Since the CTA changed its approach from funding institutions to deliver programmes to funding DHBs to disburse funding to their nurses, cost as a barrier to further study has been largely removed (see survey and consultation results below in this report). An effect of the transition in how CTA funds are managed has meant that there may be variation across the country reflecting how DoNs interpret and make decisions. Also as a result of this change, the dynamics of uptake of programmes offered by particular institutions has altered as nurses now have choice of programme, for example affecting the previously CTA funded tertiary programme at Victoria University. In addition to CTA funding, some DHBs offer scholarships (e.g. funds established through bequests), and the Auckland Cancer Society has endowed scholarships for nurses from Auckland and Northland to undertake postgraduate studies in cancer nursing at the University of Auckland’s School of Nursing. Three scholarships have been made available each year - 2006, 2007 and 2008 - and cover the cost of University fees for a postgraduate Certificate in Advanced Nursing.

Hospice NZ has been able (through a donation from BMI) to make scholarships available for people (including nurses) employed by or individual members of Hospice New Zealand to undertake education at postgraduate level. Information is available on the website:  
http://www.hospice.org.nz/scholarships1/

3.2.2 Generic Courses and Programmes at Postgraduate Level in Advanced Nursing and Related Subjects

All the courses and programmes reported above reflect principles of flexible learning in the delivery, allowing nurses from outside the immediate area to access the courses. These include: use of study blocks, delivering study blocks at other sites in addition to the educational institute, use of CD and web-based learning. Even with this flexibility, nurses working with clients with cancer and palliative care needs can and do prefer generic postgraduate programmes and courses/papers suitable for advanced nursing more convenient and accessible to them (as evidenced by the findings of the nurse surveys and stakeholder consultations in the present study). Examples of this preference are courses in chronic care,
gerontology and ageing, health assessment, pathophysiology and prescribing; these courses may be specifically for nurses or interdisciplinary. New Graduate programmes at postgraduate level also advance new graduate nurses’ knowledge and skills in generic areas such as health assessment, pathophysiology and a chosen clinical area. Many institutions, however, also offer ‘special topic’ courses that allow students to conduct personalised study in their specialist area. The availability of generic courses/papers and programmes in advanced nursing and related subjects, identified in the Nursing Council website, are set out in Table 3.2. (see http://www.nursingcouncil.org.nz/educa.html#pg). Institutions displayed in Table 3.1 also offer equivalent generic courses and programmes to nurses, such as endorsements in Gerontology in both The University of Auckland and the Christchurch School of Medicine & Health Sciences; these institutions already identified are not included in Table 3.2.

Table 3.2 Generic courses/papers and programmes in advanced nursing and related subjects

<table>
<thead>
<tr>
<th>Institution</th>
<th>Location</th>
<th>Qualifications</th>
<th>Relevant Endorsements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland University of Technology</td>
<td>Auckland</td>
<td>PG Certificate</td>
<td>Acute Medical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PG Diploma Masters</td>
<td>Gerontology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Masters</td>
<td>General Surgery</td>
</tr>
<tr>
<td>Eastern Institute of Technology</td>
<td>Hawke's Bay</td>
<td>Masters</td>
<td>Disease management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Elder health</td>
</tr>
<tr>
<td>Massey University</td>
<td>Auckland</td>
<td>PG Certificate</td>
<td>Adult &amp; older adult</td>
</tr>
<tr>
<td></td>
<td>Wellington</td>
<td>PG Diploma Masters</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palmerston North</td>
<td>Masters</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Distance mode</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unitec</td>
<td>Auckland</td>
<td>PG Certificate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PG Diploma Masters</td>
<td></td>
</tr>
</tbody>
</table>

3.2.3 Masters Programmes

Nurses completing a postgraduate diploma specialising in cancer or in palliative care, and who achieved the required grade, can continue on to Masters Degree. A number of such nurses, known to the researchers, have completed Masters Theses and dissertations in the subjects of cancer and palliative care. Nurses with postgraduate diplomas in advanced nursing and other interdisciplinary programmes that are not so specialised can also go on to complete a Masters degree, and this provides an opportunity for nurses working in cancer or palliative care to focus their thesis on their specialty area.
3.2.4 Doctoral Programmes

All Universities have doctoral programmes which enable nurses, who meet the entry requirements, to undertake advanced study in their chosen specialty, including cancer or palliative care nursing. Presently in New Zealand, at least one nurse known to the researchers is engaged in doctoral research in palliative care.

3.3 Graduate Courses

Whilst a suite of postgraduate programmes (as outlined above) are appropriate for many nurses, in particular for graduates of Bachelors programmes, others prefer the relevance and applied focus of courses offered at the graduate level (level 700 on the NZQA framework). One provider of such courses is the Christchurch Polytechnic Institute of Technology (CPIT). CPIT offers a wide range of graduate papers and specialty practice focused graduate certificates. The courses are not at postgraduate level and focus on developing specialty based knowledge and skills. Only registered nurses can enrol and the courses tend to attract nurses who are older or who do not wish to study at a postgraduate level, although approximately 5% continue on to study at a postgraduate level. The nurses who participate are mainly located in the South Island. There are over 50 courses available and the delivery of these is rotated. Some content may be online but the majority have a classroom based component, as nurses prefer the contact with lecturers and peers.

A generic programme called Graduate Certificate in Nursing Practice allows nurses to select from a range of courses depending on their specialty area of practice – for example palliative care. There are also named specialty Graduate Certificates, the content of which are more prescribed and nurses must complete specific courses – for example oncology.

The Graduate Certificate in Nursing Practice (Oncology) may be taken over 3-6 years. Core courses include:

- Understanding cancer
- Management of cancer related problems
- Communication and bereavement and ethics
- Health assessment of adults or assessing the acutely unwell child
- Pain management or management of acute pain.
Students then choose from a wide range of other courses to complete the certificate e.g.

- The nursing management of breast & gynaecological cancers
- Administration of cytotoxic medications
- Nursing people with haematological disorders
- Paediatric oncology.

Clinical staff, oncologists and specialty nurses teach on the courses and approximately five courses related to oncology are run each year from the Christchurch campus.

### 3.4 Short Courses and In-service Education

Concluding the overview of educational opportunities for New Zealand nurses specialising in cancer and palliative care, some employers offer in-house courses providing an introduction to the specialty area. Although particular DHBs’, hospices’ and other providers’ in-house courses are not identified, relevant topics would include: certification in intravenous administration, grief and loss, Treaty of Waitangi and cultural competence. In addition to assuring the competence of nurses working in the areas, an added benefit of such courses is to motivate nurses to further their knowledge through formal for-credit academic education. To illustrate this type of education, the Mary Potter Hospice offers several short workshops which have been endorsed by Hospice New Zealand:

- Syringe Driver Competency workshop – 2 hours self directed
- Exploring Grief and Loss workshops – 2 workshops (18 hours total) are run annually and are popular with nurses and allied health professionals.

As well as particular organisations and employers offering continuing education, Hospice NZ offers a monthly breakfast education session into which health professionals can participate via teleconference. All hospices and DHB hospitals can join the series free of charge, and other interested parties can participate for a minimal fee. Nurses can use the series to gain professional development hours for their competency portfolios (for more information see [http://www.hospice.org.nz/got-breakfast-lectures1/](http://www.hospice.org.nz/got-breakfast-lectures1/)).
3.5 Summary

This review of nurse education has highlighted several issues pertinent to the present day and future educational provision for cancer and palliative care nurses. A significant issue is the crowded and integrated nature of curricula at undergraduate level, where nurses are prepared for registration as nurses but not for working in a specialised capacity. Programme directors consulted foresee difficulties in accommodating additional material, and argue that other specialty areas also wish to see more content and time for their given specialty. Even New Graduate programmes, where basic knowledge and skills are advanced, are characterised by being generalist rather than specialist and furthermore, frequently newly graduated nurses have not yet settled on their preferred specialty.

Registered nurses have two avenues for advancing their knowledge and skills in cancer or palliative care nursing. One is to participate in informal educational opportunities including: personal reading of journals and books; employers’ in-house courses; conferences, seminars and workshops; and short courses such as those offered by Mary Potter Hospice. These approaches provide an entry to the specialties. The other avenue is to participate in formal, for-credit academic education.

Graduate (700-level) courses are well suited to some nurses, e.g. those who have no desire to pursue postgraduate education but wish to improve their knowledge and skills, and those for whom access and availability are deciding factors. However, a major drawback is that such courses may not articulate with postgraduate educational pathways leaving the nurse without entry to further advanced study.

Embarking on postgraduate study is an option equally available to new graduates, whose programmes are at postgraduate certificate level, as well as to more experienced nurses commencing studies in generic postgraduate courses/papers that are relevant to cancer or palliative care nursing, and to experienced nurses working and studying in the specialist area. Advantages of postgraduate courses include: flexibility, allowing nurses to plan a study pathway that suits their needs and situations; portability, allowing them to apply for completed credits in different but related fields and in other institutions to count toward a chosen programme; and progression, since these provide the opportunity to build on completed
postgraduate qualifications (e.g. certificate) by completing the next level qualification to a doctorate if desired.

A final note related to this education review is that advanced educational preparation of registered nurses to work in specialty areas has been undergoing considerable change in recent years. Prior to the 1990s, pre-registration nursing programmes shifted from certificate to diploma levels, both sub-degree and hospital certificates, usually in-house specialty based courses, were common avenues to pursue specialty education. As educational institutes increasingly took on advanced nursing education, graduate certificates, or level 700 programmes on the NZQA framework, were commonly offered, and preceded the postgraduate (NZQA level 800 and University) programmes. In the early 1990s, an undergraduate degree became the national entry qualification for registration as a nurse in New Zealand. Since that time post registration programmes and qualifications have commonly been at the postgraduate level. These changes are reflected in data on nurses working with patients with cancer and palliative care needs in the following chapter (particularly regarding palliative care nurses who are an identifiable specialty nurse workforce in Nursing Council data), and especially in Chapter 5 where the four DHB cases are reported.
4. National Stocktake of the Nursing Workforce in Cancer and Palliative Care Services

4.1 Introduction

The purpose of this chapter is to report on available national-level data, from DHBs, NGO providers, professional and registering bodies, on the numbers, roles and educational levels of nurses working with clients with cancer and palliative care needs. To describe a context for the stock take, firstly published Ministry of Health documents and reports relevant to the study were reviewed. Finding that there was little or no published information available on the nursing workforce in these specialty areas, the present project employed three methods to describe more accurately the nursing workforces in cancer and palliative care services, with considerable assistance from these organisations:

- Nationally available data from Nursing Council of New Zealand was obtained and analysed
- The Health Workforce Information Programme was approached and supplied data
- Organisations employing nurses in the specialties and associations to which nurses belonged supplied data and
- The Nurse Executives organisation assisted in supplying information from individual DHBs.

The results of each of these approaches are reported separately. In spite of the time-consuming process and combined efforts of all involved, unfortunately national data remains sketchy, incomplete and therefore unreliable. Recommendations arising from this stock take include highlighting the need for improved specification of nursing workforce data.

4.2 Background

The policy contexts for the development of the nursing workforce in the clinical specialties of cancer and palliative care services include:

- Health Workforce Development (Ministry of Health 2006)
- New Zealand Palliative Care Strategy (Ministry of Health 2001)
- New Zealand Cancer Control Strategy (Ministry of Health 2003) and the related
Central to the Cancer Control and Palliative Care Strategies are specialised workforces. In his Foreword to the Cancer Control Workforce Stocktake and Needs Assessment (2007) Childs states: “Implementation (of the Action Plan) cannot succeed without a highly motivated, skilled workforce”. In the case of nursing, the specialty knowledge and skills required, for example, for the administration of chemotherapy drugs and in bone marrow transplant care are specific to those clinical areas and not transferable; a lack of skilled capacity has been reported to delay treatment (p.51) and an absence of an educational framework limits skilled workforce development. Childs went on to comment on good information in some cancer specialisms (e.g. medical oncology) but the lack of available detail regarding other areas, such as in palliative care and the nursing workforce in cancer services.

The future capacity of the nursing workforce, and its skill mix, to keep up with advancements in cancer treatment were identified as key issues in workforce development; an associated need identified was for a national clinical education framework for nurses to develop those specialist skills. Table 4.1 describes the palliative care nursing workforce as reported in the workforce stocktake (MoH 2007). This table indicates that growth in the palliative care nursing workforce is mainly among those without palliative qualifications. The same report noted that in the six cancer centres there were 13 palliative nurse specialists and 11 “nurse practitioners” (p. 65). As noted in the analysis of Nursing Council’s Nursing annual Nursing Workforce Survey (see below), to date the Nursing Council has approved only one nurse specialising in palliative care in the Nurse Practitioner scope of practice; the reported 11 Nurse Practitioners is incorrect, and this raises concerns about the reliability of other reported numbers.

### Table 4.1 Palliative Care Nursing FTE (modified from MoH 2007, p. 59)

<table>
<thead>
<tr>
<th></th>
<th>2002/3 FTE</th>
<th>2003/4 FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs with palliative qualifications</td>
<td>178</td>
<td>154</td>
</tr>
<tr>
<td>RNs without palliative qualifications</td>
<td>46</td>
<td>99</td>
</tr>
<tr>
<td>Enrolled nurses</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>259</strong></td>
<td><strong>299</strong></td>
</tr>
</tbody>
</table>
Table 4.2 summarises trends in the nursing workforce (FTEs) in the six Cancer Centres (MoH 2007, p.50). This table suggests growth in the specialist cancer nursing workforce, even though vacancies nationwide have fallen. However this table excludes cancer nurses outside of those centres, and 25% of chemotherapy is now administered outside cancer centres (ibid p.50).

Table 4.2 Cancer Centre Nursing FTEs (modified from MoH 2007, p. 50)

<table>
<thead>
<tr>
<th>October 2005 FTE</th>
<th>Vacancies</th>
<th>June 2006 FTE</th>
<th>Vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>95.6</td>
<td>2.0 (2.1%)</td>
<td>100.37</td>
</tr>
<tr>
<td>Waikato</td>
<td>36.3</td>
<td>1.0 (2.8%)</td>
<td>41.02</td>
</tr>
<tr>
<td>MidCentral</td>
<td>26.4</td>
<td>2.1 (8%)</td>
<td>32.5</td>
</tr>
<tr>
<td>Capital &amp; Coast</td>
<td>29.35</td>
<td>1.6 (5.5%)</td>
<td>32.8</td>
</tr>
<tr>
<td>Canterbury</td>
<td>52.5</td>
<td>1.6 (3%)</td>
<td>56.7</td>
</tr>
<tr>
<td>Otago</td>
<td>23.5</td>
<td>- (0%)</td>
<td>22.58</td>
</tr>
<tr>
<td>TOTALS</td>
<td>263.65</td>
<td>27.2</td>
<td>285.97</td>
</tr>
</tbody>
</table>

The above data are limited for several reasons: they are partial (Table 4.2); dated (Table 4.1); not comparable; and do not describe skill mix.

4.3 Health Workforce Information Programme

Recent efforts, including the Cancer Control Workforce Stocktake (MoH 2007), to place nursing workforce development on a sound evidence base have grappled with the lack of credible data (see DHBNZ 2006). Addressing the issue of good workforce data DHBs, as the largest employers of health workers, through the DHBNZ organisation, have embarked on a Health Workforce Information Programme (HWIP). The first report, a “snapshot” base data report of the DHB workforce in June 2006, reported a total 5,308 medical FTE (12% of the total) and 16,465.6 nursing FTE (36% of the total DHB workforce) (DHBNZ 2006 p.22). Whilst a detailed breakdown of the medical workforce according to occupational medical specialties was given, nurses’ specialist clinical areas are not broken down in the same way; indeed by far the majority of RNs are not classified. In order to more accurately describe the cancer and palliative care nursing workforce, the HWIP team at DHBNZ worked with the present investigators. Our correspondent in DHBNZ commented on the “infancy” of the HWIP programme, and that the data on the numbers and employment locations of cancer nurses...
were not readily available. The following process was therefore followed in an attempt to better
describe the nursing workforce using fields in the existing database:

**Step 1:** The fields identified as useful in processing the request were: Facility of Usual
Employment; Health Service; Scope of Practice; Job Title; Qualification. Our correspondent
noted that, of these, only “Job Title” is completed by all, whilst up to just 20% of other fields are
completed. A search in “Job Title” yielded 12 records where the nurse’s job title included
“palliative” and “oncology.” Our correspondent also observed that, because the database
contains 55,300 records, at the present time “it is unlikely to get accurate information about
nurses involved in palliative care and oncology based on HWIP data”.

**Step 2:** HWIP sent an Excel spreadsheet listing all primary services nurses are involved with in
21 DHBs (517 services listed) and asked us to identify which of those would provide cancer
and palliative care services. Subsequent clarification indicated that primary service data were
incomplete in the case of five DHBs, and altogether lacking in the case of two. These seven
DHBs included those DHBs with tertiary cancer services. Nineteen of the 517 services were
clearly cancer and palliative care services by the service name, e.g. Oncology, Haematology,
and Hospice.

The result was a collection of figures that clearly did not accurately represent the specialist
nursing workforce and did not reflect previously reported data (e.g. MoH 2007; Nursing Council
data). In addition, cancer and palliative care nurses were not reported separately; nurses with a
primary role in cancer and palliative care nursing deployed in general services (e.g. District
Nursing, general surgery) were not captured; and only one third of DHBs were reported on. The
numbers are not reported here to avoid them being quoted out of context, further confusing
information on nursing stock. Our conclusions from this approach were to concur with our
correspondent that HWIP is not yet able to deliver detailed and accurate information. This is
partly because of incomplete data supplied by DHBs to HWIP and because nurses are not
classified according to specialty.

As a consequence of the lack of success using HWIP, other available sources of data were
identified and approached. These included: Nursing Council of New Zealand, New Zealand
Nurses Organisation and the Cancer Society of New Zealand. In addition, to extend and
confirm information from those sources, Directors of Nursing in all DHBs were approached and requested to supply data on their organisations.

4.4 Nursing Council of New Zealand Data on Palliative Care Workforce

The following summary on the palliative care workforce has been drawn from the national data collected annually by the Nursing Council of New Zealand (NCNZ) through the Nursing Workforce Survey. The survey is conducted and data collected at the same time as the annual practising certificates are renewed by all nurses currently registered and active in New Zealand. Data are reported according to the Nursing Council approved scope of practice. There are four possible scopes of practice: Nurse Practitioner, Registered Nurse, Enrolled Nurse and the Nurse Assistant. Of these, only the first two are the professional categories (Nurse Practitioner and registered nurse) that have been analysed for the purposes of this report; enrolled nurses and nurse assistants were excluded as the work of these nurses must be supervised by registered nurses.

Information analysed was that held by the Nursing Council at 4 July 2007 and based on nurses who had returned their surveys and whose practising certificates had been renewed by that date. As the process is ongoing throughout the year, the data on some nurses could have been up to 12 months old. It was not possible to independently verify the details provided.

4.4.1 Main Area of Clinical Practice – Palliative Care

The Nursing Workforce Survey included a total of 23 choices for nurses to identify the main and secondary areas of clinical practice that best describe their work. The choices do not focus on specific disease states and vocational specialty areas (as do the equivalent Medical workforce Survey) but rather focus on: the organisational contexts of practice (district nursing, public health, medical, surgical); broad population groups receiving care (child health, mental health, intellectually disabled); type of care (palliative care, continuing care); and roles (research, education, or management). Whilst palliative care was one of the options available for nurses to select, cancer nursing was not an option available for choice. Therefore palliative care only is discussed below.
Overall a total of 1377 nurses identified palliative care as either the main or secondary area of their clinical practice. The 598 who selected palliative care as their secondary area of clinical practice are excluded from further analysis. This leaves 670 nurses (1.6% of all registered nurses) who identified that palliative care best described their main area of nursing practice. This subset of data has been further analysed and is reported on below. Of this subset there was one Nurse Practitioner in palliative care, with the remainder being in the Registered Nurse scope of practice.

4.4.2 Employment Codes

As described above, each year when renewing their Annual Practising Certificates New Zealand nurses are required to report on their employment setting by ticking against a number of options. Although ‘Hospice’ was not listed as an option to tick, the majority of the nurses stated that they worked in a hospice. The following lists the settings and organisations where the 670 nurses, whose main area of practice was palliative care, were employed. The total exceeds 670 because some nurses ticked more than one box.

- 200 (30%) – Hospice setting or community palliative care
- 133 (20%) - Private or non-public hospital
- 124 (18.5%) – Private or non-public primary health care/community service
- 88 (13%) – Rest home/residential care
- 60 (9%) – Public hospital DHBs
- 35 (5%) - DHB public community service
- 13 (2%) – Nursing agency
- 57 (8.5%) Selected ‘other’ option
- 2 (0.3%) Self employed
- 2 (0.3%) Employed by a government agency e.g. MOH, ACC, prisons etc.

4.4.3 DHB Geographic Location

Most nurses (86%) worked in the North Island with only 93 working in South Island DHB regions. The two most common DHB geographical areas of practice were Christchurch and the Far North (66 nurses each area). Auckland’s North Shore was third (43 nurses) followed by Lower Hutt and Manukau (both 38 nurses). Tauranga, Wellington, Palmerston North, Dunedin and Hamilton all had between 38 and 27 nurses working in the areas.
4.4.4 Hours of Work

Just over a quarter of the nurses worked 20 hours or less per week (n = 175; 26%). The remainder worked more than 20 hours (15 did not respond to the question or put 0).

The main reason for part time employment was parental responsibilities (n = 123); however work on a casual basis and personal choice were also common reasons cited. A further 11% of the nurses (n=77) stated that they had reduced their hours due to high workload.

4.4.5 Education Qualifications

Almost a quarter of the nurses indicated that they had a postgraduate certificate qualification or higher (n = 145; 22%). A number did record that they had a graduate certificate or hospital certificate but no further description was available. Since the early 1990s an undergraduate degree became the national entry qualification for registration as a nurse. Since that time post registration programmes and qualifications have commonly been at the postgraduate level.

4.4.6 Registration in New Zealand and Overseas

The majority of the nurses (76%) gained their initial nursing registration in New Zealand (n = 508); this figure was higher than the national average. Of the overseas-educated nurses, 84 nurses (12%) were educated in United Kingdom while 14 were educated in Australia and 15 in either Zimbabwe or South Africa.

4.4.7 Age Range

The average age of a nurse in New Zealand is increasing and now stands at 47 years. The nurses in this subset have an even higher average age with 63% (n = 421) aged 47 years or over. Only 12% are aged less than 36 years (see Table 4.3). Within 20 years, therefore, nearly 2/3 of the present palliative care nursing workforce will likely be retired.
Table 4.3 Age of palliative care nursing workforce in NZ

<table>
<thead>
<tr>
<th>Year of birth</th>
<th>Current age range</th>
<th>Number</th>
<th>Percent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1931-40</td>
<td>67-76 yrs</td>
<td>34</td>
<td>5%</td>
</tr>
<tr>
<td>1941-50</td>
<td>57-66</td>
<td>133</td>
<td>20%</td>
</tr>
<tr>
<td>1951-60</td>
<td>47-60</td>
<td>254</td>
<td>38%</td>
</tr>
<tr>
<td>1961-70</td>
<td>37-46</td>
<td>167</td>
<td>25%</td>
</tr>
<tr>
<td>1971-80</td>
<td>27-36</td>
<td>73</td>
<td>11%</td>
</tr>
<tr>
<td>1981+</td>
<td>&lt;27 yrs</td>
<td>8</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Nursing Council data. Note that total does not total 670 due to missing data.

Concluding comments on Nursing Council data

The Nursing Council data provide a description of the national nursing workforce working in the palliative care area. However, a possible limitation is that the data are dependent on self-reporting of the category that most closely reflects the main aspect of the nurse’s work; this may lead to under or over-reporting of contact or engagement in palliative care activities. Comparing these data in mid-2007 with the MoH (2007) figures reported for 2003/4, the numbers of nurses whose main area of work was in palliative care has more than doubled, having increased from 299 (MoH 2007, p.59) to the current figure of 670. Unfortunately, the Nursing Council was not able to provide equivalent data on the nursing workforce in cancer services.

4.5 Data from New Zealand Nurses Organisation

In view of the lack of Nursing Council information on the cancer nursing stock, other sources of national level data were identified, one of which is the New Zealand Nurses Organisation (NZNO). The NZNO has a Cancer Nurses section and the national picture of membership for this is presented in Table 4.4. Based on these data, there appears to be similar numbers of nurses working in cancer and palliative care services. However, a limitation of the NZNO data is firstly, that not all nurses are members of the NZNO, and secondly, that it is not known if all nurses working with patients with cancer and who are members of NZNO belong to the Cancer Nurses section. In addition, details on such issues as age, ethnicity, hours worked and specialist educational qualifications were not available.
Table 4.4 NZNO Cancer Nurses section

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bay of Plenty</td>
<td>44</td>
</tr>
<tr>
<td>Christchurch</td>
<td>127</td>
</tr>
<tr>
<td>New Plymouth/Palmerston North/Wanganui</td>
<td>55</td>
</tr>
<tr>
<td>Wellington Region</td>
<td>56</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>12</td>
</tr>
<tr>
<td>Waikato</td>
<td>74</td>
</tr>
<tr>
<td>Southland</td>
<td>76</td>
</tr>
<tr>
<td>Greater Auckland Region</td>
<td>113</td>
</tr>
<tr>
<td>Top of South Island</td>
<td>32</td>
</tr>
<tr>
<td>West Coast</td>
<td>10</td>
</tr>
<tr>
<td>Northland</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>614</strong></td>
</tr>
</tbody>
</table>

4.6 Data from Nurse Executives of New Zealand

In view of the lack of progress using HWIP data and the limitations of Nursing Council and NZNO data, the Directors of Nursing (through the Nurse Executives of New Zealand network) were contacted to facilitate the collection of information from their nurse leaders on nurses whose primary role was in cancer or palliative care nursing. As these senior nurses have day to day contact with, and know the skills of, the nurses delivering patient care, we anticipated more complete information. They completed a pro-forma developed for the purpose on cancer and/or palliative care nurse employees on the following areas:

- Numbers (FTE and persons)
- Weekly hours worked (full or part time and actual weekly hours)
- Age (by age band), gender and ethnic profile
- Geographical regions, scopes of practice (Enrolled or Registered Nurse) and levels (staff and senior levels and roles) where nurses worked
- Educational levels (post-qualification) and
- Any additional information.
Using this approach, data from a small selection of DHBs were received. In addition to an incomplete set of data received, a further limitation of this approach was the apparently different interpretations of respondents of nurses in cancer and palliative care services, leading to unexpectedly high numbers in some DHBs without specialist services, and conversely surprisingly low numbers in DHBs with specialist services. Although the pro-forma simply asked for numbers and details against the areas listed above, the range of responses suggest that respondents’ interpretations of their nurses’ cancer and palliative care roles were diverse. For example while one respondent might apply a narrow interpretation of ‘palliative care’ (e.g. as a specialist area), others may have a more liberal interpretation, such as regarding much of district nursing and continuing care as having a palliative care component. Similarly a narrow interpretation of ‘cancer’ nursing may reflect nurses working in specialist wards and centres only, whilst another might include those nurse in general wards and departments where some patients with cancer receive aspects of treatment.

For these reasons, the numerical data is not displayed here, to avoid the risk of it being used out of context, and because at best it provides only a snapshot in time. The exercise did, however, provide some useful insights. Information received suggested that the sizes of specialist cancer nursing workforces per DHB differ significantly between tertiary centres and DHBs without such centres. In the tertiary treatment centres there was a range of specialist nursing roles, such as breast care nurses, haematology nurse specialists, nurse educators, and these numbers were included in the FTE figures. Satellite cancer clinics are delivered by tertiary cancer centres in many of the DHBs without such centres, and here too specialist cancer nurses are needed.

Additional comments made by some respondents go some way to explain why the collection of accurate data is problematic. One respondent observed that:

“Lots of roles provide palliative care in medical, surgical and aged care wards plus district nursing. Cancer nurses are not dedicated just to cancer (services)”.

Another commented that determining FTE is difficult because of the mix of full-time and part-time nurses, and because only proportions of some jobs may be dedicated to cancer or palliative care nursing. Furthermore, specialist nurses deliver services in a range of settings and services, and nurses not identified as “specialist” provide services to patients with specialised needs:
“We certainly aren’t big players, however, like everywhere have a growing need within these services... Palliative care is delivered as part of the District Nurse service. A CNS Palliative Care role has been proposed in the Palliative Care Strategic Plan, and three District Nurses have recently commenced a PG Cert in Palliative Care. The DHB is just about to advertise for a Clinical Nurse Specialist in Oncology”. (A small regional DHB.)

Some respondents provided demographic information: this described the specialist cancer and palliative care nursing workforce as predominantly female, older (late 40s upwards), and European, with a mix of full-time and part-time nurses employed, a profile confirmed in the survey of nurses. The data also indicate a reasonable uptake of specialist postgraduate qualifications, and in the case of the cancer nursing workforce higher in DHBs with tertiary cancer centres. A regional DHB servicing a large Maori population made these observations regarding the need for a higher representation of Maori nurses:

“35% [of the] population is Maori. They do have a Maori Cancer nurse A DHB plan for service delivery (currently being developed) includes recruitment of Maori nurses.”

**Hospital Palliative Care Nursing in New Zealand**

More detailed information on hospital palliative care services were, however, established. There are nine District Health Board funded hospital palliative care teams throughout New Zealand. These include North Shore, Auckland, Middlemore, Waikato, Hawkes Bay, Palmerston North, Wellington, Christchurch and Dunedin Hospitals. In addition a small number of hospices provide DHB hospitals with palliative care advice and support. These services are funded by the local hospice particularly in the small provincial centres.

All but one of the DHB funded hospital palliative care teams’ works in a consultative model of care and are referred patients by the primary medical team to provide advice and support for those with complex palliative care needs. In addition to clinical advice and support these teams are responsible for providing education to clinicians to ensure there is a basic level of palliative care knowledge and skill throughout the hospital. At the point of discharge either from hospital or from the palliative care service, most patients are referred to the community based palliative care teams for ongoing care.
Nurses working in hospital palliative care teams in New Zealand are, in the main, employed as Clinical Nurse Specialists (the exception is in Canterbury where they are called Clinical Nurse Consultants). These nurses make up a component of the nursing workforce that delivers what is referred to as specialist palliative care (Definitions of Palliative Care in NZ, 2006) which is in addition to those nurses working in hospice palliative care services (see Hospice NZ nursing data).

The following information pertains only to those hospital palliative care teams currently funded by the District Health Boards. A total of 25 (23.6FTE) nurses are working in the nine hospital palliative care teams across the country; 22 of the 25 nurses have a post graduate qualification in palliative care. These qualifications range from a post graduate certificate, diploma or Masters Degree. One nurse has a PhD.

### 4.7 Data from the Cancer Society of New Zealand

To augment individual DHB data, another source of the cancer nursing workforce at the national level was the Cancer Society. Four of the Cancer Society branches have nurses employed and functioning as registered nurses additional to those employed by DHBs: Auckland and Northland (which comes under Auckland Cancer Society), Canterbury and Waikato/Bay of Plenty. The other branches may have registered nurses or enrolled nurses employed as a coordinators or support workers but they are not employed to fulfil the RN/EN role.

The Auckland and Northland area employ 16 nurses (see Table 4.8)

Canterbury employs 9 nurses (see Table 4.9)

Waikato and Bay of Plenty employ 4 nurses (see Table 4.10)

Hawke’s Bay employs 2 (both RNs) and Southland employs 3 nurses (1 RN and 2 ENs) but in both areas, they are employed as support staff and not in a registered nurse capacity.
### Table 4.8 Auckland and Northland Cancer Society Nurses

<table>
<thead>
<tr>
<th>FTE</th>
<th>Persons</th>
<th>F/T</th>
<th>P/T</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.7 (Auckland)</td>
<td>13</td>
<td>1</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>2.2 (Northland)</td>
<td>3</td>
<td>12</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>29&lt;</td>
<td>35-39</td>
<td>45-49</td>
<td>55-59</td>
<td>Male</td>
</tr>
<tr>
<td>30-34</td>
<td>40-44</td>
<td>50-54</td>
<td>60&gt;</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>all</td>
</tr>
<tr>
<td>ENs</td>
<td>Staff Nurse</td>
<td>Senior nurse</td>
<td>Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-registration qualification</td>
<td>PG Cert</td>
<td>PG Dip</td>
<td>Masters</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 4.9 Canterbury/West Coast Cancer Society Nurses

<table>
<thead>
<tr>
<th>FTE</th>
<th>Persons</th>
<th>F/T</th>
<th>P/T</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.4</td>
<td>9</td>
<td>3</td>
<td>6</td>
<td>256</td>
</tr>
<tr>
<td>29&lt;</td>
<td>35-39</td>
<td>45-49</td>
<td>55-59</td>
<td>Male</td>
</tr>
<tr>
<td>30-34</td>
<td>40-44</td>
<td>50-54</td>
<td>60&gt;</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>all</td>
</tr>
<tr>
<td>ENs</td>
<td>Staff Nurse</td>
<td>Senior nurse</td>
<td>Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Pre-registration qualification</td>
<td>PG Cert</td>
<td>PG Dip</td>
<td>Masters</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Note: In addition is 1 Radiation Therapist Female (40-44 age) PG Diploma

### Table 4.10 Waikato/Bay of Plenty Cancer Society Nurses

<table>
<thead>
<tr>
<th>FTE</th>
<th>Persons</th>
<th>F/T</th>
<th>P/T</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2</td>
<td>3</td>
<td>165</td>
<td></td>
</tr>
<tr>
<td>29&lt;</td>
<td>35-39</td>
<td>45-49</td>
<td>55-59</td>
<td>Male</td>
</tr>
<tr>
<td>30-34</td>
<td>40-44</td>
<td>50-54</td>
<td>60&gt;</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>all</td>
</tr>
<tr>
<td>ENs</td>
<td>Staff Nurse</td>
<td>Senior nurse</td>
<td>Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pre-registration qualification</td>
<td>PG Cert</td>
<td>PG Dip</td>
<td>Masters</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Note: Two each of the RNs are in Tauranga and Hamilton and 1 is in Rotorua
4.8 Data from Hospice New Zealand

The majority of palliative care nurses are employed in 37 hospices across New Zealand. The majority of patients (90%) admitted to hospice are cancer sufferers, though hospices do cater for all terminal illnesses, including Motor Neurone Disease, end stage organ failure, CORD and HIV. Funding for the services that the hospices provide are partially Government funded and the rest of their operational costs are sought through fundraising in the community. Hospice New Zealand is a national umbrella organization for hospices that is involved in research and education, workforce development, and in establishing standards of healthcare. It provides information and advice to hospices, stakeholders and to the general public as well as helping and supporting hospices nationwide.

In a survey in 2006 by Hospice New Zealand there were approximately 227 full-time equivalent (FTE) palliative care nurse employed in hospices in New Zealand. That number includes the following:

- 182 FTEs Registered Nurses (range 1.45 – 29.5 FTEs)
- 30 FTEs Enrolled Nurses (range 0.88 – 5.7 FTEs) and
- 10 FTEs Health Care Assistants (range 0.4 – 4.4 FTEs).

Just under 15 registered nurses were involved in management positions. At the end of 2007 the total number of nursing FTEs employed nationally in hospices had increased significantly, to 415.

4.9 Summary

The principal conclusion is that the data collected remain partial, for reasons that include Nursing Council data describing only the palliative care and not cancer nursing workforce, and that not all DHBs supplied data, and that its accuracy is questionable. There are three main explanations for the latter: firstly, because nurses are not classified according to specialisation; secondly, because of differences in how nurses providing cancer and palliative care services were defined and counted; and thirdly, the state of flux affecting nursing services as overall services are developed and changed. The only method of collecting accurate data in a consistent way is for investigators to personally collect data from source and not rely on available databases or on others to supply data. However the design of the present study did not allow for such a time-consuming and costly exercise. Furthermore, even an accurate and
complete stocktake is of limited value: it is only ever a snapshot at a single point in time, and thus of limited use in health services characterised by change.

In order to improve and facilitate nursing workforce planning, the following conclusions arose from stocktake:

- That like doctors, nurses need to be classified consistently according to clinical practice area
- The annual nursing workforce survey ideally should collect data on the full range of clinical practices area as well as the health system context (primary, secondary, tertiary etc) and role (research, education, management etc)
- Another source of information is the employer, and so if employers recorded nurses’ clinical practice areas in their databases, this then would be helpful to supplement national data
- If nurses (and other health professionals) had unique identifiers, this would enable tracking of employment and deployment, thereby reducing the present dependence on occasional stocktakes and surveys, and reliance on employers as the main source of workforce data.
5. District Health Board Case Studies – Survey

In order to facilitate a more detailed examination of the cancer and palliative care workforce and the educational needs of their nurses, four District Health Boards (DHBs) were selected as cases. This chapter presents the results of a postal survey, using a questionnaire designed for the purpose, of nurses carrying out the day to day care of patients in cancer and palliative care services within these DHBs. Clinical settings surveyed included generalist and specialty areas and services such as oncology, district nursing, other community providers, pain teams, medical and surgical wards, and intensive care units. An inclusive, rather than exclusive, approach was adopted to elicit data from a wide sample of the cancer and palliative care nursing workforce.

Over 40 additional interviews were also conducted with nurses within the DHBs to complement the survey data to ensure that the results were meaningful and representative of nurses providing cancer and palliative care services within these DHBs: these results are reported in the following chapter.

The four DHBs that took part in the survey were Auckland, Counties Manukau, West Coast and Bay of Plenty; details of these DHBs are provided in Chapter 1.

5.1 Methodology

5.1.1 Sample and Recruitment

The first sample included nurses working in the provider arms of the four DHBs. Within each of the four DHBs, a link person was nominated by the Director of Nursing, who was instrumental in identifying relevant contacts and working through the DHB systems. The target group for the survey was all nurses (registered nurses and enrolled nurses) whose client group included cancer or palliative care clients either most, or some, of the time. In three of the DHBs, the names and place of work of the nurses identified were provided through access to the general nursing staff list; the questionnaires were subsequently addressed to the individual nurses and mailed through the DHBs' internal mail systems. The majority of questionnaires were sent in this way. In the fourth DHB, numbers for each clinical area were estimated by the key contact person and through telephone calls. The survey packs were then delivered to the contact person who distributed them to the clinical areas.
The second sample was nurses working in the private and NGO providers within the DHB regions. The funding and planning division of each of the DHBs provided a list of private hospitals that were contracted to deliver private cancer or palliative care services; this included one that provided surgical services. In one DHB, all private hospitals were surveyed as the total number was low. In others, a purposive sample of was generated, to include small and large provider organisations that were privately owned, religious or trust based, or owned by a large ‘for profit’ organisation. These included hospices and Primary Healthcare Organisations (PHOs): all the hospices in each of the DHB areas were contacted and invited to take part in the survey; only one was unable to accept. A range of PHOs, including those that identified as Maori or Pacific providers, small and large general practices and covering a range of geographic areas, were contacted and invited to participate in the survey; the relevant number of questionnaires were subsequently sent to each practice. Where the PHOs were large organisations, each 4th general practice was included in the survey.

Each nurse manager was contacted by phone and the study was explained. The quantities of survey packs estimated by the contact person were dispatched to the relevant facility. The relevant number of unnamed questionnaires was then posted to the facility.

The third sample was self-generated. The study team was also contacted by some nurses working in health facilities that were outside the four DHB areas. They had heard about the study and wanted to take part; these nurses were sent survey packs as requested.

Each survey pack, distributed to the samples and using methods described above, included: the questionnaire, information about the study and rights of participants and a freepost envelope to return the completed questionnaire.

5.1.2 Variables Measured

The questionnaire was based on an instrument recently used in New Zealand to establish educational needs of nurses working in primary health care, with permission, modified for the purposes of the present survey. Key variables measured included the following:

- Type of care provided (i.e. cancer, palliative or both)
- Full or part-time working
• Age, gender ethnicity, and length of service
• Current level of practice
• Educational requirements
• Formal and informal training/education completed (including undergraduate, orientation in the area, speciality skills, speciality training, including ongoing education requirements)
• Attitude and intentions regarding undertaking further education and
• Perceived limitations to access to training/education for role requirements or for career in speciality.

A total number of 3504 questionnaires were distributed to nurses within the four selected DHB regions; for the detailed breakdown of questionnaires distributed, see Table 5.1.

**Table 5.1 Questionnaires distributed to DHB regions**

<table>
<thead>
<tr>
<th>DHB region</th>
<th>DHB staff</th>
<th>Private Hospitals</th>
<th>PHOs</th>
<th>Hospices</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>1114</td>
<td>191</td>
<td>68</td>
<td>45</td>
<td>1418</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>829</td>
<td>121</td>
<td>86</td>
<td>39</td>
<td>1075</td>
</tr>
<tr>
<td>West Coast</td>
<td>301</td>
<td>29</td>
<td>28</td>
<td>Nil</td>
<td>358</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>337</td>
<td>138</td>
<td>55</td>
<td>48</td>
<td>578</td>
</tr>
<tr>
<td>Other</td>
<td>75</td>
<td></td>
<td></td>
<td></td>
<td>3504</td>
</tr>
</tbody>
</table>

The total number of returned completed questionnaires was 649; a response rate of 18.5% (range 9-28%). The low response rate is typical of postal surveys, but was nonetheless disappointing given the high levels of interest expressed during the recruitment process. One explanation for the low response rate is related to the recruitment and distribution process. Some nurse managers and leaders wanted the survey packs distributed to a far wider nurse population and in services beyond that initially identified by the researchers; these requests were accommodated. However feedback received indicated that many nurses in generalist areas who received the packs felt it was not relevant to them. In the DHB that chose to manage the distribution the researchers do not know how many packs were distributed.

Responses were provided from nurses working in a variety of provider settings (see Tables 5.2 & 5.3); some nurses aligned themselves with more than one setting.
Table 5.2 Type of provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public non acute</td>
<td>25</td>
<td>3.9</td>
</tr>
<tr>
<td>Private acute</td>
<td>20</td>
<td>3.1</td>
</tr>
<tr>
<td>Private non acute</td>
<td>60</td>
<td>9.4</td>
</tr>
<tr>
<td>Rural</td>
<td>10</td>
<td>1.5</td>
</tr>
<tr>
<td>Maori provider</td>
<td>9</td>
<td>1.4</td>
</tr>
<tr>
<td>Pacific provider</td>
<td>9</td>
<td>1.4</td>
</tr>
<tr>
<td>Aged care</td>
<td>99</td>
<td>15.6</td>
</tr>
<tr>
<td>Rest home</td>
<td>53</td>
<td>8.2</td>
</tr>
<tr>
<td>Hospice inpatient</td>
<td>31</td>
<td>4.8</td>
</tr>
<tr>
<td>Hospice community</td>
<td>46</td>
<td>7.1</td>
</tr>
<tr>
<td>Primary care</td>
<td>46</td>
<td>7.1</td>
</tr>
<tr>
<td>Public community service</td>
<td>32</td>
<td>4.9</td>
</tr>
<tr>
<td>Private organisation</td>
<td>12</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Table 5.3 Service / area of work

<table>
<thead>
<tr>
<th>Area of work</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>179</td>
<td>27.6</td>
</tr>
<tr>
<td>Medicine</td>
<td>43</td>
<td>6.6</td>
</tr>
<tr>
<td>Specialist Cancer</td>
<td>54</td>
<td>8.3</td>
</tr>
<tr>
<td>Specialist Palliative</td>
<td>79</td>
<td>12.2</td>
</tr>
<tr>
<td>Adult ICU</td>
<td>26</td>
<td>4.0</td>
</tr>
<tr>
<td>Paediatric ICU</td>
<td>6</td>
<td>0.9</td>
</tr>
<tr>
<td>Specialist Day Clinic</td>
<td>10</td>
<td>1.5</td>
</tr>
<tr>
<td>Community/primary care</td>
<td>79</td>
<td>12.2</td>
</tr>
<tr>
<td>Gynaecology/women's health</td>
<td>26</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>180</td>
<td>27.7</td>
</tr>
</tbody>
</table>

Overall, 13% (n = 83) of the nurses responding to this survey indicated that their work solely involved cancer patients, 14% (n = 89) worked with palliative care patients, while the majority (72%, n = 70) care for both cancer and palliative care patients. Table 5.4 shows the breakdown of these groups by DHB region.
<table>
<thead>
<tr>
<th>District Health Board Region</th>
<th>Role</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland (ADHB)</td>
<td>Cancer Care Patients</td>
<td>49</td>
<td>63.6</td>
</tr>
<tr>
<td></td>
<td>Palliative Care Patients</td>
<td>57</td>
<td>65.5</td>
</tr>
<tr>
<td></td>
<td>Both</td>
<td>189</td>
<td>42.5</td>
</tr>
<tr>
<td>Counties Manukau (CMDHB)</td>
<td>Cancer Care Patients</td>
<td>18</td>
<td>23.4</td>
</tr>
<tr>
<td></td>
<td>Palliative Care Patients</td>
<td>15</td>
<td>17.2</td>
</tr>
<tr>
<td></td>
<td>Both</td>
<td>92</td>
<td>20.7</td>
</tr>
<tr>
<td>West Coast (WCDHB)</td>
<td>Cancer Care Patients</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>Palliative Care Patients</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td></td>
<td>Both</td>
<td>30</td>
<td>6.7</td>
</tr>
<tr>
<td>Bay of Plenty (BoPDHB)</td>
<td>Cancer Care Patients</td>
<td>9</td>
<td>11.7</td>
</tr>
<tr>
<td></td>
<td>Palliative Care Patients</td>
<td>14</td>
<td>16.1</td>
</tr>
<tr>
<td></td>
<td>Both</td>
<td>134</td>
<td>30.1</td>
</tr>
</tbody>
</table>

The clinical areas where the nurses cared for the cancer and palliative care patients covered a broad spectrum, shown in Table 5.5.

<table>
<thead>
<tr>
<th>Clinical areas</th>
<th>Cancer patients</th>
<th>Palliative care patients</th>
<th>Both cancer and palliative care patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist cancer</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Specialist and general cancer</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist surgery</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>General surgery</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Gynaecology / women’s health</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Adult ICU</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Paediatric ICU</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Specialist medical</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>General medicine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Specialist medical and palliative care</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Specialist day centres</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Specialist palliative care units</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community settings including general practice</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Aged care units including rest homes and rehabilitation units</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Overall, the length of service for the nurses, when analysed by DHB region, was as follows (see Table 5.6).

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Mean years of service of nurses</th>
<th>Range years of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>12</td>
<td>&lt;1- 35</td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
<td>12</td>
<td>&lt;1- 41</td>
</tr>
<tr>
<td>West Coast DHB</td>
<td>17</td>
<td>&lt;1- 34</td>
</tr>
<tr>
<td>Bay of Plenty DHB</td>
<td>14</td>
<td>&lt;1- 39</td>
</tr>
</tbody>
</table>

The shorter mean length of service for ADHB and CMDHB regions possibly reflects the more rapid turnover over nursing staff that would be expected in these urban settings, when compared to the more rural settings of the Bay of Plenty and West Coast.

The profiles of each nursing workforce presented by the patient group with whom the nurses predominantly worked (Cancer; Palliative Care; or ‘Both’ - Cancer and Palliative Care) are now described. Detailed analysis by DHB is only presented where applicable to minimise the risk of participant identification.

### 5.2 Cancer Nursing Workforce Demographics

The characteristics specific to those nurses working with cancer patients are reported below. The earliest year of registration was 1961, and the most recent was 2006. Over half (60%) had gained their nursing qualification in New Zealand. The remainder had gained their registration overseas including: India, South Africa, UK, Philippines and Fiji. Nurses held a range of registrations including:

- Registered General and Obstetric Nurse (41%)
- Registered Comprehensive Nurse (37%)
- Registered General Nurses (13%) and
- Enrolled Nurses (6%).

A first degree was the highest qualification held by a third of the cancer nurses, and post graduate qualifications were held by a further 14%. Almost half (47%) indicated that they did not possess a graduate or postgraduate qualification.
Most cancer nurses worked within:

- Public hospital acute care sector (58%)
- Private non-acute (17%)
- Private acute hospital setting (16%)
- Community including primary health care (10%)
- Aged care settings including rehabilitation units and rest homes (4%) and
- Voluntary organisations such as the Cancer Society, Maori or Pacific Health providers, and in rural settings (1%).

The nurses worked a range of hours in these settings, from 5 to 80 hours per week; 40% indicated that they worked full-time, while for part-time workers, 24, 32 or 36 hours were the most frequently worked each week.

The cancer nurses had a range of years of experience; from 5 years or less (30%) to greater than 20 years (20%). The longest period of time providing cancer care was 36 years. For just under half, they had only had one previous post in cancer or palliative care, while for others, two or three previous posts was the norm. Just over a third indicated that their current post was their first in cancer services provision. Almost all the respondents belonged to the New Zealand Nurses Organisation (98%); College of Nurses Aotearoa (NZ) membership was minimal and four had links with other specialist organisations or groups such as the Breast Care Nurse Specialist group.

The cancer nurses’ ages ranged from 21 to 65 years, with a mean of 45 years and a mode of 46 years. They identified themselves predominantly as NZ European (64%), with Indian (11%), Other European (6%) and Asian (6%) being the next most commonly cited ethnicities. Only one nurse identified herself as Maori.

5.3 DHB Palliative Care Nursing Workforce Demographics

Nurses working in hospital palliative care teams in New Zealand are, in the main, employed as Clinical Nurse Specialists (the exception is in Canterbury where they are called Clinical Nurse Consultants). These nurses make up a component of the nursing workforce that delivers what is referred to as “specialist palliative care” (Definitions of Palliative Care in NZ, 2006) which is in
addition to those nurses working in hospice palliative care services (see Hospice NZ nursing data).

Just as for the group that affiliated itself to cancer nursing predominantly, those participating in this survey who indicated that they work primarily with patients requiring palliative care service tended to be mainly Registered Nurses, with just two nurses in this group indicated that they were Enrolled Nurses. The earliest year of registration was 1960, and the most recent was 2007; similar again to the cancer nursing workforce. Slightly more palliative care than cancer nurses (69% compared with 60%) had gained this first qualification in New Zealand, whilst the UK accounted for a further 19%.

Nurses were registered as:
- Registered Comprehensive Nurse (44%)
- Registered General and Obstetric Nurse (37%)
- Registered General Nurses (18%).

Nationally, a total of 25 (23.6FTE) nurses are working in nine hospital palliative care teams across the country. One service works across the tertiary primary interface while all others provide a consultative service within the acute hospital setting only. 22 of the 25 nurses have a post graduate qualification in palliative care. These qualifications range from a post graduate certificate, diploma or Masters Degree. One nurse has a PhD. Within this survey, almost three quarters of this group indicated that they held a graduate qualification or higher (70%), with a first degree held by 46% of the palliative care nurses. Post graduate qualifications were held by a further 23%. The numbers not possessing a tertiary qualification of this nature were lower than for the cancer workforce (30%).

Settings in which the nurses worked with palliative care patients and families were:
- Public hospital acute care facilities (45%) and a further 2% in the public non acute settings
- 27% in the various aged care facilities
- 25% in the hospice community services
- 12% in the hospice in-patient setting and
- 8% in private non acute services.
The palliative care nurses appeared to have slightly more years of experience in this field of practice, when compared with their cancer nursing colleagues; with 60% having at least 10 years experience (for cancer nurses this figure was 47%). The range however was similar, being from one to 31 years. Slightly fewer stated that this was their first position (29%), although the majority had between one and three previous posts in palliative care. Compared with cancer nurses, slightly fewer nurses belonged to the New Zealand Nurses Organisation (82%). Membership in the College of Nurses Aotearoa (NZ) was low (6%), while 18% had links with other specialist organisations such as Hospice NZ, and Palliative Care Nurses Forum (NZ) as well as groups such as the District Nurses Palliative Care group.

The range of hours worked was from eight to 56 hours per week; slightly fewer worked 40 hours or full-time (33%), while 60% worked 36 hours each week or less, with 24 hours being the next most commonly worked.

The ages of this group ranged from 21 to 68 years, with a mean of 44 years and a mode of 46 years. They, too, identified themselves predominantly as NZ European (58%), with more ‘other Europeans’ than in the cancer nursing workforce (18%). There were slightly more Maori nurses in this group (7%) when compared with the cancer workforce.

5.4 Nursing Workforce Demographics for those Working in both Palliative Care and Cancer

A third sub-group was identified in this nursing population; those that indicated they cared for both cancer and palliative care patients. This was a much larger group (n = 454). Once again, the earliest year of registration was 1961, and the most recent was 2007. Three quarters had first registered in New Zealand, whilst the UK accounted for a further 9%. Like the previous groups, this sector of the cancer and palliative care nursing workforce tended to be:

- Registered Comprehensive Nurse (44%)
- Registered General and Obstetric Nurse (37%)
- Registered General Nurses (11%)
- Enrolled Nurses (8%).
With regard to tertiary education, 34% indicated that they held a first degree, whilst 20% had gained post graduate qualifications. The numbers not possessing a tertiary qualification of this nature accounted for a further 45%.

The nurses who indicated that they cared for both cancer and palliative care patients worked in a similar range of settings:

- Acute public hospital setting (65%)
- Aged care settings including rest homes (27%)
- Private non-acute sector (8%)
- Hospice in-patient and community settings (4%)
- Community settings (3%)
- Maori, Pacific and rural health provider organisations (1%).

The range of years of experience was from one to 42, with at least half having more than 10 years experience in this field of practice. For most, they had between two and four previous positions in this area of practice; just 28% indicated that this was their first. The length of time in this current position ranged from one to 40 years, with 55% being in the post for four years or less. The breakdown of membership to professional organisations was similar to the other groups, with links also to other specialist organisations such as Hospice NZ or local hospice groups, the Palliative Care Nurses Forum (NZ), regional cancer or palliative care forums, the District Nurses Palliative Care group and internationally based organisations such as the UK’s Royal College of Nursing’s cancer and palliative care groups.

The range of hours worked was from one to 72 hours per week, and almost half (48%) worked full-time in the role; a further 24% worked between 32 and 39 hours each week.

The ages of this group ranged from 21 to 66 years, with a mean of 44 years and a mode of 53 years. They identified themselves predominantly as NZ European (65%), with a further 8% identifying as ‘other European’. Maori accounted for 4% of this group, with a similar percent identifying themselves as Pacific Island peoples.

Tables 5.7, 5.8 and 5.9 summarise the qualifications, years of experience and hours of work of nurses, and demographics of each group of nurses.
### Table 5.7 Educational characteristics of nurses in each group and professional affiliations

<table>
<thead>
<tr>
<th>Registration and qualifications</th>
<th>Cancer</th>
<th>Palliative care</th>
<th>Both cancer and palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCompN</td>
<td>37%</td>
<td>44%</td>
<td>44%</td>
</tr>
<tr>
<td>RGON</td>
<td>41%</td>
<td>37%</td>
<td>37%</td>
</tr>
<tr>
<td>RGN</td>
<td>13%</td>
<td>18%</td>
<td>11%</td>
</tr>
<tr>
<td>EN</td>
<td>6%</td>
<td>&lt;0.5%</td>
<td>8%</td>
</tr>
<tr>
<td>Bachelors degree</td>
<td>33%</td>
<td>46%</td>
<td>34%</td>
</tr>
<tr>
<td>Graduate</td>
<td>39%</td>
<td>70%</td>
<td>35%</td>
</tr>
<tr>
<td>Postgraduate</td>
<td>14%</td>
<td>23%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Professional affiliations

<table>
<thead>
<tr>
<th></th>
<th>Cancer</th>
<th>Palliative care</th>
<th>Both cancer and palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZNO</td>
<td>98%</td>
<td>82%</td>
<td>85%</td>
</tr>
<tr>
<td>CNA (NZ)</td>
<td>1%</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Specialist groups</td>
<td>7%</td>
<td>18%</td>
<td>11%</td>
</tr>
</tbody>
</table>

### Table 5.8 Experience and hours of work of nurses in each group and professional affiliations

<table>
<thead>
<tr>
<th>Years experience in specialty</th>
<th>Cancer</th>
<th>Palliative care</th>
<th>Both cancer and palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 or less</td>
<td>30%</td>
<td>25%</td>
<td>24%</td>
</tr>
<tr>
<td>6-10</td>
<td>17%</td>
<td>35%</td>
<td>23%</td>
</tr>
<tr>
<td>At least 10 years</td>
<td>47%</td>
<td>60%</td>
<td>47%</td>
</tr>
<tr>
<td>&gt;20 years</td>
<td>20%</td>
<td>6%</td>
<td>16%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hours work p.w.</th>
<th>Cancer</th>
<th>Palliative care</th>
<th>Both cancer and palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 hours&gt;</td>
<td>45%</td>
<td>36%</td>
<td>43%</td>
</tr>
<tr>
<td>30-39 hours</td>
<td>29%</td>
<td>28%</td>
<td>36%</td>
</tr>
<tr>
<td>&lt;30 hours/ casual</td>
<td>26%</td>
<td>36%</td>
<td>21%</td>
</tr>
</tbody>
</table>

### Table 5.9 Demographics of nurses in each group and professional affiliations

<table>
<thead>
<tr>
<th></th>
<th>Cancer</th>
<th>Palliative care</th>
<th>Both cancer and palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range (yrs)</td>
<td>21-65</td>
<td>21-68</td>
<td>21-66</td>
</tr>
<tr>
<td>Mean age (yrs)</td>
<td>45</td>
<td>44</td>
<td>53</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Cancer</th>
<th>Palliative care</th>
<th>Both cancer and palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>64%</td>
<td>58%</td>
<td>65%</td>
</tr>
<tr>
<td>Other European</td>
<td>6%</td>
<td>18%</td>
<td>8%</td>
</tr>
<tr>
<td>Maori</td>
<td>1%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Pacific</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Indian</td>
<td>11%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Asian</td>
<td>6%</td>
<td>6%</td>
<td>3%</td>
</tr>
</tbody>
</table>
These characteristics highlight that the three groups are broadly similar in profile, and that in all three groups the nursing workforce is characterised as older, predominantly European, the larger proportion having been educated as nurses in hospital based programmes, and with the exception of palliative care nurses, with an overall low uptake of graduate and especially postgraduate education. Compensating for the low levels of advanced education in the specialties, these nurses are rich in experience in the respective areas.

5.5 Workforce Retention

Workforce retention is a major issue that healthcare providers in New Zealand are currently addressing locally and nationally, and assumes greater importance in the light of the high mean age of the nursing workforce described above, as well as the widely reported nursing shortages. Nurses surveyed were overall positive about their work and work environment, factors that encouraged them to remain in their current role. There was minimal variation noted across the different DHB regions and between the three groups of nurses. The factors rated included:

- Job satisfaction (mean 80% range 75-94%)
- Variety of work (mean 76%; greatest in WCDHB at 85%)
- Working in a supportive environment (mean 74%, range 70-78%).

Flexible working did not feature highly for any of the groups as a factor that has encouraged them to stay in their current role, although several nurses in each of the DHB regions and the groups commented that the job hours do need to accommodate the needs of the nurses, particularly those with families.

Added comments provided by the nurses reflect the enjoyment they generally get from their work and the positive regard that the nurses held for their work, their employers and their colleagues. Comments specific to DHBs included:

- The challenges faced (predominantly by those in the ADHB region)
- The ease of travel to work, and closeness of retirement and the lifestyle issues related to the area (BOPDHB) and
- The pressures that face nurses working in small teams, in geographically isolated areas and the lack of other options open to them (WCDHB).
5.6 Level of Current Practice

The nurses’ current levels of practice were explored in two ways; firstly to capture the nurse’s perceptions about his or her competence level (based on Benner, 1984, and reflected in Nursing Council frameworks (2001, 2005), Ministry of Health (2003) education and career pathway model (2003) and the College of Nursing (2004) documents advising on advanced nursing education) in either palliative or cancer care (see Tables 5.10 and 5.11). (See also Sections 1.2 and 8.2.2 regarding terms and definitions for generalist and specialist nurses.)

Table 5.10 Overall perceived competencies in palliative care

<table>
<thead>
<tr>
<th>Competency description</th>
<th>N</th>
<th>Percent %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginner palliative care nurse</td>
<td>100</td>
<td>17.8</td>
</tr>
<tr>
<td>Competent palliative care nurse</td>
<td>239</td>
<td>42.4</td>
</tr>
<tr>
<td>Proficient palliative care nurse</td>
<td>189</td>
<td>33.6</td>
</tr>
<tr>
<td>Advanced or specialist palliative care nurse</td>
<td>35</td>
<td>6.2</td>
</tr>
</tbody>
</table>

Table 5.11 Overall perceived competencies in cancer nursing

<table>
<thead>
<tr>
<th>Competency description</th>
<th>N</th>
<th>Percent %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginner cancer nurse</td>
<td>113</td>
<td>20.9</td>
</tr>
<tr>
<td>Competent cancer nurse</td>
<td>247</td>
<td>45.6</td>
</tr>
<tr>
<td>Proficient cancer nurse</td>
<td>139</td>
<td>25.7</td>
</tr>
<tr>
<td>Advanced or specialist cancer nurse</td>
<td>42</td>
<td>7.8</td>
</tr>
</tbody>
</table>

Secondly, the descriptions of level of practice that most closely matches the nurse’s actual role were captured (according to the specific activities they undertake) and are presented in Table 5.12).
Table 5.12 Description of current nurse role

<table>
<thead>
<tr>
<th>Current role description</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner with a range of nursing experience (Beginner)</td>
<td>237</td>
<td>39.0</td>
</tr>
<tr>
<td>Experienced practitioner without a post-registration qualification (Competent)</td>
<td>284</td>
<td>46.8</td>
</tr>
<tr>
<td>Experienced practitioner with a post-registration qualification (Proficient)</td>
<td>69</td>
<td>11.4</td>
</tr>
<tr>
<td>A highly experienced practitioner with specialist postgraduate qualification (Advanced)</td>
<td>17</td>
<td>1.2</td>
</tr>
</tbody>
</table>

The survey results showed that nurses rated their competence levels higher than levels expected by actual practice (or what the nurse’s role includes) and levels of specialist post-registration education. The actual roles suggest that, in general, the nurses are not required to hold a specialist qualification and yet many nurses perceive themselves to be working at proficient or advanced nurse levels. The responses were then analysed according to the groups identified earlier (i.e. cancer, palliative care or both cancer and palliative care). This is a key finding of the survey as it highlights a divergence between nurses’ own views and the highly regarded seminal work of Patricia Benner (1984), “From Novice to Expert”, that has influenced the Nursing Council (2005) in its professional development framework and the proposed education and career pathway model for primary health nurses in New Zealand (MoH, 2003, p. 39).

Just over half the nurses providing care predominantly to cancer patients perceived their skills with regard to palliative care provision as mainly in the beginner to competent categories (see Table 5.13; this is very similar to the perceived competency levels of the palliative care nurses and those providing care to both cancer and palliative care patients. However differences did emerge for the proficient competency category, in which a third of the nurses in the two groups indicated that this was their perceived competency level. For advanced or specialist competency, 12.5% of the palliative care group and 5% of the ‘both’ group aligned themselves to this category.
Table 5.13 Cancer Nurses’ Perceived competence level in palliative care

<table>
<thead>
<tr>
<th>Cancer Nurses</th>
<th>N</th>
<th>Percent %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginner palliative care nurse</td>
<td>15</td>
<td>20.8</td>
</tr>
<tr>
<td>Competent palliative care nurse</td>
<td>21</td>
<td>29.2</td>
</tr>
<tr>
<td>Proficient palliative care nurse</td>
<td>16</td>
<td>22.2</td>
</tr>
<tr>
<td>Advanced or specialist palliative</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>care nurse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For palliative care nurses, their perceived competencies in providing cancer care aligned with the competent level in this aspect of care provision, with 6% indicating that they performed at the level of competency of an advanced or specialist cancer nurse (see Table 5.14). Similar perceptions related to competency were noted for the group undertaking care of both palliative and cancer patients.

Table 5.14 Palliative Care Nurses’ Perceived competence level in Cancer Care

<table>
<thead>
<tr>
<th>Palliative Care Nurses</th>
<th>N</th>
<th>Percent %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginner cancer nurse</td>
<td>19</td>
<td>22.9</td>
</tr>
<tr>
<td>Competent cancer nurse</td>
<td>37</td>
<td>44.6</td>
</tr>
<tr>
<td>Proficient cancer nurse</td>
<td>14</td>
<td>16.9</td>
</tr>
<tr>
<td>Advanced or specialist cancer nurse</td>
<td>5</td>
<td>6.0</td>
</tr>
</tbody>
</table>

With regard to their current roles, almost half in each group indicated that they were working at the level of an experienced nurse but without specialist qualifications in the speciality be this cancer or palliative care. Between 9% and 12% of nurses in the three groups did have specialist qualifications however, only one person in the cancer group, seven in the palliative care group and seven in the combined group indicated that they were currently in roles that reflected advanced practice and leadership activities in the relevant areas of practice.
5.7 Formal or Informal Education

It appears that almost all of the nurses in each of the three groups did have informal and formal educational opportunities that have helped to prepare them for their current roles, although they recognised that gaps in their knowledge did exist. Some short courses run by hospices, universities or polytechnics, were also attended, as well as national or international conferences and other professional update events.

In-service education sessions had been attended by many, with just under half indicating that they had attended sessions related to cancer nursing (n = 299), and 51% (n = 323) had attended sessions related to palliative care. Topics covered in the in-service sessions for cancer nurses included breast cancer issues, wound management, chemotherapy, pain control, grief management, symptom control, parental issues, urology cancers, and a range of palliative care topics. Topics of sessions attended by the palliative care nurses included pain control, multidisciplinary care, end of life care, psychological issues, paediatric oncology, symptom management, wound care, Liverpool Care Pathway, counselling for patients and their family, and hospice care. A similar variety of topics were covered in sessions attended by the nurses caring for both groups of patients.

At least a quarter of the nurses in each of the DHB regions were currently engaged in formal postgraduate study (see Table 5.15).

Table 5.15 Current postgraduate study

<table>
<thead>
<tr>
<th>District Health Board</th>
<th>Studying</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>ADHB</td>
<td>Yes</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>74</td>
</tr>
<tr>
<td>CMDHB</td>
<td>Yes</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>73</td>
</tr>
<tr>
<td>WCDHB</td>
<td>Yes</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>71</td>
</tr>
<tr>
<td>BOPDHB</td>
<td>Yes</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>78</td>
</tr>
<tr>
<td>Other</td>
<td>Yes</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>67</td>
</tr>
</tbody>
</table>
Across the three groups (i.e. cancer, palliative care or ‘both’ - cancer and palliative care), there was some variation but the differences were small. There were fewer cancer nurses (by percentage) currently studying when compared with the other two groups (14% vs. 30% and 27% respectively). However, this study was not always in the specialty field as illustrated on Table 5.16 below. Subjects and programmes that were currently being studied included the following.

### Table 5.16 Subjects of current postgraduate study

<table>
<thead>
<tr>
<th>Specialty area</th>
<th>Cancer</th>
<th>Palliative care</th>
<th>Both cancer and palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td>Breast cancer</td>
<td>PG cert. Palliative Care</td>
<td>PG cert. Cancer nursing</td>
</tr>
<tr>
<td>Mastectomy</td>
<td>PG Cert. Cancer Nursing</td>
<td>Graduate cert. Palliative Care</td>
<td>PG cert. Palliative Care</td>
</tr>
<tr>
<td>PG Cert. Cancer Nursing</td>
<td>Psychosocial issues in Palliative care</td>
<td>PG cert. Oncology</td>
<td>Advanced breast care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>End of life care</td>
<td></td>
</tr>
<tr>
<td>General-relevant clinical</td>
<td>Intensive care</td>
<td>Cardiac nursing</td>
<td>PG cert. Health Science</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intensive care</td>
<td>PG Cert. Maori Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child health</td>
<td>Pharmacology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacology</td>
<td>Community Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacology</td>
<td>Paediatric care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacology</td>
<td>Sexual Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacology</td>
<td>Stomal Therapy Nursing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacology</td>
<td>Primary Care – Chronic care management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacology</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacology</td>
<td>Respiratory care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacology</td>
<td>Technician Specialists in Sleep</td>
</tr>
<tr>
<td>General-other</td>
<td></td>
<td>Health care management</td>
<td>PG cert. Clinical Teaching</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PG Dip. Health management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rural Health</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>Bachelors degrees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Masters degrees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Doctoral study</td>
</tr>
</tbody>
</table>

Between 50% and 64% of the three groups of nurses indicated that they did intend to take part in further study related to cancer or palliative care nursing, with a further third indicating that further study was a possibility for the future. These intentions are set out in Table 5.17.

### Table 5.17 Intention to undertake further education by patient-related group

<table>
<thead>
<tr>
<th>Patient-related group</th>
<th>Response</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Yes</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>34</td>
</tr>
<tr>
<td>Palliative care</td>
<td>Yes</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>32</td>
</tr>
<tr>
<td>Both – Cancer and Palliative care</td>
<td>Yes</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>30</td>
</tr>
</tbody>
</table>
When analysed by DHB region, West Coast nurses expressed a slightly greater wish to engage in further education but the differences were small (see Table 5.18).

**Table 5.18 Intention to undertake further education in relation to cancer or palliative care**

<table>
<thead>
<tr>
<th>DHB region</th>
<th>Response</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB</td>
<td>Yes</td>
<td>57%</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>35%</td>
</tr>
<tr>
<td>CMDHB</td>
<td>Yes</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>30%</td>
</tr>
<tr>
<td>WCDHB</td>
<td>Yes</td>
<td>73%</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>24%</td>
</tr>
<tr>
<td>BOPDHB</td>
<td>Yes</td>
<td>69%</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>24%</td>
</tr>
<tr>
<td>Other</td>
<td>Yes</td>
<td>61%</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>28%</td>
</tr>
</tbody>
</table>

However, a number of key factors were identified that the nurses saw as major barriers to study (see Table 5.19).

**Table 5.19 Overall barriers to further study**

<table>
<thead>
<tr>
<th>Barriers to further study</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient funding</td>
<td>226</td>
<td>35%</td>
</tr>
<tr>
<td>Release from clinical duties</td>
<td>238</td>
<td>37%</td>
</tr>
<tr>
<td>Personal/family issues</td>
<td>231</td>
<td>35.5%</td>
</tr>
<tr>
<td>Lack of time</td>
<td>287</td>
<td>44%</td>
</tr>
</tbody>
</table>

Lack of relevant courses was not perceived to be a major barrier to most of the nurses who responded to this survey, with only 18% of the cancer nurses, and 30% of the palliative care and ‘both’ groups indicating that it was a problem. Some regional differences did emerge in that 33% of the Bay of Plenty nurses expressed concern that for them, lack of available courses was a barrier; an issue revisited during focus group interviews. Similarly, distance to travel due to geographical isolation was not a barrier for most, although West Coast nurses in particular, (67%), identified this as a factor that had a significant impact on their education. Overall 25% of the nurses identified this as a big or the biggest barrier.
Lack of time, however, was rated as the biggest barrier to further study by almost half of the respondents and it was deemed to be a big problem for about three quarters of the nurses in each of the groups. The cancer group saw lack of time as a slightly bigger problem when compared with the other groups of nurses.

The palliative care nurses identified insufficient funding as an issue for them (40%), whilst the cancer and ‘both’ (cancer and palliative care) groups found that barriers were related to release from clinical duties. Since 2006, changes to the Clinical Training Agency funding (CTA) has assisted with the costs of postgraduate education through devolving funding to DHBs to allocate. According to nurses surveyed those working in NGOs have not had the same level of access to this funding, and so funding has remained a barrier for them. It appears that this experience is a reflection of the recency of CTA funding devolution and associated inexperience of both NGOs and DHBs; whether or not this remains a barrier in the longer term will be dependent upon NGOs lobbying the DHBs to gain access to this funding.

Lack of confidence, difficulties with computer access, organisational support, and lack of mentoring did not appear to be barriers affecting this sector of the workforce. In general, attitudes to further study were positive and there was a high level of agreement that education is essential to support advanced clinical practice and to advance a nursing career, and that experiential learning alone is not sufficient for meeting the needs of today’s patients.

A range of topics for further education were identified in the literature, and the responses from this survey supported these. Asked to rank subjects according to level of importance, the main topics of highest and lower importance for further study are listed in Tables 5.20 and 5.21.
### Table 5.20 Areas of highest importance for further study

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Cancer nurses %</th>
<th>Palliative Care Nurses %</th>
<th>Cancer and Palliative Care Nurses %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer/palliative care updates</td>
<td>92</td>
<td>94</td>
<td>96</td>
</tr>
<tr>
<td>Drug therapies</td>
<td>91</td>
<td>89</td>
<td>94</td>
</tr>
<tr>
<td>Symptom management</td>
<td>86</td>
<td>91</td>
<td>92</td>
</tr>
<tr>
<td>Understanding cancer as a disease</td>
<td>88</td>
<td>83</td>
<td>86</td>
</tr>
<tr>
<td>Cancer pathophysiology</td>
<td>87</td>
<td>82</td>
<td>87</td>
</tr>
<tr>
<td>Community resources</td>
<td>80</td>
<td>85</td>
<td>76</td>
</tr>
<tr>
<td>Cancer treatments</td>
<td>88</td>
<td>89</td>
<td>92</td>
</tr>
<tr>
<td>Pain control</td>
<td>78</td>
<td>91</td>
<td>88</td>
</tr>
<tr>
<td>Ethical issues</td>
<td>80</td>
<td>88</td>
<td>87</td>
</tr>
<tr>
<td>Psychosocial issues</td>
<td>89</td>
<td>78</td>
<td>86</td>
</tr>
<tr>
<td>Pain assessment</td>
<td>86</td>
<td>81</td>
<td>81</td>
</tr>
<tr>
<td>Complementary/alternative therapies</td>
<td>82</td>
<td>85</td>
<td>88</td>
</tr>
<tr>
<td>Evidence based practice</td>
<td>85</td>
<td>84</td>
<td>89</td>
</tr>
</tbody>
</table>

### Table 5.21 Areas of lower importance for further study

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Cancer nurses %</th>
<th>Palliative Care Nurses %</th>
<th>Cancer and Palliative Care Nurses %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss/grief</td>
<td>77</td>
<td>79</td>
<td>82</td>
</tr>
<tr>
<td>Communication skills</td>
<td>75</td>
<td>72</td>
<td>66</td>
</tr>
<tr>
<td>Needs of Maori</td>
<td>65</td>
<td>72</td>
<td>74</td>
</tr>
<tr>
<td>Needs of Pacific people</td>
<td>70</td>
<td>81</td>
<td>76</td>
</tr>
<tr>
<td>Needs of Asian people</td>
<td>72</td>
<td>81</td>
<td>75</td>
</tr>
</tbody>
</table>
These results show little difference between the three groups in identified subjects; an interesting finding in the light of differences in the patient populations and their care needs.

When asked to identify topics not listed, differences across the three groups emerged:

**Cancer nurses:**
- Care of PICC lines
- Counselling
- Impact of late effects of treatment for survivors of childhood cancer.
- Management of metastases
- Clinical treatments including tracheostomy tube management, and chemotherapy.

**Palliative Care nurses:**
- Assessment tools for palliative care including Liverpool Care Pathway
- Multidisciplinary care
- Access to evidence
- Nutritional needs
- Clinical assessment skills
- Needs of non-cancer palliative care patients.

**Cancer and Palliative Care nurses:**
- Specific support issues for patients and families
- Counselling
- Hospice care
- Disease specific cancer care
- Handling difficult situations
- New technologies
- Technological practicalities
- Management within generalist setting
- Meeting needs of patients and families in the home.
5.8 Care Delivery

In relation to the more practical aspects of care delivery, questions were asked in order to generate a typology of the services provided, confidence levels in undertaking these activities and workload issues.

The number of patients cared for in an average day ranged, for the majority, between one and four adult or paediatric patients. The nurses caring for children tended to have fewer allocated to them on a daily basis when compared with adults (50% cared for one of two children).

The care that the nurses deliver to their patients has been categorised as clinical, communication and evidence-based practice, and results are reported in order of frequency (see Tables 5.22-5.24).

Table 5.22 Clinical activities

<table>
<thead>
<tr>
<th>Clinical Activity</th>
<th>Carry out confidently /independently (%)</th>
<th>Carry out with supervision /support (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing basic nursing care</td>
<td>97</td>
<td>3</td>
</tr>
<tr>
<td>Taking a new patient's history</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>Collecting specimens</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>Pain assessment</td>
<td>87</td>
<td>13</td>
</tr>
<tr>
<td>Assess needs for symptom control</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>Planning short term and longer term care</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>Pain management</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>Administering chemotherapy</td>
<td>41</td>
<td>59</td>
</tr>
</tbody>
</table>
### Table 5.23 Communication/education activities

<table>
<thead>
<tr>
<th>Communication Activity</th>
<th>Carry out confidently /independently (%)</th>
<th>Carry out with supervision /support (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responding to non-verbal abuse</td>
<td>91</td>
<td>9</td>
</tr>
<tr>
<td>Communicating with family/whanau</td>
<td>88</td>
<td>12</td>
</tr>
<tr>
<td>Liaising with other health providers</td>
<td>83</td>
<td>17</td>
</tr>
<tr>
<td>Providing information and education</td>
<td>78</td>
<td>22</td>
</tr>
<tr>
<td>Providing culturally appropriate care</td>
<td>78</td>
<td>22</td>
</tr>
<tr>
<td>Multidisciplinary team collaboration</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>Responding to emergencies</td>
<td>70</td>
<td>30</td>
</tr>
<tr>
<td>Discussing significant news</td>
<td>66</td>
<td>34</td>
</tr>
<tr>
<td>Handling difficult situations</td>
<td>66</td>
<td>34</td>
</tr>
<tr>
<td>Preparing family/whanau for bereavement and loss</td>
<td>60</td>
<td>40</td>
</tr>
</tbody>
</table>

### Table 5.24 Evidence-based practice/research activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Carry out confidently /independently (%)</th>
<th>Carry out with supervision /support (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using evidence based assessment tools</td>
<td>80</td>
<td>20</td>
</tr>
<tr>
<td>Enabling access to information and support</td>
<td>77</td>
<td>23</td>
</tr>
<tr>
<td>Reflection on and evaluation of practice</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>Facilitating integration of resources</td>
<td>65</td>
<td>35</td>
</tr>
<tr>
<td>Identifying and accessing sources of evidence</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>Participating in research</td>
<td>53</td>
<td>47</td>
</tr>
</tbody>
</table>

These results suggest that nurses were most confident in practising generic nursing skills, and less confident in those activities where specialised skills were needed in working with patients with cancer and palliative care needs. This is an important finding as first, the greater proportions of the nurses rated themselves as at least competent, and second, the overall levels of advanced qualification in the specialty were low. In addition, the activities appear to align the subject areas where there were demands for further education. Confidence tended to be greater in the clinical activity area, with the exception of administration of chemotherapy agents. However, evidence-based practice activities of research and standard development stood out as activities where the nurses felt less confident to do them independently.
Results have been reported for all participants as a whole as minor differences only between the three nursing groups emerged. The differences were that the palliative care nurses felt slightly less confident than their colleagues in the other groups in the areas of administering chemotherapy, and liaising with other groups of healthcare providers. However they appeared to be more confident in relation to communication issues and cultural aspects of care, particularly the multidisciplinary team collaboration, responding to non-verbal abuse and discussing significant news.

**5.9 Visiting Patients in Their Own Homes**

Despite finding that most of the nurses working in public hospital settings, care delivery for both palliative and cancer services is changing in response to the changing needs of the population. Therefore it was important to determine the extent to which services were being delivered in homes and in settings other than the acute care setting. A number of nurses indicated that they did visit patients in their own homes to provide care and meet needs. Those in the West Coast appear to provide a greater level of homecare than elsewhere, although other regions also offered this service - see Table 5.25.

<table>
<thead>
<tr>
<th>Table 5.25 Visit patients in their own homes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DHB region</strong></td>
</tr>
<tr>
<td>ADHB</td>
</tr>
<tr>
<td>CMDHB</td>
</tr>
<tr>
<td>WCDHB</td>
</tr>
<tr>
<td>BOPDHB</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

Overall, 33% of the palliative care nurses visited people to provide care in their home environment, compared with 9% of the cancer nurses and 17% of palliative and cancer nurses. Interventions carried out in the home included: dressings and other aspects of nursing care, needs assessments, symptom control, administration of medications or advice related to medications, provision of education and information, follow up of care following discharge from hospital or hospice, and coordination of care.

Other reasons for home visits included post bereavement support and follow-up, liaison with other services, psychosocial support for the patient and family/whanau, and multidisciplinary...
team-working especially those from the hospice. On-call services are also offered by some palliative care and cancer teams in which nurses go out to people in their homes when required.

5.10 Correlation Analysis

Correlation analysis was undertaken to identify any relationships between the following variables:

- Clinical roles and length of service
- Length of service and education
- Clinical roles and education
- Clinical roles and limitations on training/education.

There was no significant correlation found between clinical roles and length of service; clinical roles and limitations on educational opportunities; and clinical roles and highest education level.

The only significant correlation was found between length of service and education (see Table 5.26).

<table>
<thead>
<tr>
<th>Highest educational qualification and length of service</th>
<th>Spearman's rho correlation</th>
<th>Sig. (2-tailed)</th>
<th>N =</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest educational qualification and length of service</td>
<td>0.260)</td>
<td>0.01</td>
<td>369</td>
</tr>
</tbody>
</table>

5.11 Summary

Surveys were completed by 649 nurses working in four district health board regions, including the DHBs themselves and NGOs with contracts with the DHBs. In spite of a disappointingly low response rate (some 3,500 survey packs were distributed) the results allow us to describe the nursing workforce and their educational needs. The cancer and palliative care nursing workforce is characterised as older, predominantly European, and the larger proportion having been educated as nurses in hospital based programmes. Less than half worked full-time. With the exception of palliative care nurses, they reported an overall low uptake of graduate and
especially postgraduate education. Compensating for the low levels of advanced education in the specialties, these nurses are rich in experience in the respective areas, many reporting very long periods of service in the specialty.

A key finding was that less than 20% overall described themselves as ‘beginner’ nurses; a high 44% described themselves as ‘competent’ (i.e. experienced practitioner without specialist qualifications), nearly 30% as ‘proficient’ (i.e. experienced practitioner with specialist qualifications) and 7% as ‘advanced’ (highly competent) practitioners. Yet only 19% of all participants reported they held a postgraduate qualification, the remainder with post-registration qualifications had graduate qualifications. For many of the nurses it was informal education that had prepared them for the role including in-house sessions and short (not-for-credit) courses. At the same time about a quarter of participants said they were currently studying for a postgraduate qualification.

A closer examination of subjects revealed that while some study was in the specialty area, others were not, reflecting general clinical nursing subjects and non-clinical study such as in management. Nurses’ rating of their ability to carry out specified clinical and psychosocial activities independently and competently reflected the rather patchy pattern of advanced education. Paradoxically, in spite of nurses’ extensive experience and high ratings of their competence and proficiency, it was the specialised activities they felt less confident in performing, and were more confident in generic nursing activities.

Finally, between 50% and 64% of nurses in the three groups indicated that they intended to engage in further study in cancer or palliative care nursing in the future, and a further third indicated they may do so. Barriers to such study were identified, with the main barriers affecting all nurses being release from clinical duties to participate in education (not covered by current funding), and nurses’ lack of time (noting the multiple responsibilities including family responsibilities of the largely female, mid-aged workforce). Lack of available, relevant courses was not a major barrier, and nor was funding now that CTA funding is administered by DHBs. However there were differences across the specific groups and regions: available courses, access and travel were greater barriers for nurses away from main population centres; cost was also greater when nurses had to travel; differential access to funding by DHB and NGO employees, and; differences in course availability in cancer and palliative care.
6. District Health Board Case Studies – Interviews

Supplementing the results derived from the survey of nurses providing day to day care to patients, a series of approximately 40 semi-structured interviews, many of which were conducted face-to-face with key individuals or groups in the DHBs, generated further data on nursing workforce development and education. In contrast with the nurses providing day to day care, the interviews were conducted with nurses working as educators, specialists, charge nurses, and community providers such as district nurses and hospice nurses in palliative or cancer care from each of the DHB regions. The topics discussed in the interviews were informed by the survey results, educational issues identified in the literature and other issues related to the provision of cancer and palliative care. The interviews were tape recorded and the key points arising from them identified, collated and analysed qualitatively. Pertinent comments were captured verbatim. Findings from the interviews are reported thematically.

6.1 Cancer and Palliative Care Service Delivery

6.1.1 Reactive vs. Proactive

Interview participants commented on the delivery of care and the perceived the nature of their work as reactionary rather than proactive. Reasons given for this included lack of time, increasing acuity of the patients and having increased case loads. The perceived low levels of administrative support and the support of social workers and psychologists on teams delivering cancer and palliative care, whether generalist or specialist, were commented on as being factors influencing the workforce. There was also a belief that nurses are too busy focusing on immediate daily tasks to be able to engage in non-contact, proactive activities, as in the following comment:

“Nurses are barriers themselves to commit to time.”

Interviewees indicated that there was a need for improved person-centred care that was documented clearly through care plans. Where care plans did exist, most indicated that these were not individual patient focused; rather they focused on the general needs of most patients.
In the non-acute settings, the interviewees believed that improvements could be made in palliative care delivery in residential facilities for the elderly, and gaps were identified in the continuum between acute and residential palliative care provision.

6.1.2 Models of Care

Associated with the last point made, comments from the interviewees supported the findings from the survey that the current workforce for both cancer and palliative care still tends to be acute care focused. They felt that the care was generally underdeveloped in community settings and that more financial support was needed to support the development of more roles to meet the needs of the population. These included greater use of nurse-led mobile units to meet the needs of people and their family/whanau in the rural areas. The shortages of medical staff in these areas were recognised and a number of nurses commented that more nurses would help to ease the burdens associated with the doctor shortages.

The current prevalence of a predominantly biomedical model was seen as a negative issue that contributed to the call for change. There was also a call for greater use of care pathways to guide care for cancer and palliative care patients. Associated with the above comments around the episodic nature of care delivery was the concern that there was no obvious continuum of care in some areas and that care pathways might be one way of addressing this problem.

6.1.3 Service Development

Linked to this were discussions around models of care delivery and the need for developing and implementing new ways of working. Interviewees identified consumer and family support deficits in all of the DHB regions and were concerned about the episodic nature of care for cancer patients. They felt that, in their experience, there were low levels of awareness that cancer is a chronic illness and so work is needed to improve that knowledge and provide ongoing support, especially by the community services, since this is needed by many patients, family and whanau.

There was an expressed need for a 24 hour palliative care service in the community but then others commented on the feasibility of maintaining such a service, especially in areas that are already overstretched.
6.1.4 Workforce Issues

A related issue raised was that of the ‘navigator’ role of the nurse in cancer and palliative services; there were positive comments related to this role being a way of improving service delivery and awareness of services particularly within the community and rural settings across New Zealand.

Discussions around the generalist or specialist role for nurses led to consensus that there was a need to better value the generalist nurse’s contributions to cancer and palliative care far more. However, when asked about the impact of the growing demand for cancer and palliative care services on the current workforce, many felt that generalist nurses were not coping, and that leadership was lacking in some areas. There was a reported high turnover of staff and some had experienced pressures being imposed by managers to provide more advanced care than the nurses felt they could safely deliver. The lack of succession planning in clinical areas was highlighted as a potential problem to care delivery in the future. There was also a call for greater regional collaboration when another DHB is the provider of the specialist care to assist practitioners. Some felt that they did not know what care was being provided to people who they were also caring for; this was strongly expressed in the more rural areas. Concerns were expressed that regional provision can deskill other areas.

In the DHBs that were experiencing employment of high numbers of overseas trained nurses, there was an identified need for focused education around the needs of Maori and Pacific peoples. This issue is significant for its variability across the four sites. Clearly the nurses from some of the DHB areas felt this was a greater problem for them than in other parts of the country. An example was given by a nurse in one of the DHBs that has “massive workforce diversity”, with approximately 180 different languages spoken by staff alone. Most nurses were concerned for the patients whose first language was not English and who have different cultural beliefs about cancer or palliation treatments. The high numbers of refugees and migrants in some DHB regions clearly presented the nurses with challenges when the model of care conflicts with alternative beliefs arising from the person's cultural background.
The low numbers of Maori nurses, especially in the areas that have large Maori populations, such as Bay of Plenty, was a further cause for concern, especially since the survey revealed the predominance of Pakeha nurses in the cancer and palliative care workforce. No suggestions were made around how to resolve this issue.

6.1.5 Skill Mix

Issues around poor skill mix also arose, as well as nurses having a higher than satisfactory workload. There was a call for incentives to improve staff retention as well as a need for positive marketing to attract younger and more junior staff into the specialist fields. An orientation programme for new staff, which had key generic elements, was put forward by several nurses as another approach to improve new staff’s awareness of cancer or palliative care services, both within and external to the DHBs.

There were mixed comments around the role of the enrolled nurse, nurse assistant or healthcare assistant to assist in the care delivery for cancer or palliative care patients.

6.1.6 Issues Specific to Geographically Isolated and Rural Areas

Specific issues that were discussed at length related to geographical isolation especially experienced by nurses the rural and semi rural areas. Concerns were raised around the travel implications related to post-graduate education, and the difficulties faced when trying to access education especially in winter. The private providers in these areas also commented on the funding difficulties that faced them since they could not automatically access CTA funding; which is dependent on the approaches taken by the DHB to include them in their CTA process.

The nurses generally felt that there was a need for greater exploration of ways of getting the courses/papers to the learners in the more rural areas. However, for these to be viable, it would need a large number of staff to be released at one time, which then depletes the workforce in that area. This imposes potentially unacceptable additional costs to the patients and organisations. Alternatives were discussed and a simple message to convey was that educators should consider putting two study days together. Some interviewees felt there was a lack of leadership at times in palliative and cancer care in the rural settings; however, the comments from the survey do not strongly support such views.
6.2 Organisational Support for Education

Comments from a large number of the interviewees focused on a perceived lack of resources for education in cancer and palliative care. Financial resources were now seen to be less problematic than previously due to the CTA funding, but interviewees felt that CTA funding was aimed at the DHBs and not the private providers including hospices, disadvantaging nurses in the latter. However as CTA funding did not cover release time, having study time was becoming increasingly difficult. Generally there was agreement that the overall costs related to education were greater for nurses in geographically disadvantaged regions. Release time appeared to affect the nurses in provincial and rural DHBs more than it did those in metropolitan areas since these tended to be further away from the education venues. The nurses attending post-graduate courses were, by necessity due to distances, away from the workplace for longer and so release costs were higher or the impact on the clinical setting and care delivery was greater. Time away from home also created personal difficulties for some nurses and, consequently, distance learning appeared to have some support. There were concerns, however, around computer literacy among the older workforce and that they might be disadvantaged. Discussions around how education could be delivered took place but there was a lack of consensus on the ideal medium.

The need to have an educated workforce to meet the needs of the increasingly complex patients being cared for in all of the DHB regions was felt to lack management support and that this consequently affected training opportunities for both junior and senior staff. Compounding the difficulties, cancer and palliative care educational needs also competed with the mandatory requirements for maintaining competence and practice.

6.2.1 Advanced Nursing Roles

The need for establishing advanced nursing roles in cancer and palliative care were discussed at length with comments being made about the opportunities for workforce development in these areas around the county. Most felt that these were in the development stage, as in these comments:

“There appeared to be a need to map out the skills required for this role and how to progress along the pathway to this level.”
There was a barrier related to the plethora of titles for advanced nursing roles in New Zealand and confusion surrounding the meaning of these. There are a variety of roles throughout the country and most nurses felt there was still lack of clarity around the criteria for holding these roles; some were set by the DHB, and there was inconsistency around the need to reflect academic qualifications. Given the lack of clarity, barriers to advancing development of such roles included feeling undervalued; lack of education and drive. There was also a feeling that, in the case of paediatrics, opportunities for role development outside existing roles were limited.

Factors favouring role development were identified and included high levels of motivation, the need for greater team-working, organisational support and development, and strong leadership. The need for mentoring or clinical supervision for nurses undertaking advanced roles was also identified.

6.3 Skills Needed for High Quality Care Delivery

The skills needed for high quality care delivery were discussed at length. There was consensus that all nurses needed to have good assessment and communication skills, a solid knowledge base around symptom control, and a high level of understanding around medications, their side effects and modes of actions. Many felt there was a need to promote the development of these skills in the undergraduate nurse education programmes. Communication skills were also singled out as needing to be better taught in undergraduate education and reinforced in post graduate levels. Running through comments was a call for new strategies to increase the amount of cancer and palliative care content in the curricula delivered by the various nursing schools in New Zealand. However, as reported in Chapter 4, nursing academics say the nursing curriculum is already packed and cannot accommodate specialist areas.

The interviewees went on to comment that developing the content of the undergraduate programmes would not address another key issue; that of perceived skill deficits of some of the current cancer and palliative care workforce who have undertaken hospital based initial training. Formal teaching around core skills was advocated and it was proposed that this
should include: psycho-social issues, cell biology, immune system, research, cancer biotherapies, cell biology, management skills, genetics, health promotion, case management, end of life decision making (such as the Liverpool Care Pathway), and counselling skills. One comment that captured the generally held belief was:

“Clinical skills need to be well developed before postgraduate study is undertaken. Nurses need something more than theory to base further study on.”

There was also acceptance that core skills needed to be clarified for specialist nurses. These, it was proposed, should include advanced communication skills, a deeper understanding of individual care options, the ability of confidently promoting care of self and other staff, well developed teaching skills and the ability to role-model advocacy practices. In addition, specialist nurses needed to be able to deliver bereavement workshops, have advanced debriefing skills to assist families and staff, as well as a clear ability to engage in reflection and other self-awareness activities. They should also have sound knowledge of other key providers to enhance integration in the non-acute care settings and to undertake the navigator role. One nurse said:

“We need to improve engaging with patients and their stories. You can’t learn this from books.”

The Nurse Practitioner role was discussed, and the absence of such roles in cancer care highlighted. There was consensus that numbers of nurse practitioners need to increase. Such nurses can play a vital part in enhancing patient health and well being, due to increasing treatment options and surveillance interventions. Greater use of their advanced assessment skills, diagnostic reasoning, and implementation of care plans, symptom control is needed. Concerns were raised that fears and challenges of postgraduate study may deter some otherwise suitable nurses.

### 6.4 Other Issues

A range of other educational issues were discussed or raised by the nurses in the interviews. There was a need expressed for educational programmes for caregiver assistants, which would help to increase the capacity in the cancer and palliative care workforce. Associated with this
was a call for further development of skills gained in the NZQA approved paper specifically for the generic skills for palliative care givers.

There was some discussion around the reliance on 700 level courses for up-skilling in some regions, and concerns expressed that these did not lead on to higher postgraduate qualifications as they did not qualify as post-graduate courses. However, it was agreed that these might be useful for some older nurses who are not interested in pursuing post-graduate study to, say, Masters levels.

Interviewees not involved in hospices raised a range of concerns about the ability and skill-levels of hospice nurses that ideally would be more widely available. Hospice nurses generally perceive themselves to be specialist providers developing, or with developed, advanced nursing skills, knowledge and practice that should be utilised more fully.

There was a strongly held view that there is a need to highlight the variety of papers offered already across the country, develop use of other media such as web-based education or increase the use of DVDs for teaching. Given the size of the New Zealand cancer and palliative care workforce, suggestions were put forward that we should increase use of overseas papers, explore national post-graduate certificates such as a National Chemo – Radiotherapy Education Certificate, and explore ways in which specialist knowledge and teaching skills can be taken to the regions.

6.5 Summary

The results of the survey of nurses carrying out day to day care of patients in cancer and palliative care services were complemented and extended by interviews with 40 senior nurses in the four DHBs. These interviews involved clinical nurse educators, clinical nurse specialists, nurse managers and leaders.

The findings of the interviews indicated that service development and models of care have not kept pace with treatment advances for the patient populations, that have transformed cancer from an acute, often terminal, disease to a chronic condition. They felt that services need to shift from being episodic and biomedically based in character, and nursing workforce development to change accordingly. Furthermore, increasingly treatment interventions are now
being carried out by nurses as overall demand for services has grown. Nursing skill levels and nursing team skill mix need to be redesigned to reflect these developments. Advanced educational preparation to meet these identified needs is agreed, but there is less consensus on the levels and modes of delivery of advanced education.

The increasing diversity of the general population, reflected in the greater diversity of patient populations, was identified as an important issue for which nurses needed to be prepared educationally: cross-cultural communication and cultural health-related beliefs and practices were seen as subjects of education. On the other hand, overseas-trained nurses, particularly from non-English speaking backgrounds, need further education to prepare them to meet the needs of Maori and Pacific patients.

Results of the nurses’ survey regarding the importance of clinical release and equitable access to available courses were reinforced in the interviews. Interviewees highlighted the importance of employer and organisational recognition and support for advanced nurse education. The following two chapters explore these issues further through a process of consultation with key stakeholders.
7. Views of Consumers

Three focus group interviews were held with consumers to elicit their thoughts and gain feedback in relation to nurses’ educational needs. Participants who could not attend the focus groups were interviewed individually. The groups involved were:

- Age Concern
- Breast Cancer Network (NZ) Inc
- Child Cancer Foundation
- Health Links
- Prostate Cancer Foundation of New Zealand.

The following is a summary of the key findings arising from these consumers’ perspectives and experience that consumers felt should be incorporated into nurses’ education that emerged from these focus groups. The issues that emerged largely reflect nurses’ professional relationships with clients and their families.

7.1 Partnership

The theme of partnership reflected the importance, to consumers, of working together with nurses. The approach was about ‘us and we’ and being treated as an individual. An example of this was highlighted when a child was re-admitted for another course of chemotherapy and he was an All Blacks fan. In preparation for his admission the nurses had obtained an All Black doll for him.

7.2 Communication

The theme of communication emerged as consumers discussed the importance of nurses in the provision and translation of information. Consumers referred to the amount of information available, partly from the range of health professionals that they come in contact with, but also due to information being available in the media and accessible via the internet. Whilst this alone could be positive, the groups also highlighted how nurses could add to or minimise conflicting information; this links to the organisation of patient information and team working.

Nurses need to have skills in adapting their communication levels to fit the people they are working with, and to be aware of pacing this communication whilst working with patients and...
families so as to act as guides. An example of this was when a community palliative care nurse asked the family if they had talked to their son about dying. The family felt that this nurse approached this conversation at the right time for them and found this particularly valuable. It was acknowledged that nurses can convey attitudes that are helpful, e.g. nurses might be busy but they always made time for you or nurses always seemed busy. Being able to use humour appropriately was also discussed along with the beneficial effects this could have. “During difficult times nurses, by their attitude and communication, could make you feel good about yourself.”

7.3 Generalist/Specialist

This theme reflected specialist areas of practice and wards, and acknowledges the specialist knowledge and skills that nurses had in these areas, which were highly valued by the consumer group participants. This engendered feelings of safety and confidence. Conversely, when patients were cared for in general areas or wards, concerns were expressed about safety and risk of errors arising. The specialist nursing role was cited as important particularly when a patient could contact the nurse for advice and management.

7.4 Organisational Issues

Many patients with cancer, or who are in need of palliative care, are seen by a number of different health professionals during this phase of their life. Nurses with good management skills could facilitate effective team working. When the families experienced high levels of continuity of care by specific nurses, this was found to be beneficial and reduced a problem that consumers identified, which was “the repetition effect”. This caused consumers to repeat their history on a number of occasions, not only to nurses but to other health professionals as well; they felt this was minimised by continuity of nurses caring for them. When this was not possible, they commented on the importance of having processes in place to minimise repetition; for example, having appropriate inter-shift handovers and handing messages over to others.

Nurses’ management skills were also recognised as being important since these create flexible systems to support families/whanau.
Additionally, having knowledge of support organisations and understanding their roles, including how they could support patients and families/whanau were all deemed to be beneficial. An example was the positive effect of being referred to the Cancer Society.

The development of specific roles was identified as being beneficial, especially those that provided psychological support to the patient and families, especially parents of children. The latter group also identified the importance of an educator role that linked with the child’s school and who could prepare teachers and other students prior to the child’s return to school. An example given was the belief by pupils at the school that they could catch cancer from a child who has had a diagnosis of cancer.

Therefore nursing roles were seen as central to helping patients and families/whanau work their way through the complex health system and associated organisations.

### 7.5 Technical Knowledge Needs

Nurses needed to have good assessment skills. Specific examples that consumers identified were knowledge of age and developmental stages for children. For all the groups, being able to assess family dynamics was important. The assessment skills should also reflect specialist knowledge that would be required, possibly related to specific cancers or treatments, for example, sexuality and incontinence assessments for men having surgery for prostate cancer.

### 7.6 Culture

Consumers felt that nurses needed to be particularly skilled in this area and provide culturally competent care to patients and families/whanau across the continuum from diagnosis to end of life care.

### 7.7 Screening

This was seen as a potential area in which nurses, particularly practice nurses, could develop; screening high risk groups for breast, colorectal, prostate and skin were mentioned.
7.8 Summary

A series of focus group interviews were held with consumers to complement nurses’ perspectives with those of individuals and communities they work with. Consumers emphasised the importance of nurses with the specialised skills working with them in partnership. A related theme was the importance of good communication skills, and also reflecting person-centred care was cultural skills. Consumers also reflected on the greater confidence they had in those nurses working in specialised services compared with the general services. Where consumers needed to interface with many services and personnel, nurses’ management and case management skills were valued. While much of what consumers valued in nurses reflected interpersonal and relational skills, technical skills including assessment and screening skills were also raised.
8. Consultation with Key Stakeholder Groups

As part of the study, other key stakeholder groups were consulted as part of this project. Consultation with Directors of Nursing (DONs) (via Nurse Executives New Zealand) was as wide as possible in view of the tight time frame, and they were provided with summary findings of the four DHB case studies as part of the consultation process. Interviews with other nurse leaders in New Zealand with particular involvement in cancer and palliative care, such as clinical managers and educators and one with the Chief Advisor Nursing (Ministry of Health) were conducted. The views of other stakeholders, external to nursing, provided perspectives on particular populations including ethnic minorities and young people. (See Appendix 2 for a list of those consulted). Overall themes from this range of sources have been summarised here.

8.1 Comments on Key Findings of Palliative Care & Cancer Nurse Survey and Related Findings from the Four DHB Cases

Directors of Nursing (DoNs) and other key stakeholders were invited to comment on draft findings from the DHB case studies. General agreement with a number of the findings was expressed, for example that the workforce in the respondent’s DHB would appear to be very similar to those studied, and that key findings seem in line with what is experienced in their institution. DONs commented on the average age of nurses in the specialty areas: average ages of 57, 50 and 45 were given for specific teams of nurses; enrolled nurses were involved in some teams; and the predominant ethnicity of nurses according to several sources as European/NZ.

A number confirmed that barriers to access to education persist in some areas and for some nurses, although CTA funding has overcome the barrier of cost. However, one respondent disagreed that there was insufficient funding for study, and neither was release from clinical duties a barrier unless it pertained to in-service study only. Barriers identified in the survey and confirmed by DONs included:

- Time constraints when undertaking study is a major disincentive, as nurses still pick up the majority of post graduate study in their own time (3 respondents)
- Limited access to computers in the workplace can be limited, especially access to the internet. While Nurse Specialists and other senior nurses have full access, computer
access is an issue for ward nurses at work in some DHBs. Internet connections have been unavailable to new users pending the installation of increased capacity here (3 respondents)

- Lack of confidence is a key aspect in willingness to continue giving chemotherapy, especially as some staff only get to remove a pump and still have to undertake the full certification process (1 respondent)
- Agreement that there is a need to increase the knowledge of the generalist workforce (1 respondent)
- Agreement about drawbacks to working in a small team, although this also has advantages (1 respondent)
- Agreement that nurses need to know a lot more about meeting the needs of Maori, Pacific and Asian people (1 respondent).

DONs also added to the findings, making comments that complemented and expanded on key results. One discussed that service delivery is the priority for DHBs:

“CTA funding is a huge benefit for the nurses, but they and the employing agency are still faced with the problem of backfilling. Although we are very committed to supporting our nurses to undertake tertiary study, and we recognize that this is an important factor influencing our ability to meet our future needs, we have to meet our current patient needs. Release time has to be considered within the constraint of staffing the service.”

There were several comments on the issues to consider in ensuring an appropriate mix of levels and subjects in graduate and postgraduate education for nurses in the specialty subjects:

- A series of 700 level papers could meet many of the educational needs identified and would be more accessible to most staff. PG options are well served already for this workforce’s needs. Need to consider wide range of options across continuum, including levels 700 and 800 plus study to support a workforce with a range of previous study qualifications and workplace needs
- In rural areas, some would like to see cancer considered more as a chronic disease and linked to that field of study than a specialty but would support a specialty branch to an existing paper
• Palliative Care nursing is a growing field expanding to people with chronic illness. This requires considerable workforce development

• PhD study options should be supported as it is there that new nursing work is created in the field. This is also a good option for furthering inter-professional research and collaborative work.

A related consideration was to do with the nursing workforce, especially in provincial areas where advanced specialisation was not characteristics of services and the workforce:

• Need to retain a generalist option for advancement in nursing practice

• There is limited local resource and these nurses often work alone after hours with non-chemotherapy certified Duty Nurse Manager support

• Problems in retaining staff with chemotherapy certification were identified because chemotherapy is seen as such a major responsibility by some staff and confidence related to administration of chemotherapy is low

• Patient volumes for chemotherapy that are episodic and low overall militate against improving confidence

• Many suspect the issue [of nurses’ concern over administering chemotherapy] is more one of confidence and support than competence

• In a long narrow country, minimizing isolation is important, especially to regions in the South Island.

A DoN explained how local characteristics of the nursing workforce and addressing their educational needs needed to be aligned:

“Nurses are often very keen to advance their knowledge, however often family commitments make this difficult. Not all nurses wish to proceed to level 800 education papers. Level 700 education papers with specialty focus assist in building a robust skill base and competency for the nursing staff delivering day to day care. The ten short courses in Cancer Nursing offered by [polytechnic] as part of the Graduate Certificate are fulfilling a valuable need.”

A final observation was a comment on the low response rate to the survey and that the response rate probably affects validity of any findings. Commenting on the low response rate,
particularly from hospices, the CEO of Hospice NZ suggested this as a reason why the report
does not convey palliative care and hospices as strongly as hoped.

8.2 Diversity of Populations

The New Zealand population is increasingly diverse. However, a constant feature is population
ageing, and ageing is related both to the prevalence of cancer and need for palliative care
services. In addition, marked differences in the socio-economic profiles of regions were noted
and this can have implications for affordability of non-DHB services.

The proportion and sizes of the Maori population vary across and within regions. One
respondent observed the alignment of higher Maori populations with higher cancer rates. Even
rural areas reported increasing ethnic diversity of the population including those of Maori and
Pacific persons. In one DHB the health care team is expected to be working alongside Maori
Services, with the protocol covering this is in the process of being developed, and a whanau
support person works alongside clinicians. A Director of Nursing noted that “the nurses’
competence culturally is variable”. Another respondent observed:

“All our nurses demonstrate cultural safety as part of their performance reviews and nursing
competencies. We have also recently appointed an excellent Maori Health Advisor and have
access to a Pacific health worker via Presbyterian Support. Both these support persons are
excellent teachers.”

The Pacific population in New Zealand is a well-established population that includes Pacific
country born and New Zealand born, and population pyramid shows a younger profile than that
the general population and much higher levels of deprivation (Ministry of Health, 2004, p.31f).
According to the Pacific Health Chart Book 2004, lung cancer in adult men across the age
bands is higher, and prostate cancer in +65 year old men, higher than the general population
(Ministry of Health, 2004 p.10). Women have higher cervical cancer mortality in the 45-64 year
age group, and higher breast cancer mortality in all groups (p. 11). However the uptake of
cervical and breast screening services is up to one third lower than for the general population
which could contribute to the high mortality rates (p. 15). Regarding risk factors, Pacific adults
consumed less than the recommended fresh fruit and vegetables (p. 25), higher rates of
obesity (p.28), and males have higher rates of tobacco use (p.30).
Mr Malakai Ofanoa (Pacific Health Section, University of Auckland) commented that working with patients with cancer and palliative care services requires particular skills. Recruiting Pacific nurses into cancer and palliative care services and educating them in the clinical skills is very important. Continuing education of Pacific nurses (who may not be as strongly grounded in Pacific culture as their elders) needs to equip them to attend to the spiritual needs of patients, especially those who are dying, and their families, to support them in the process.

The issue of health promotion and prevention, particularly regarding uptake of screening services, is important to address in education of nurses working with Pacific patients. In view of the taboos surrounding the genitals, cervical screening particularly is most acceptable if carried out by a trusted palangi nurse in preference to a Pacific smear taker or any male professional. Lifestyle and behavioural issues such as use of tobacco and protective patterns related to diet, and obesity reduction, are seen as important inclusions in nurse education.

While it is often preferable that a Pacific nurses works with patients, this is not always possible, and palangi nurses need education in augmenting their skills with an understanding of Pacific values and culture. For example, there is generally an acceptance of cancer treatments, and patients may augment this with techniques such as massage. It is important to patients who are hospitalised to have family presence and support, an issue that nurses need to be aware of. Acceptance of the presence of family, their bringing in food for the patient and the provision of space for them to rest, are all issues to include in nurse education.

Pacific patients approaching death often prefer to be cared for at home. Families and communities, including church communities, provide very good care but may need support, especially concerning technical interventions. Education of nurses providing care at patients’ homes should also include teaching family members in skills where appropriate.

There are also broader services delivery issues to address, such as available support (e.g. Cancer Society, hospice,) and the support available to family care givers. Nurses’ own education therefore needs to include the range of services and support they can refer clients to. As older Pacific persons may have limited English, the availability and use of interpreters and cultural liaison persons are very important, and nurses need to be educated on the risks of
using convenient lay interpreters (family members, cleaners etc) in such sensitive areas. The risks include misinterpretation, loss of trust, disturbed community dynamics.

Larger cities were characterised by large immigrant populations, in particular, diverse Asian ethnicities, with increasing numbers of African ethnicities and non-British Europeans. This provides an ongoing requirement that culturally appropriate services are provided to all members of the community. The Asian populations, in particular, were noted as presenting considerable challenges with language and culture barriers and differences. The Asian Health Services in an urban DHB provide in-house education, accessible to all staff.

The Director of the Centre for Asian Health Research and Evaluation [CAHRE], University of Auckland, Dr Samson Tse, was consulted regarding the present and future needs of the Asian community.

According to the Asian Health Chart Book 2006 (Ministry of Health, p.49f) cancer registrations and mortality are significantly lower among Asians for all age groups compared with the general population, and among Asians “other Asian females” is the highest. Mortality rates increase as duration of residence increases to the 5-9 year band (except for Indian males), but not as duration extends beyond 9 years (p.56). Breast cancer rates are significantly lower than for the general population, with rates among Indians higher than other Asian groups (p. 60), but stomach cancer diagnosis and mortality rates are higher among Chinese females and other Asian males (p. 61). Use of services including screening (cervical screening and mammography, p.74f) is lower among Asian populations compared with the general population, though the differences reduce as duration of residence increased. Tobacco use is lower, particularly among females, than the general population (p.91ff), as are rates of cancer, while the consumption of fresh fruit and vegetables are higher except among the Indian population (p.96ff).

Commenting on the demographic profile of the population based on the census, in addition to the younger adult population there is a rapidly growing population of older adults, many of whom settled in New Zealand through the Family Reunification policy (see Fig.8.1). Chinese, Indian and Filipino are the dominant ethnicities.
One implication for education of nurses working with Asian patients generally is related to the issue of health promotion and prevention, particularly regarding uptake of screening services, and also use of primary care services where clients are known to the clinics. Considering the relationship between duration of residence and reduction of positive differences compared with the general population, there needs to be a focus on behavioural issues such as use of tobacco and protective patterns related to diet and exercise.

In relation to working with patients with cancer and palliative care needs, the view communicated was that nurse education needs to include Asian cultures and world views including: expression of pain and management of pain; the unacceptability of referring explicitly to cancer, death and dying; the value placed on the correct foods (culturally) given to a patient; and the use of alternative treatments to augment Western medical interventions including for what purposes. A key consideration is the sensitivity of the topics and how to deal with these while also ensuring the patient and family are fully informed on aspects of the treatment and care.

However, there are also broader services delivery issues to address, since Asians born overseas may be unfamiliar with available support (e.g. Cancer Society, hospice,) and the
support available to family care givers. Nurses’ own education, therefore, needs to include the range of services and support they can refer clients to. The availability and use of professionally trained (medical) interpreters and cultural liaison persons are very important, and nurses need to be educated on the risks of using convenient lay interpreters (family members, cleaners etc) in such sensitive areas. The risks include misinterpretation, loss of trust, disturbed community dynamics. Preferably the interpreter(s) are included as a key member of the multi-disciplinary team.

In response to the question: Do nursing workforces also reflect diversity?, one DoN commented that many in the general nursing workforce in hospitals, and current palliative care nurses and some cancer nurses themselves are new to New Zealand and reflect culturally diversity, but the diversity among nurses does not reflect that of the population served. In other teams, the current workforce is all European. A South Island DHB reported a predominately female (in some cases entirely female) nursing workforce, mainly of New Zealand European descent, with fewer than 4% Maori and a similar under-representation of Pacific peoples. A provincial North Island DHB observed that it is difficult for nurses to reflect community ethnic patterns when their numbers are so small.

While increasing diversity of nursing workforces is a benefit when working with diverse populations, it presents new challenges with regard to working with Maori. The following requirements and initiatives were identified by respondents:

- All nurse specialists attend cultural awareness sessions
- Nurses are working safely culturally. We are still working towards immersion in total competence of Palliative Care
- All staff have attended Treaty workshops
- The Whanau Liaison person offers in-house and community education
- All nurses demonstrate cultural safety as part of their performance reviews and nursing competencies (a Nursing Council requirement and component of the PDRP)
- The Palliative Care team is expected to demonstrate cultural responsiveness at all times. The Maori Health Team and Community agencies support them when required
- They must all meet the NCNZ’s cultural competencies for competent practice and they are required to attend Treaty of Waitangi training. All have done this.
Population diversity highlights the importance for nurses who are working with patients with palliative care needs to understand the populations and their specific needs, such as those of rural communities, inner city communities, Maori and so on. Thus the changing needs of the population were high on NGOs’ list of priorities and strategic planning including ways of meeting the needs of Maori and Pacific People, especially to complement lack of diversity in other workforces, e.g. DHB cancer and palliative care nursing workforces.

8.2.1 Age-Related Demographic Considerations for Services and Nursing Workforce Development

Population demographic changes also impact on nursing workforces. Remarking on a rapidly growing older population in an area attracting retired persons, one source noted that in the near future nurse numbers and skills will have to increase. In addition, increased treatment options and an ageing population were observed by a DoN to have significantly increased the workload as cancer becomes a ‘chronic illness’, with an associated need to increase nursing levels to meet the projected demand over the next few years.

With the nursing workforce itself ageing, an issue frequently perceived as problematic, one respondent commented that:

“We’ve found that personal and professional maturity is important, whether or not the person has previous palliative care practice experience.”

She went on to caution about recruitment of new graduate and junior nurses “to ensure renewal of the workforce” without at the same time providing funded educational development opportunities.

It was observed that the historical tendency to associate palliative care nursing with cancer nursing must be discarded. Nursing expertise in palliative care is needed in many settings, and is a key part of the Aged Care strategy. While recognising that there is some role overlap, particularly in smaller centres, palliative care nursing services are provided in contexts as varied as intensive care, to patients at home or in rest homes, residential care.

The non-government organisations (NGOs) were all actively involved in activities that enhanced service provision, either within their own organisation or that of the DHB. For
example, CanTeen commented on their support for new adolescent cancer wards and other new role developments. Each NGO has been developed to meet the needs of specific groups within the population. For example, CanTeen staff need to have the specialist knowledge of working with teenagers, family dynamics, high level of communication skills and alert to determine other input e.g. social work. They expressed their concern around the lack of educational provision in New Zealand in relation to care delivery for some of these specific populations, and the need to use overseas programmes.

8.2.2 Services and Service Development

Cancer and palliative care services are delivered by a range of Government (District Health Board) and non-Government (NGO) organisations, and at primary, secondary and tertiary levels. Episodic, continuing care and residential care in institutional and community bases settings are delivered by the above range of providers. Arising from the complexity of service delivery and multiple providers are needs to ensure integration and the appropriate provider is selected.

The use of terms “generalist” and “Specialist” proved controversial. Some stakeholders cautioned against nursing adopting a “medical model” in vocational specialisation, arguing that nursing is essentially generalist in nature, and that the advantages of flexibility in deployment would be lost. The opinion expressed was that palliative care should not be a named specialty, and some redefinition of practice categories by the Nursing Council and Ministry of Health is called for:

“We need to be careful not to follow the medical model of vocational registration because this will restrict the flexibility of the nursing workforce too much.”

Others had a different view, and provided the definitions below (based on the New Zealand Palliative Care definitions). In this perspective, generalist and specialist nursing care needs to be part of an integrated framework of care provision which may be facilitated through local and regional networks, with defined formal linkages to key services including community primary care, local acute hospitals, regional cancer centres and other regional providers. Views on the preferred levels of and access to graduate and postgraduate education also reflected positions on generalist and specialist nursing.
**Generalist Palliative Care Nursing**: refers to palliative care provided for those affected by life limiting illness as an integral part of standard nursing practice by nurses who are not part of a specialist palliative care team. Generalist palliative care in the community is provided by nurses working in general practice teams, Maori health care teams, district nursing teams and aged residential care facilities. It is provided in hospitals by nurses working in general ward environments, as well as disease specific teams such as oncology, respiratory, renal and cardiac teams. These nurses may well be specialists within their particular clinical setting and providing generalist palliative care as part of their practice. They will have defined links with a specialist palliative care team for the purposes of support and advice or in order to refer patients with complex needs. They will also have access to palliative care education to support their practice.

**Specialist Palliative Care Nursing**: is provided by those nurses who have undergone specific training in palliative care, working in the context of an expert interdisciplinary team of palliative care health professionals. They work in hospice or hospital based palliative care teams where patients have access to at least medical and nursing palliative care specialists. Specialist palliative care is provided through services or organisations that work exclusively in palliative care and meet specific palliative care standards as they are developed nationally. Specialist palliative care nursing practice builds on the palliative care provided by generalist palliative care nursing and reflects a higher level of expertise in complex symptom management, psychosocial support, grief and bereavement.

Another respondent agreed on the need to review nursing practice categories, wondering if the current categories used by the Nursing Council had become incoherent over time through a mix of historical decisions. A suggestion is that Nursing Council workforce categories are reviewed and changed to articulate with the Australia-New Zealand Classification of Occupations, as used by Statistics New Zealand and the Department of Labour in their labour surveys. An outcome of such a review would be to better develop career pathways, especially clinical pathways.

The provider organisations interviewed commented on the good links that exist between such provider organisations and that this enhances communication. Each was committed to providing support for carers and for their staff, although they recognised that progress in
relation to supervision or mentoring was slow. They are overall satisfied with the educational opportunities that are available in New Zealand and that the value gained from education is recognised and valued.

In a complex environment with many providers, interests and stakeholders, organisational goals need to be clearly stated and understood so that the appropriate organisation is identified for service provision. For example, the Cancer Society aims to provide cancer but not palliative care support and services and so health professionals need to understand the boundaries of the services offered by different providers.

Implementation by DHBs of Government strategies for cancer control and palliative care, and for health workforces in general, through the development of strategic plans, has helped focus attention on what is required for the region for the future. These developments have brought into focus the adequacy of numbers of nurses and future needs. For example in a rural DHB numbers were identified as low and the need for services to better connect and work together highlighted.

General practice is one context where nurses are involved in caring for patients with cancer and palliative care service needs, but as a group their contribution and educational needs are frequently overlooked. According to a large support organization for primary health organizations, there are no identified nurse specialists or leaders in these specialties. However a particular strength is that all practice nurses would have contact with clients and families with cancer and palliative care needs. Furthermore, historically practice nurses have been a stable workforce, and know the families well, thus likely to be a source of information and support to clients and families. With changes to the primary care sector this is changing: turnover is higher, and there are more younger and inexperienced nurses working as practice nurses. An issue of concern is the highly variable professional relationships in practices affecting autonomy of nurses; some are regarded as ‘handmaids’ and semi-receptionists, while others professionally autonomous in team context. An issue for practice nurses is that they seldom encounter specialists (medical or nursing) in their day to day work, limiting them in advancing their knowledge informally.

Rural DHBs faced particular challenges. There are important differences between urban and regional settings, as between DHBs with tertiary centres and others. In some areas nurse
numbers are low (highlighted by strategic planning), in others adequate. A large DHB serving an urban centre and its rural hinterland with a tertiary cancer centre noted the different levels of therapeutic and diagnostic services for patients in the city compared with rural centres. Palliative care was described as more consistent in level, involving nurses working in interdisciplinary teams with a particular contribution to community based services. However in that DHB nurses working in rural centres still held post-registration qualifications in the specialty field, suggesting that competency was consistent. A respondent observed:

“It can be quite difficult for nursing staff working with cancer and palliative care patients when there are no medical specialists in the district. [Specialists] visit the area only, and although they are as helpful as possible from afar this can cause problems and does not allow the benefits of working within an interdisciplinary team environment on a daily basis for these staff, especially the ability to learn from them.”

In order to build on the knowledge and expertise of the generalists providing palliative care in general settings, a DHB described a specialty multi-disciplinary palliative care service working in a consultancy model. The availability of specialist skills was identified as a particular issue influencing services and workforce development, with support for a model of generalists supported by specialists advocated:

“I am strongly in support of the development of generalist skills and knowledge in providing care and support for the patient with cancer and for the palliative patient. Increasingly the specialist role should be in supporting the generalist in delivering the specialist care.”

Clinical nurse specialist and nurse practitioner roles will potentially help alleviate the lack of support of medical specialists in areas and contexts away from tertiary centres. However, they also have different functions within a team context. Commenting on a range of nurse specialist roles, a DHB noted that all incumbents have tertiary qualifications and are undertaking further tertiary study; they have the potential to be Nurse Practitioners thus supporting further service development. The importance of senior nursing leadership roles to carry forward strategies and ensure a skilled nursing workforce was endorsed, with one person saying that “the sector needs champions to take it forward and the process needs recognition, funding, support and a sector driven approach.”
Unlike in palliative care, a nurse practitioner role for cancer nursing has not yet been developed. Its development could be guided by that of a palliative care nurse practitioner (of which there is only one at the time of writing). It would be a challenge to define the role and associated responsibilities as cancer care is a broader, more complex area of health care than palliative care. Decisions would also need to be made around such questions as where it would be based, whether hospital or community.

Nursing leadership in cancer and palliative care was an area identified as needing development. Cancer nurse leaders do exist but they are often not recognised, nor are they necessarily in touch with one another. Compounding this, there is no forum for leaders to gather to share ideas, seek advice, discuss issues and plan for the future. Rather, they are often only recognised within their more immediate region and teams. The length of time between the opportunities to meet and network means that positions change and people lose touch. It would be useful to have an up-to-date contact list and online forum to help ensure leaders can work together. Development of the role of Lead Cancer Nurse could follow that of the UK cancer network. In this network, the lead cancer nurse is one of the most important positions. It is known for “getting things off the ground”. Regular forums are held to bring the lead cancer nurses together within and between networks. The Ministry of Health in New Zealand should consider including lead cancer nurses in its cancer network. Nurses need to be involved in order to guide directions, role definition and development and educational initiatives. After all, nurses are the biggest part of the workforce in cancer care. Despite this, according to a clinical leader in the cancer network, inclusion of nurses in the network is not a current priority.

A small number of stakeholders consulted felt that nursing leadership in the sector was lacking, in both cancer and palliative care services. The present lack of focus on leadership was attributed to the emphasis on clinical competence at the expense of leadership development. In addition the organisational structures of hospices had hindered and reduced the opportunities for nursing leadership development in hospices. In contrast, a South Island DoN described nurse-led quality initiatives that have already been taken up by some NZ hospitals including the ‘Liverpool Care Pathway’. Implementation of such strategies, including Chronic Care Management strategies, requires a project manager.
8.3 Nursing Workforce in Cancer and Palliative Care: Trends and Future Educational Subject Needs

A DoN of a DHB with a cancer tertiary centre remarked on nursing services becoming increasingly specialised and the rapidity of change unprecedented. Specialty knowledge is expanding at a very rapid rate in Cancer Nursing. While technology is making dissemination of new knowledge easier, RNs adapt to the knowledge explosion in various ways, so a multifaceted educational strategy is required to maintain desired skills.

Another urban DHB, not a cancer tertiary centre, described the range of roles nurses filled as follows:

- Palliative care nurse specialists working on a ward resource nurse model to provide a link into the wards with the service to build on the knowledge and expertise of the generalists providing the care
- Haematology nurse specialists providing direct care for oncology patients, and supporting generalist nurses in ambulatory care and in the medical wards for the limited number of inpatients receiving chemotherapy
- Breast nurse specialists providing specialty services to outpatients with breast cancer-support, education, wound management
- Colorectal nurse specialists providing specialty services to colorectal cancer patients with support from the surgeons and generalist nursing workforce.

Leaders in oncology nursing agreed on the importance of cancer nursing achieving recognition as a specialty area, and career pathways and advanced education need to move forward together. Several compared the state of development of cancer nursing as a specialty unfavourably with that in palliative care, noting the latter was more coherent and advanced. A nurse educator and leader in oncology nursing observed that palliative care nursing is better placed than cancer nursing because palliative care is a recognised specialty and there is dedicated training available at Victoria and Auckland Universities. Relatively speaking, they said, there is more cohesion in palliative care nursing than cancer care nursing. In contrast, cancer care nursing education is more ad hoc. The workforce is fragmented as cancer nursing is not seen as a specialty and is not well defined. While there are some courses in Auckland, Victoria, and Christchurch, the enrolment numbers are often low and therefore they are not necessarily run every year. Furthermore, there is little cohesion between cancer centres. This
is changing with the development of the cancer network, but nursing is not directly involved in this yet as is not seen as a priority by those running the network. One respondent identified several concerns to be addressed:

- Cancer nurses need to be working towards gaining recognition as nurses with specialist knowledge
- A career pathway for this needs to be explicitly defined
- The career pathway and education for cancer nursing needs to more broadly encompass all aspects involved in caring for cancer patients
- Recognition as a specialist cancer nurse needs to be linked to remuneration
- There is a need to link professional development to consistent standards
- Minimum standards need to be developed as a measure of nurses’ skills and competencies
- There is a need to define competency and proficiency in the area of specialist cancer nursing
- Relevant educational curricula should align more closely with defined standards of competency and proficiency
- Inconsistencies between centres in terms of the professional development offered, PDRP requirements and standards required of cancer nurses
- Nurses ought to have a “passport” that ensures they are fit to practice across centres to facilitate moving between centres; this would help ensure consistency of standards and skills in cancer nursing across the country
- Centres need to develop in-house programmes to ensure new employees understand the centre-specific issues that will affect practice (e.g. cultural issues, team and individual issues).

A colleague of the above respondent, attached to another cancer centre, stated that cancer nursing competencies are under development at present, and cancer nursing standards are being developed into competencies. The group working on these has found it challenging to reach agreement on the competencies, and there needs to be consensus on how to take these forward. It is important that New Zealand has a document specifying agreed cancer competencies in nursing to avoid confusion and increase the likelihood of the competencies being understood and met. Education needs to be aligned with the competencies to help ensure nurses achieve the competencies and perform appropriately. In addition, DHBs need to
join together and have NZ-wide guidelines on cancer care, similar to those that have been developed in palliative care. However, competencies also need to be developed in palliative care nursing, with the involvement of the Nursing Council.

Palliative care stakeholders were less positive about developments in their own specialty than were cancer nursing views of palliative care. One leader in palliative care saw as a key point the relationship between the role that generalists have in relation to palliative care, and that the generalists and specialist palliative care nurses need to work together. As specialist palliative care has developed, so too has the risk that specialist roles can deskill and undermine generalists; New Zealand is not alone in this unintended development. She felt strongly about the importance for generalist nurses to have competencies in palliative care, and in having access to education, not necessarily at an advanced level, to support their practice. A related concern was to advance the skills of the community nursing workforce to enable them to manage patients with increasing levels of complexity.

Community nursing teams providing palliative care have an important role in preventing readmission to hospital and hospice palliative care services. There is a need to consider what environment is required to support nurses in the community, and those nurses working between the community and hospices and hospitals. A positive example was given of a small rural health service where palliative care is managed by an inter-professional palliative care team, involving hospital and community team members, with key nursing input from district and general ward staff. Concerns are captured in this comment:

“In the community, we need to continue developing a workforce with the skills and expertise for palliative care and symptom management. Nursing expertise in Palliative Care is needed in many settings, and is a key part of the Aged Care strategy. While recognising that there is some role overlap, particularly in smaller centres, the historical tendency to associate Palliative Care nursing with Cancer nursing must be discarded. Palliative Care nursing services are provided in contexts as varied as intensive care, to patients at home or in rest homes, residential care. Curriculum design must accommodate the interface between Gerontological Nursing and Palliative Care for papers to articulate smoothly.”

A summary of issues to be addressed in palliative care nursing development included:

clear strategies of practice development:
- Specific professional development plans linked to the Nursing Council’s PDRP, as offered in DHBs, to also be established in non-government organisations (such as hospices) if currently unavailable
- A focus on development of generalist nurses providing palliative care, not only specialist nurses as per present
- Clarification of generalist and specialist roles, to improve the roles complementing each other, with the specialist role supporting generalist nurses in providing basic palliative care
- An associated clear strategy with incentives to enable nurses to study
- The view held especially by hospices that palliative care nurses need to be mature and experienced that is discouraging new graduate recruitment is questioned and
- Support for a more inclusive approach to working collaboratively with others in the community e.g. in aged care.

An issue of key importance arising out of the above is that in the development of career pathways in cancer and palliative care nursing there are multiple stakeholders affected, and these stakeholders need to work together. Nursing professional organisations and groups participating in developing standards and competencies, nurses’ employers including DHBs and NGOs and tertiary educational institutes providing the formal postgraduate educational courses and programmes need to collaborate and understand the strengths of and constraints on each.

Support for advanced practice is important also, as one respondent said:

“Currently Victoria University offers advanced practice for nurses which focuses on national and global trends in cancer nursing, a focus on what influences nurses’ own practice, and development of writing, research and literature reviewing skills. One aim is to support advanced nurses in developing well-articulated, evidence based proposals to assess and advance practice. Such skills are important in order to advance leadership in cancer care nursing in NZ. In addition, a named Masters in cancer care nursing is required. These all require access to online learning and resources, given the dispersion and rurality of some nurses. Although there are some good free information and resources on the internet, many
nurses in New Zealand do not know of it and much of it lacks a New Zealand perspective. We need more online resources that are directly relevant to nursing in NZ."

Overall it was agreed that there is a need for all nurses in all services to be better prepared, both clinically and at a post graduate level, to provide care to cancer and palliative care patients. This includes general nurses, who need to have a better understanding of the basics around cancer care, as they play an important role in caring for many cancer patients. General topics around communication skills, support, hope, cultural safety and other key nursing skills are very valuable at all levels and also in relation to cancer and palliative care. Comments ranged from specific applied educational events, e.g. in certification, to more general academic programmes, and covered in-service and continuing education processes. One DHB described an “in house education plan has been developed by the 2006 Palliative Care project” that involves university courses, in-house teaching, journal clubs and professional development meetings. Priorities and perspectives varied widely depending on the area, its services and associated needs. For example, a chemotherapy certification process was described as needing change because it is not user-friendly, and was not consistent with other certifications in that a ‘closed book’ examination was used.

The need for registered nurses to undertake specific training and education to meet more general emerging priorities were noted, e.g. Advanced Communication Training. Turnover of nursing staff creates problems for advanced nurses who induct and teach: the task of clinical teaching in cancer and palliative care skills was described as “constant and ongoing”. At that DHB packages of learning were based on staff feedback and identified gaps developed; symptom management was a prominent topic.

New Graduates came in for specific mention: it was felt that they need to be inducted into a professional/career development process from the start that offers opportunity to develop specialty and advanced practice within an operational clinical context.

Noting that many nurses have some involvement in cancer care, a respondent commented on the importance of all nurses being confident in their abilities to contribute to cancer care, to recognise where their skills and knowledge is limited and to acknowledge where other nurses and health care professionals can assist. Educational curricula need to reflect the reality that nurses may work in roles that mean they play some part in cancer care throughout their career,
such as detection and screening or paediatrics. Whilst such nurses are not specialising in cancer care, and their main responsibility is not around actively treating cancer patients on a regular basis, they still require a basic, broad knowledge of cancer across its continuum and the skills that basic cancer care requires.

Practice nurses, working in the primary care arena, require generalist, not specialist, education to support their practice. Patients would be better served by practice nurses who were more proactive in contacting and following up clients and families on receipt of summaries from hospital and specialists. Examples of skills needing strengthening included: counselling; pain and symptom management; treatment and side-effects; available specialist, support and alternative therapy services, and; initiating referrals. Educational needs included: basic consultation and assessment, communication, questioning and listening skills, cultural awareness, self awareness (of own values and perspectives on cancer, death & dying, survivorship, etc). Delivery approaches that would suit practice nurses include self-paced packages such as CD,DVD, web-based, face to face groups (“learning cells”) with specialists, e.g. in evenings, weekends (day or half-day). The importance of nurses obtaining credits for competencies was emphasised, since a few may study formally for academic credit.

There are an increasing number of HCAs coming into the workforce who will require training in cancer care. Their learning needs will be in areas including their own safety (e.g. radiation is going to return to the wards soon; safety around chemotherapy); communication; understanding and dealing with grief, death and dying. Similarly, hospital level rest homes are taking more palliative care patients. Staff in these institutions have different skill sets and are likely to require some more core skills in areas such as symptom management and treatment options.

Finally, given the wide application of palliative care interventions, a respondent argued that “Palliative care nursing content must be explicit in the BN curriculum”. A key respondent said that undergraduate education provides insufficient knowledge and skills around basic cancer care and palliative care. For example, he said, “it has proved challenging to teach 3rd years about acute cancer care as they lack a basic understanding of cancer and chemotherapy”. More undergraduate palliative care education is needed, as it is widely applicable and in demand, particularly among nurses who are not going to go on to postgraduate education.
8.3.1 Views on the Type of Education Needed

There was consensus on the need for a range of educational opportunities for nurses in the two specialty areas, noting that nurses have different requirements and circumstances. Indeed, a palliative care stakeholder emphasised the importance of a continuum of educational opportunity, both academic and professional development. Canterbury DHB stakeholders preferred:

“A synergistic process to postgraduate nursing workforce planning which avoids duplication, enhances local capability, without any diluent effect on viability. This will require co-operation from educational providers. Planning must take account of the continuum of professional development. Nursing services in tertiary hospitals are becoming more and more specialised and the rapidity of change is unprecedented. Specialty knowledge is expanding at a very rapid rate in Cancer Nursing. While technology is making dissemination of new knowledge easier, RNs adapt to the knowledge explosion in various ways, so a multifaceted educational strategy is required.”

Overall there was high support for postgraduate study. In at least one DHB all clinical nurse specialists in palliative care were required to participate in postgraduate studies. However not all nurses will wish to undertake postgraduate study, seeking rather continuing education to support their practice and up-skill themselves.

Some education may be provided internally (in-service continuing education) by the DHB, and in some areas a local hospice may contribute. Participation in professional groups and in team meetings also supports informal learning. The following approaches used by palliative care nurses were listed: journal clubs, practice development needs and exploring evidenced based practice/involvement in research. In-house training was seen as important, particularly in areas such as symptom management and updates on treatment options, in part because not all nurses choose to continue to postgraduate education.

Between informal not-for-credit education and formal postgraduate education is the graduate education level 700 education offered in a few places (e.g. in Christchurch). Graduate-level training is worthwhile, popular and practical. It can also serve as a good introduction to postgraduate education. The graduate-level training offered in Christchurch, for instance is held
in positive regard. The main disadvantage is that 700 level courses do not articulate with postgraduate study, and nurses who subsequently wish to advance their studies find themselves unable to credit that study. A second drawback is that only postgraduate courses are eligible for CTA funding. Nurses nearing the end of their careers who do not wish to invest in PG study find the more focused 700 level courses attractive and their employer supports this. For many a basic understanding of the nursing care associated with treatment regimes is really helpful and is possible to deliver at the 700 level. In spite of the drawbacks identified above, one respondent felt strongly that not only is maintenance of graduate (700) courses important, the delivery of these should be increased, given the profile of the nursing workforce, for the following reasons:

- The widespread perception among nurses that 800 level = masters and therefore too hard
- The high cost of university courses
- The need to cater for older nurses not interested in higher qualifications
- The need to cater for the many who do not hold degrees
- The high proportion of nurses with families, and needing to finance the tertiary education of their children.

A key stakeholder said that DoNs would prefer to see a few centres of excellence rather than a plethora of courses of variable content and quality. These centres need to cater for both graduate and postgraduate levels, and should be located near tertiary treatment centres. A contrasting opinion was that there is a mismatch between the demand for nurses with higher level skills in rural and remote areas, and the lack of training opportunities in rural areas. More up-skilling is required, and education needs to be more accessible. Another person added to this view, noting that it is important not to run a lot of courses across the country in different institutions. The goal needs to be having viable numbers enrolling so that courses can continue to run regularly and there is consistency in what is taught. It is therefore also important to have flexible learning modes available to cater for people around the country. It was felt that funding needs to come from the DHBs, but that they need to have money allocated for these courses. Through this, more nurses will eventually get to Master’s level and beyond and more much-needed leadership positions will be developed.
Views varied from an identified priority on specific courses to raise skills, to support of a wide
scope of study in preference to a lot of narrow focus specialty degrees. For some DHBs a
specific cancer qualification was not a priority “due to our small numbers”, while palliative care
study was seen as more suited, as it was “allied with chronic care specialty and symptom
control papers”, i.e. applicable to a wider range of patients and their clinical needs.
Commenting on the need for palliative care services by older adults, a source argued that
curriculum design must accommodate the interface between Gerontological Nursing and
Palliative Care for papers to articulate smoothly. Said one Director of Nursing:

“There is substantial similarity in the core competencies of advanced practice across
specialties and given the diversity of rural areas a specialty paper/s within a framework of
advanced care core skills is most useful to us.”

A key stakeholder expressed strong views on the importance of consultation with industry,
citing a recent instance of a new postgraduate programme developed without consultation with
nursing in the region. Flow-on problems of this include: the programme is not approved by
Nursing Council, and therefore not CTA funded. Improved consultation between educational
institutions and health organisations regarding scheduling and delivery of courses is also a
priority, e.g. to plan study blocks to best suit potential students. The questions to consider
include: Who will provide this education (e.g. DHB or Universities)? How will it be provided
(online or face-to-face)?

In addition to industry leaders, the views and needs of potential students also need to be
canvassed when developing courses. One matter of importance concerns whether a particular
course or suite of courses is seen by those who approve applications for CTA funding as
relevant to the applicant’s area of practice. It is important, therefore, that courses are clearly
named and/or described so that relevance can be established. A respondent also argued that
to attract students, the content must be seen to be relevant to their practice:

“They are not necessarily interested in spending more of their time studying theory, for instance
which doesn’t appear to relate directly to their daily practice. Many just want to ‘do their job’.”

8.4 Educational Availability and Access
While some DHBs and local hospices offer some internal training, for many postgraduate education must be accessed outside the region. For some DHBs, the geographical distance to access formal education programmes is small, but for others access is a major challenge. Respondents felt there is an ongoing need for education to be provided both locally and in tertiary institutions that are not too far away.

One respondent felt strongly that much more needs to be done to develop distance modes including electronic delivery: NZ is “way behind” in this area. Improved on-line resources are required. Distance study is available in some areas, but some providers schedule weekly tutorials, or schedule occasional sessions, difficult for some such as rural staff from small practices. Teleconferencing is increasingly used, but when scheduled at fixed times for many people three hours on a teleconference is no better than having to attend in terms of release time, and classes are often at peak times of the day.

It was generally agreed that CTA funding has reduced the financial barrier to access for nurses undertaking post graduate certificate, diploma and masters courses. Further, CTA funding largely addresses issues of equitable access as provides assistance with travel and accommodation. However currently CTA funding does not provide for release time, and this is an area that needs to be remedied:

“Even with CTA funding, within smaller services, there is limited facility to release staff over and above class time because of staff shortages. Full time staff have difficulty fitting in the demands of study especially in isolated practice roles.”

As a result of the CTA funding, it was noted that each year more RNs are completing Clinical Masters. However, one respondent commented that due to the recent changes in CTA funding, where a programme in an educational institution was dependent on CTA funding that is now gone, enrolment numbers have dropped, and courses have to stop running as a result. From comments made, DHBs vary on how they manage CTA funding, particularly regarding access by NGOs. One person suggested that “a national standard on right of access” might be needed to ensure consistency.

While no criticisms about the educational content of courses were raised, the difficulty with all education programmes is the ability to release staff due to staff shortages. In spite of the value
on advanced education and willingness to have nurses participate, staff shortages have created barriers to participation. One DoN noted that there is limited facility to release staff in paid, or even unpaid, leave over and above class time because of staff shortages. Even with CTA funding, within smaller services there is limited facility to release staff over and above class time because of staff shortages. It was noted that as release time is a problem, involving both funding relief nurses and the availability of nurses to provide relief, and the problem is the greater when geographical location necessitates longer away from the workplace, delivery of educational programmes becomes critical.

Many nurses with particular skills in cancer care are also busy with other responsibilities in other areas such as management of general nursing teams and duties. Issues are summed up by a nurse manager of oncology:

“The barriers to access are largely around release time from work. The staffing is skeleton-like (there is “no fat in the system”) so backfill is a real challenge if a nurse wishes to take time away from work to study. Often those who wish to study and further their skills and knowledge base are in positions of particularly high demand (small teams, specialised skills and services) making replacement of them especially challenging. Cancer nurses are a key resource in cancer care. Simply finding replacements when they want to take annual leave can be hard enough.”

In addition, full time staff have difficulty fitting in the demands of study, as nurses often need to study in their own time as little study time given to nurses undertaking further education. Even in larger urban DHBs there is the risk of burnout as advanced nurses juggle clinical nursing and study:

“Better organisational structures [are needed] to support advanced skills of postgraduate clinical masters study that reduce risk of isolation and burn out as roles expand in the Clinical Nurse Specialist area where greater clinical responsibility is undertaken.”

Other barriers identified included: lack of awareness of educational opportunities available and of funding sources/scholarships; lack of DHB funding/support. Not all nurses will search the internet to find out what is on offer, limiting awareness of educational opportunities. It can be daunting for nurses to make the first step and investigate options for further study, as is making
sense of different crediting systems depending on the educational institution. They may find it off-putting to see the many and varied options, the fact that travel may be required, and the time and associated costs that can be a barrier. Funding can be a particular problem for nurses who don’t quite meet criteria for support, e.g. nurses working in community practice roles that are hospital-run rather than PHO based, therefore not qualifying for additional rural funding. Some respondents disagreed that DHB support was poor, commenting that their DHB was a proactive organisation, supporting staff in further education wherever possible. However, problems of nurses not seeing the relevance of further study and difficulties in backfilling remain barriers.

Other barriers are related to perceived obligations and additional responsibilities:

“The obligations perceived to be associated with undertaking further study may be another barrier. In the past, nurses were bonded to the organisation upon completing further study. For instance, if they were supported by the DHB to study, they were then bound to remaining on staff for at least the 12 months after completing the study, or were expected to pay the study fees back. Although this is no longer the case, it may still cloud nurses’ perceptions of the expectations held of them as a result of studying with the use of DHB funding. Furthermore, nurses may be put off by the potential expectations of them once they have gained further skills (e.g. being a resource nurse, having more managerial responsibilities).”

More training opportunities are required in particular in cancer care at an advanced level for nurses. The generally held view was that the country needs more nurses with this level of training, and these should be located around New Zealand, not just in the main centres. Some nurses have sought international education and travelled overseas on scholarships, e.g. to the Royal Marsden College. Unfortunately scholarships for this travel are no longer available. However, overseas qualifications may not easily articulate with New Zealand contexts. Comment was made on the alignment of overseas specialist qualifications for nurses with opportunities and expectations for applying to New Zealand nursing service contexts:

“In Paediatric Oncology, an issue pertains to registration of UK “Children’s Nurses”. In the UK, the ‘child branch’ of pre-registration nursing education leads to entry to the xxx part of the Nursing and Midwifery Council register. Nurses, who have undertaken this programme, spend one year in a comprehensive common foundation period, alongside adult, mental health, and
learning needs branch students, before moving into the two year branch specific part of the programme. In NZ this can create problems within a paediatric nursing team, particularly in general hospitals, since there is an expectation that NZ nurses are generalist nurses and therefore their skills can be transferred in times of need to other areas. However this practice is not encouraged in some other countries and so has the potential to create a two tier system of nursing internationally.”

Finally a key stakeholder expressed the opinion that nurses specialising in cancer and palliative care were no different from nurses in other clinical areas; the difference was that the cancer control strategy has driven the focus on these groups of nurses. Moreover, she feels the needs of these nurses are well met, especially in palliative care, with a choice in programmes and courses.

8.5 Summary

The consultation process with key national stakeholders confirmed many of the results of the survey of nurses and interviews in four DHBs. While not all agreed with all findings, others expanded on issues identified, and some explained how issues varied in their areas.

The issue of a largely New Zealand European nursing workforce caring for an ethnically diverse population of patients and their families and whanau has significant implications for both nurse recruitment and for advanced education. Key informants representing interests of Asian and Pacific peoples identified a range of cultural concerns that nurses need to be cognisant of that could, and should, be included in continuing education. On the other hand is the increasing representation of overseas trained nurses in the nursing workforce who need to be educated on New Zealand and Maori culture, including the Treaty of Waitangi and cultural safety.

There was a great deal of comment on the topics, types of programmes and mode of delivery of educational courses. As expected the opinions reflected a range of views and preferences. Overall it was agreed that a range of opportunities was needed, including postgraduate, graduate, continuing education and in-house, to meet the diversity of nurses’ circumstances and preferences. There was also agreement that flexible learning, including technology-assisted learning, needed to be further developed. However, the success of CTA funding,
devolved to DHBs to administer, in addressing many previous barriers to postgraduate education was widely confirmed. There was consensus on the need to also fund release time, but nurse shortages related to difficulties in finding nurses to fill in is an added barrier that is more difficult to remedy.

Many stakeholders confirmed the importance of general nurses, working in hospital, primary health and community settings where they are caring for patients with cancer and palliative care needs, also having the education needed to give them the skills and confidence needed to work with these patients. Increasingly, unregulated nurses such as health care assistances are also involved in patients’ care and have educational needs. But it was the need for the coherent development of career pathways for cancer and palliative care specialties, involving standards and competencies, the educational pathways to support specialty practice and the employment recognition of specialty practice, that received a great deal of comment. Arising from this, collaboration among the professional, employer and educational stakeholders was identified as of key importance, along with open engagement and improved understanding of each others’ contributions and constraints.
9. Gap Analysis against International Benchmarks

A series of gap analyses were undertaken using the international literature, making comparisons for the following variables:

- Workforce
- Competencies
- Education programme content: pre-registration and post-registration.

9.1 Workforce Gap Analysis: Cancer Nursing

Workforce planning in response to national cancer control strategies is evident in the literature although for nursing, few quantitative measures appear to exist and benchmarks are sparse. Consequently, as was found in the Cancer Control Workforce Stocktake and Needs Assessment (MoH 2007), comparisons with workforces internationally are difficult to make; it was indicated that “benchmarks for numbers and skill mix could help to modify what has been described as a ‘vacancy filling’ or ‘just in time’ approach to the cancer nursing workforce” (p53).

Workforce planning has taken place in the countries that comprise the UK. Scotland, England, Wales and Northern Ireland have all indicated that an educated knowledgeable nursing workforce is needed to meet the growing cancer needs of the populations. However, specific workforce measures have not been developed, rather the emphasis has been on creating frameworks or career pathways. The Royal College of Nursing (2002) worked collaboratively with clinicians to develop a framework for cancer nursing. This identifies four levels of practice which includes unregulated healthcare workers. The senior role is that of Nurse Consultant; which resembles that of Nurse Practitioner (NP) in New Zealand (see Figure 9.1). The UK also has advanced practice nurses in the form of network lead cancer nurses.
Minimum education and professional criteria have been established, with a career pathway developed to aid professional and career development (RCN 2002; NHS 2006) (see Figure 9.2).

**Figure 9.1 RCN level of Practice for Cancer Nursing (2002)**

**Figure 9.2 RCN specialist cancer nursing career pathway (2002)**

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**Table: Experience and Learning**

<table>
<thead>
<tr>
<th>Generic</th>
<th>Specialist area</th>
<th>Specialist nursing</th>
<th>Senior practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>- eg general services with some cancer patients</td>
<td>- cancer-related case area, with generic nurses supported by specialists in cancer nursing</td>
<td>- higher and advanced specialist practice</td>
<td>- at least 2 years clinical experience</td>
</tr>
<tr>
<td>- needs supervision and learning from experienced cancer nurses</td>
<td>- proven development in exponential and academic learning eg (former) national board course</td>
<td>- developing autonomy in expert specialist practice</td>
<td>- able to plan care needs for clients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- substantial specialist learning to (cancer) diploma or Bachelor degree</td>
<td>- cancer-related Bachelor or taught Masters</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- building on experience, education and skills of senior practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- tripartite role of clinician (50%) management and education</td>
</tr>
</tbody>
</table>

**Preferred academic level**

- II – III
- III – PG Dip, MA, MSc
- MA, MSc – (MPH, PhD)

**Table: Specialist nursing care pathways**

<table>
<thead>
<tr>
<th>CARE PATHWAYS</th>
<th>CHARGE NURSE / SISTER</th>
<th>CLINICAL NURSE SPECIALIST</th>
<th>NURSE CONSULTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>significant experience in cancer patient care</td>
<td>expert in clinical field of cancer care</td>
<td>clinical expert, spending at least 50% of working time in clinical practice</td>
</tr>
<tr>
<td>Management</td>
<td>manages designated area of cancer care services</td>
<td>specialist leadership roles; contributes to policy development</td>
<td>expert in leadership skills and strategic consultancy, involved in all stages of policy development</td>
</tr>
<tr>
<td>Education and research</td>
<td>cancer-focused diploma or degree, and continuing development in clinical and managerial education</td>
<td>able to share effectively expertise, eg through teaching, advising and at conferences</td>
<td>clinical resource to cancer and other nurse specialists; raising profile of nursing research and dissemination of findings in multiprofessional forums</td>
</tr>
</tbody>
</table>

**Preferred academic level**

- Specialist degree or PG Dip
- Specialist degree – MA, MSc
- MA, MSc – (MPH, PhD)
The roles undertaken by nurses in New Zealand reflect closely those of the UK when mapped against each other (see Table 9.1).

**Table 9.1 Mapping of nursing roles in cancer care - UK and NZ**

<table>
<thead>
<tr>
<th>Generalist</th>
<th>Specialist areas</th>
<th>Specialist nursing</th>
<th>Nurse Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>General services with cancer patients; Needs supervision and learning from experienced cancer specialist nurses</td>
<td>Cancer-related care area, provided by generalist nurses who are gaining experience in cancer care; Supported by specialists in cancer nursing. These nurses should be commencing postgraduate study whilst gaining further experience in cancer nursing.</td>
<td>Specialist cancer nurses with higher and advanced specialist practice skills; developing autonomy in expert specialist practice. These nurses have substantial specialist learning at a minimum level of post-graduate certificate in cancer care, working towards masters level education.</td>
<td>Senior cancer nurses with at least 4 years clinical post-registration experience within the scope of cancer nursing. Must meet the competencies laid down by Nursing Council including the ability to demonstrate expert practice working collaboratively across setting and within interdisciplinary environments. A tripartite role of clinician (50%) leadership and education.</td>
</tr>
</tbody>
</table>

Comparing New Zealand with the UK, what appears to be lacking in New Zealand is a career pathway and senior advanced practice roles in the form of Nurse Practitioners. This may be just a matter of time but attention should be paid to this development.

In New Zealand, DHBs can draw on the overseas data to plan future workforce needs. However, clear gaps exist in availability of the data nationally, and in the level of future proofing the data collection that has been undertaken to date. Each of the regional cancer centres provided current data on their workforces and in June 2006, details of the cancer nursing skill mix in the six cancer centres in New Zealand were collated (see Table 9.2).
Table 9.2 Cancer nursing skill mix based on job title (MoH 2007)

<table>
<thead>
<tr>
<th></th>
<th>Senior nurses (FTE)</th>
<th>Registered nurses (FTE)</th>
<th>Proportion senior nurses</th>
<th>Total proportion senior nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>10.60</td>
<td>46.10</td>
<td>19%</td>
<td>15%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>4.00</td>
<td>39.67</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Waikato</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>2.00</td>
<td>29.82</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>1.00</td>
<td>8.20</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>MidCentral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>1.00</td>
<td>18.00</td>
<td>5%</td>
<td>12%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>3.00</td>
<td>10.50</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Capital &amp; Coast</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>1.50</td>
<td>21.60</td>
<td>6%</td>
<td>11%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>2.00</td>
<td>7.70</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Canterbury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>4.50</td>
<td>38.10</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>4.00</td>
<td>10.10</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Otago</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>1.60</td>
<td>13.58</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>1.00</td>
<td>6.40</td>
<td>14%</td>
<td></td>
</tr>
</tbody>
</table>

In October 2007, the nursing workforce (FTE) data in the same centres revealed increased FTEs (see Table 9.3). The turnover of staff varies from month to month but all the centres do appear to have successfully recruited more nurses into the services providing cancer care.

Table 9.3 Nursing Workforce in Cancer Care Services-Tertiary Centres

<table>
<thead>
<tr>
<th></th>
<th>Cancer FTE</th>
<th>Change in FTE since June 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>111</td>
<td>+11</td>
</tr>
<tr>
<td>Waikato DHB</td>
<td>56</td>
<td>+15</td>
</tr>
<tr>
<td>MidCentral Health DHB</td>
<td>37.6</td>
<td>+5</td>
</tr>
<tr>
<td>Capital &amp; Coast DHB</td>
<td>38.5</td>
<td>+5.7</td>
</tr>
<tr>
<td>Canterbury DHB</td>
<td>91.85</td>
<td>+35.1</td>
</tr>
<tr>
<td>Otago DHB</td>
<td>28.2</td>
<td>+5.6</td>
</tr>
</tbody>
</table>

Nursing workforce data have also been provided by other DHBs in New Zealand (see Table 9.4).
Table 9.4 Nursing Workforce in Cancer and Palliative Care services-Sample of other DHBs

<table>
<thead>
<tr>
<th>DHB</th>
<th>Cancer FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland</td>
<td>5.6</td>
</tr>
<tr>
<td>Waitemata</td>
<td>6.7</td>
</tr>
<tr>
<td>Manukau</td>
<td>10.3</td>
</tr>
<tr>
<td>Lakes</td>
<td>1.6</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>11</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>1</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>1</td>
</tr>
</tbody>
</table>

Variance clearly exist around the country; the size of the nursing workforce and distance from the cancer centre will impact on services offered.

9.2 Workforce Gap Analysis: Palliative Care

With regard to workforce planning for palliative care nursing, benchmarks internationally are again limited and so local or regional evaluations are required to ensure the workforce plan matches the need. In England, NICE (2004) provided high level guidance and recommended a minimum level of service provision by specialist palliative care teams, which consist of palliative medical consultants, and palliative care nurse specialists, as:

“The team should be staffed to a level sufficient to undertake face-to-face assessments of all people with cancer at home or in hospital, 0900-1700, seven days a week. In addition, there should be access to telephone advice at all times (24 hours, seven days a week). Provision for bed-side consultations in exceptional cases outside the hours of 0900-1700, seven days a week is also desirable” (NICE 2004 pp 129)."

The team is supported by additional nursing staff that have received education at an introductory level on the principles and practice of palliative care. In one region of England (Cumbria & Lancashire), figures have been included in their investment plan for the community and hospital palliative care services to match the recommendations of NICE; nursing numbers are cited as being 3.2 FTE Community Specialist Palliative Care Nurses, and 3 Hospital Specialist Palliative Care Nurses with admin support. This is for a population size of 1.5 million people (http://www.cancercumbria.org.uk/cancer_network_investment_plan.doc).
The Victorian government (2006) in Australia also projected the size and mix of its palliative care workforce for 2006-2011, using workforce capacity measures. However, it is unclear if these measures can be transferred to the New Zealand health system, since there appears to be less clarity in New Zealand around classifications of care delivery, and these may not match easily.

In New Zealand, several DHBs have already analysed the changing population needs for palliative care and the workforce required to service this need e.g. Bay of Plenty DHB conducted their evaluation in 2003 and highlighted the specific needs of Maori, children, older people and people with disabilities. Similar measures, such as those developed in overseas, may be useful either as a benchmark for New Zealand, or to assist the remaining DHBs with their own projections.

Career pathway development for palliative care nursing has also taken place in a similar way to that for cancer nursing. Unlike cancer nursing, progress has been made with regard to the Nurse Practitioner role in Palliative Care in New Zealand; currently there is one such person working within this scope of practice. It is unclear however, if other advanced nurses plan to seek Nurse Practitioner endorsement from the Nursing Council of New Zealand in this field of practice. For both palliative care and cancer nursing, one obstacle is the process and verification required by NCNZ for endorsement; this is currently subject to review.

9.3 Educational Gap Analysis

A gap analysis of both undergraduate and postgraduate programmes has been undertaken. The key countries for benchmarking education programmes for cancer and palliative care are the United Kingdom and Australia due, primarily, to the similarities with New Zealand in relation to health and education systems.

9.3.1 Undergraduate Education

In the UK, there has been a call for several years to have cancer-related learning (including palliative care) incorporated into the pre-registration curriculum (O'Connor & Fitzsimmons 2005). Although this has not yet been mandated by the UK’s Nursing and Midwifery Council, there is a review of pre-registration nursing taking place, which is currently the subject of
consultation (NMC 2007). One suggested model has been presented by the RCN (see Figure 9.3).

Figure 9.3 RCN Cancer-related learning proposal (2002)

In New Zealand, the consultation with key stakeholders outlined in this report indicated a wish for greater inclusion of cancer and palliative care learnings in undergraduate nursing curricula. There was consensus that upon graduation, nurses do not possess the breadth of knowledge required for cancer and palliative care nursing. The suggestion made in the key stakeholder consultation was that either, this should be addressed within the pre-registration curricula, or through the new entry to practice programmes and associated postgraduate study.

The analysis of postgraduate education identified a gap in relation to pathways for specialisation in cancer or palliative care nursing, especially ones linked to educational levels.

9.4 Competencies for Cancer and Palliative Care Nursing Gap Analysis

Separate competencies for cancer and palliative care nurses are in varying stages of development internationally. One thing all appear to have in common is a strong association with educational levels and programmes. For example, in Europe, the European Oncology
Nursing Society (EONS) in 2005 published a curriculum for post-basic cancer nursing which specifies practice competencies belonging to 8 domains including:

- The context of cancer nursing (4 competencies)
- Basic science and treatment of cancer (5 competencies)
- Nursing skills in assessing people with cancer (4 competencies)
- Decision making and communication (4 competencies)
- Impact of cancer on the individual and carer (3 competencies)
- Nursing interventions in the management of cancer (6 competencies)
- Clinical leadership and managing nursing resources (6 competencies)
- Informatics and applied research in cancer care (5 competencies).


For cancer nurses, the Australian EDCaN project is currently carrying out work to develop competencies; draft competencies are currently available. These have been adapted from those set out for RNs, advanced RNs, and specialist breast nurses. They are organised into 4 domains, with between 2 and 7 competencies per domain and between 3 to 7 performance criteria (PC) per competency:

- Provision and coordination of care*
- Disease treatment and related care (2 competencies, 10 PC)
- Supportive care (2 competencies, 10 PC)
- Coordinated care (1 competency, 5 PC)
- Information provision and education (2 competencies, 12 PC)
- Collaborative and therapeutic practice (2 competencies, 10 PC)
- Development and maintenance of client-centred therapeutic relationships
- Collaboration with client and other health care team members
- Critical thinking and analysis (4 competencies, 12 PC)
- Quality improvement
- Developing evidence-base and applying it to practice
- Professional development
- Advising and mentoring colleagues
- Professional practice (3 competencies, 13 PC)
- Informed critique and influence of health and cancer care
- Appropriate self-monitoring of performance
- Practices within ethical, professional and legislative standards.

*Provision and coordination of care is a domain comprising 4 divisions, each containing up to 2 competencies.

The EdCaN project is not due to be completed for two years but no doubt will help to inform developments in competencies for general and specialist cancer nurses in New Zealand.

Competencies for palliative care nursing in Australia were published in 2005 (Canning et al) and are aimed at the specialist nurses in this field. Five interrelated domains of specialist practice are included: therapeutic relationships; complex supportive care; collaborative practice; leadership; and improving practice. They appear to apply for the care of children as well as adults. The domains used in the Australian framework closely match those of the Nurse Practitioner competencies for New Zealand. In New Zealand, work is continuing on the development of similar competencies in palliative care, building on the training standards identified by the Clinical Training Agency in 2001 (MoH 2001). This has been advanced significantly by the support of the Donny Trust which is currently sponsoring one specialist nurse training position for palliative care. In cancer care, however, no similar New Zealand competencies exist nationally although local standards may have been developed. One document that would be helpful to further the development of competencies for cancer and for palliative care is that published by the Scottish Partnership for Palliative Care (2007). This was produced in collaboration with NHS Scotland to aid managers, teams and individual health professionals to identify the competencies needed to provide palliative care services to their specific populations.
10. Conclusion and Recommendations

The purpose of this report was to assess the current nursing workforces working with patients with cancer and palliative care needs, including their educational preparation and needs to work in the areas, and to make recommendations regarding future nursing workforce and educational needs. Although the focus of the study was the educational needs of nurses working with patients receiving cancer and palliative care, the different strands of the study demonstrated that nursing workforce development and educational preparation to support the workforce in the specialty areas are intimately related. The following are the key findings and associated recommendations related to both nursing workforce development and nurses’ educational needs arising from the study.

1. Cancer nursing and palliative care nursing are distinct specialty areas; there are different nursing knowledge and skills for each area. The survey found a divergence between nurses’ perceptions of their competency and existing formal benchmarks.

   Recommendation: Competency frameworks are produced for each specialty, defining levels of nursing knowledge and skill to create a professional development pathway.

2. Several strands in the study highlighted the importance of advanced educational programmes for nurses being clinically relevant and effective in improving competence and confidence. In addition to delivering a skilled nursing workforce to work with these patients, a likely consequence is that retention of nurses in the specialty areas will improve, and less experienced nurses have the quality of preceptoring and clinical leadership to encourage them to work in the specialty areas too.

   Recommendation: Educational requirements are outlined to support professional development within these competency frameworks for each specialty.

3. The survey and consultation process did not indicate a need for more specialty courses and programmes. However, it is noted that uptake of specialty study is fairly low, and the researchers caution that if specialist qualifications becomes a requirement for employment in the specialty areas, at least in leadership roles, then there may be a need to consider increasing availability of programmes. Several stakeholders
advocated that pre-registration programmes increase content related to cancer and palliative care in the curricula.

Recommendation: Collaboration between nursing leaders and educationalists (from DHBs, NGOs and education providers) aligns education programmes, from undergraduate to specialty post graduate, to support the professional development pathway.

4. Funding support for nurses to undertake advanced study was found not to be a major constraint. However obtaining release time from clinical work areas and distant geographical location from available courses remained a constraint. In some cases nurses not employed by DHBs did not have access to the funding.

Recommendation: DHB senior nursing management work with the Ministry of Health to develop strategies to address ongoing constraints (in particular release time) to nurses participating in specialty education.

5. Like the nursing workforce generally, the median ages of nurses working in cancer and palliative care services is rising. An implication is that older nurses may not want to embark on several years of postgraduate study, yet wish to improve their skills. The ageing nursing workforce highlights the need to recruit and retain younger nurses into the specialty areas as a priority.

Recommendation: Specialty education programmes are oriented to respond to the range of different needs of those working in the two specialties.

6. As well as nurses specializing in nursing in each of these specialties there are many generalist nurses working with patients receiving cancer and palliative care services. Examples of generalist nurses include those working in general practices and primary health care, aged care, district nursing and general medical and surgical wards, and it is likely their clients will use both cancer and palliative care services.

Recommendation: Nurses working in general clinical settings (ie not specialised cancer and palliative care services) have access to appropriate specialty educational opportunities (resources, courses and/or elements of specialist education programmes).
7. The Study found that nurses were predominantly of Pakeha/European ethnicity, but their patients were ethnically diverse, including Maori, Pacific and other ethnicities. 

Recommendation: Different cultural needs of clients are addressed through appropriate cultural safety education for nurses in these specialties.

8. Stakeholders interviewed acknowledged that nursing leadership in the two specialties needs to be strengthened.

Recommendation: Leadership within each specialty is promoted through support for networking, education and national and international collaboration.

9. The nurses’ survey found that only about half of those working with cancer patients and three quarters of those in palliative care had undertaken post-registration education and a quarter were currently studying. These proportions are considered low, and may not adequately support the levels of skill and competency required in specialty services, especially in cancer services.

Recommendation: A strategic approach to specialty workforce nursing development, based on skill mix requirements, is adopted by the DHBs, Ministry of Health and NGOs.

10. A national stocktake of the nursing workforce engaged in cancer and palliative care demonstrated good workforce data is not available. Classification of nurses is broad and seems to lack a clear rationale, with the vast majority of nurses not classified, making it impossible to assess the nursing workforce in given areas.

Recommendation: Specialty nursing workforce data is improved by the relevant agencies to enable better forecasting.

- Nurses are classified accurately according to their specialisation
- Employers record specialisations in their databases
- That the annual nursing workforce survey collect data on the full range of specialisations
- That the classification system harmonises with the Australia-New Zealand Classification of Occupations (used by Statistics NZ in census and the Department of Labour in household labour market surveys) and
- That a working group is established to work with the Nursing Council to determine criteria for specialty clinical practice and review the current annual
nursing workforce survey design in order to better determine nursing stock in specialty areas, monitor trends and project future needs.

10.1 An integrated career pathway and educational framework:
Bringing all aspects of the study together – the DHB case studies, national stakeholder consultation, literature review and gap analysis – the following framework (Fig 10.1) is proposed as a basis for discussion and further development. The framework reflects both the RCN (2002) pathway, and the proposed education and career pathway for primary health nurses (MoH, 2003, p.39). Each role and its associated competency level is linked to a recommended level of education to prepare for the competency level and its associated role, e.g. a level 3 or 4 RN would be expected to have completed or be working toward postgraduate qualifications, and clinical specialist and nurse practitioner to have a Masters degree or higher. Nurses in general clinical services who are working with patients with cancer and palliative care needs would not be expected to hold specialist postgraduate qualifications, but would complement their post-registration education (e.g. in gerontology or surgical nursing) with short courses including in-house education. The framework proposes a linking between formal educational engagement (as shown at the bottom of each arrow) and advancement in the respective specialties (shown at the top of each arrow).

<table>
<thead>
<tr>
<th>Competency level</th>
<th>New graduate</th>
<th>Generalist nurse</th>
<th>Competent in cancer &amp; palliative care specialty</th>
<th>Proficient in cancer &amp; palliative care specialty</th>
<th>Advanced in specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical career pathway</td>
<td>Level 1 RN</td>
<td>District, primary care, general wards, aged care etc.</td>
<td>Level 2-3 RN</td>
<td>Level 3-4 RN</td>
<td>Clinical nurse specialist/ Nurse practitioner</td>
</tr>
<tr>
<td>Preparatory education</td>
<td>Pre-registration bachelors degree</td>
<td>Orientation Continuing education</td>
<td>In-house courses: orientation certification skills</td>
<td>Specialty graduate qualification PG Certificate</td>
<td>Masters or Doctoral degree in specialty</td>
</tr>
<tr>
<td>Non-formal education engagement</td>
<td>New graduate programme: generic</td>
<td>In cancer &amp; palliative care: Short courses Seminars Workshops</td>
<td>In-house courses:</td>
<td>In-house courses:</td>
<td>In-house courses:</td>
</tr>
<tr>
<td>Formal</td>
<td>New graduate</td>
<td>In own area of</td>
<td>Active in</td>
<td>Active in</td>
<td>Small numbers</td>
</tr>
<tr>
<td>education engagement</td>
<td>programme: generic practice (gerontology, primary care, chronic care etc): Graduate &amp; PG qualifications</td>
<td>graduate &amp; PG education in generic topics -assessment -science -prescribing</td>
<td>Masters degree of higher</td>
<td>will be active in Doctoral studies</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>Professional activities and related continuing professional development</td>
<td>Join professional association</td>
<td>Join special interest sections Conference attendance</td>
<td>Active in special interest sections and conferences</td>
<td>Leadership roles in professional organisations and conferences</td>
<td></td>
</tr>
</tbody>
</table>

**Fig. 10.1** Career pathways and educational framework for nurses working with clients with cancer and palliative care needs
References


European Oncology Nursing Society (2005) *Post-basic curriculum in Cancer Nursing*. EONS. Brussels


http://www.moh.govt.nz/moh.nsf/82f4780aa066f8d7cc2570bb006b5d4d/a4d86036478a63a7cc256bde006ff204/$FILE/InvestingInHealth.pdf


Nursing Council of New Zealand (2005) *Framework for the Approval of Professional Development and Recognition Programmes to meet the Continuing Competence Requirements for Nurses*. Wellington: NCNZ


Appendix 1: Ethics Committee Approval

Dear Bridie

MED/6736/EXP
A report on palliative care and Cancer Nurses’ Educational Needs

The above study has been given ethical approval by the Chairperson of the Multi-region Ethics Committee.

Approved Documents
- Protocol: A report on Palliative Care and Cancer Nurses’ Educational Needs
- Questionnaire for Nurses Working With Cancer and Palliative Care Patients, final version dated June 2007
- Participant Information Sheet version 1 dated 21 June 2007

Final Report
The study is approved until 30 November 2007. A final report is required at the end of the study and a report form to assist with this is available at http://www.newhealth.govt.nz/ethicscommittees. If the study will not be completed as advised, please forward a report form and an application for extension of ethical approval one month before the above date.

Amendments
It is also a condition of approval that the Committee is advised if the study does not commence, or is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. The organisation may specify their own processes regarding notification or approval.

Yours sincerely,

Sue Fish
Administrator, Multi-region Ethics Committee
Ministry of Health
DOI: 04 470 0646
http://www.newhealth.govt.nz/ethicscommittees
mailto:Sue_Fish@moh.govt.nz

Administered by the Ministry of Health    Approved by the Health Research Council    http://www.newhealth.govt.nz/ethicscommittees
Appendix 2: Consultation List

Auckland DHB
- Natalie James, Clinical Nurse Manager, Starship Paediatric Oncology
- Anne Fraser, Nurse Educator, Starship Paediatric Oncology
- Pip Brown, Nurse Educator, Haematology
- Gill Gibbs, Clinical Nurse Specialist, Home Health
- Jackie Robinson, Palliative Care Nurse Practitioner
- Karyn Bycroft, Nurse Specialist, Paediatric Palliative Care
- Yvonne Bray, Lecturer in Palliative Care, Faculty of Medical and Health Sciences, University of Auckland
- District nurses – Oncology/palliative care
- Senior nurses - regional cancer service

Bay of Plenty DHB
- Lorraine Hammersley, Cancer Care Co-ordinator
- Maori health providers
- Palliative Care Nurse Specialists/Generalists
- Cancer services - selection of nurses
- Whakatane Nurse Specialist
- Primary care nurses

Canterbury DHB
- Glynis Cumming, Nurse Specialist, Canterbury DHB
- Nanette Ainge on behalf of Mary Gordon, Executive Director of Nursing, CDHB.
- Clinical Nurse Manager, Children’s Haematology Oncology Centre (CHOC)
- Nursing Director (Haematology/ Oncology)
- Nursing Director (Surgery)
- Director of Nursing (Women’s Health: Gynaecology)
- Director of Nursing (Ashburton Hospital)

Capital & Coast DHB
- Wayne Naylor, Nurse Educator/Lecturer (Oncology / Haematology)

Consumer consultation
- Noel Ackroyd
- Keith Blackburne
- Ann Cater
- Adrienne Costar
- Marion Dimond
- Chris Jones
- Rosa Hyman
- Carolyn Mercer
- Sue Solomon
- Barry Young

Counties Manukau DHB
- Denise Kivell, Director of Nursing,
- Palliative Care Nurses (2)
- Nurse Educators (3)
- Older Persons Care nurse (1)
- Charge Nurses (Haematology outpatients; haematology inpatients)
- South Auckland Hospice nurse (1)
• Primary Health Care Nurse Advisor (1)
• Kidz First - Charge Nurse (Surgical); Charge Nurse (Medical)
• Community Public Health nurse (1) – no response after several approaches and calls

Hawkes Bay DHB
• Moira Gillespie

Hospice NZ
• Margaret Schumacher, CEO

Mid-Central DHB
• Charge Nurse/Manager (Oncology)
• Sue Edgecombe, Clinical Nurse Manager – Oncology
• Petro Nel, Charge Nurse – Medical and Radiation Oncology

Ministry of Health - Chief Nurse Advisor
• Mark Jones

New Haven Hospice, Whangarei
• Helen Blaxland (General Manager) & Colleagues

New Zealand Nurses Organisation
• Trish Clark, Charge Nurse manager, Southland DHB, Chair NZNO, Cancer Nurses Section
• Maureen Morris,(ex Clinical Nurse Manager, Oncology, ADHB) Whangarei DHB, Vice Chair, NZNO Cancer Nurses Section
• Anne Brinkman, Professional Nurse Advisor, NZNO, Cancer Nurse Section

Nurse Educators Tertiary Sector (NETS)
• Kathryn Holloway, Associate Dean, Faculty of Health Education & Social Services, Whitireia Polytechnic

Nurse Executives New Zealand (NENZ)
• Diana Gunn, Director of Nursing, Burwood,
• Taima Campbell, Director of Nursing, ADHB

Other organisations contributing to the report:
• CanTeen
• Cancer Society
• Hospice New Zealand
• DHBNZ
• Age Concern
• Breast Cancer Network (NZ) Inc
• Child Cancer Foundation
• Health Links
• Prostate Cancer Foundation of New Zealand
• Kaitiaki Services
• Pacific provider
• Tamaki PHO

St Joseph's Hospice, Auckland
• Senior nursing team

Waikato DHB
• Jenny Baylis

West Coast DHB
• Palliative Care Nurse Specialists
• Clinical Nurse Educators
• Senior nurses at Reefton Hospital
• District Nurses
• Rest homes – selection of senior staff
• Director of Nursing
• Nurse Consultant
Appendix 3: Cancer Nursing - Levels of Practice and Nursing Roles, Education and Competencies

European picture

The EONS survey (2004) found that postgraduate nursing programmes were available in 16 of 20 countries in Europe. The duration of these ranged from 6-24 months and 40-800 teaching hours. The EONS core curriculum on Cancer nursing was being used as a guide in 18 of the countries. There was no evidence available to demonstrate the impact of cancer nursing education in any of the countries. Data on the number of specialist cancer nurses were available for England and Iceland but not in any of the other European countries. In just 11 of the countries surveyed, cancer nursing was classed as a speciality. More information on the specialist and advanced roles was not provided and differences in terminology across the 20 countries not explored, apart from acknowledging that there was a great variety.

UK picture

In 2003, the Royal College of Nursing in the UK developed a Framework for Adult Cancer Nursing in the UK (2003) to support the National Cancer Programme (DoH, 2000). Care delivered by registered and unregistered health care providers were included, with roles defined (see Table 1).
Table 1 Nursing roles in Cancer Care (modified from the RCN 2003 p21)

<table>
<thead>
<tr>
<th>Generic</th>
<th>Specialist areas</th>
<th>Specialist nursing</th>
<th>Senior Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>General services with cancer patients; needs supervision and learning from experienced cancer nurses</td>
<td>Cancer-related care area, provided by generic nurses supported by specialists in cancer nursing. These nurses should have proven development in experiential and academic learning</td>
<td>Specialist cancer nurses with higher and advanced specialist practice skills; developing autonomy in expert specialist practice. These nurses have substantial specialist learning at a minimum level of (cancer) diploma or Bachelor degree.</td>
<td>Senior cancer nurses with at least 2 years clinical experience. These are able to plan care needs for clients. Cancer-related Bachelor or taught Masters degree. The Nurse Consultant role builds on experience, education and skills gained from a number of years of senior practice. A tripartite role of clinician (50%), management and education.</td>
</tr>
</tbody>
</table>

In addition, the RCN framework proposed specialist nursing care pathways; clinical, managerial and education and research. Each of these pathways is linked to an academic level of preparation, with degree pathways in specialist practice recommended for those nurses who will be working in an advanced nursing practice role that incorporate management, supervision and/or education (see Table 2).
Table 2 Specialist Nursing Care Pathways (RCN 2003 p21)

<table>
<thead>
<tr>
<th>Care Pathways</th>
<th>CHARGE NURSE / SISTER</th>
<th>CLINICAL NURSE SPECIALIST</th>
<th>NURSE CONSULTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>Significant experience in cancer patient care manages designated area of cancer care services cancer-focused diploma or degree, and continuing development in clinical and managerial education</td>
<td>Expert in clinical field of cancer care development</td>
<td>Clinical expert, spending at least 50% of working time in clinical practice</td>
</tr>
<tr>
<td>Management</td>
<td>Manages designated area of cancer care services</td>
<td>Specialist leadership roles; contributes to policy development</td>
<td>Expert in leadership skills and strategic consultancy; involved in all stages of policy development</td>
</tr>
<tr>
<td>Education and Research</td>
<td>Cancer-focused diploma or degree, and continuing development in clinical and management education</td>
<td>Able to share effectively expertise, eg through teaching, advising and at conferences</td>
<td>Clinical resource to cancer and other nurse specialists; raising profile of nursing research and dissemination of findings in multiprofessional forums</td>
</tr>
<tr>
<td>Preferred Academic Level</td>
<td>Specialist degree or PG Dip</td>
<td>Specialist degree- MA/MSc</td>
<td>MA/MSc-(Mphil/PhD)</td>
</tr>
</tbody>
</table>

The aim of the career pathway was to provide a blueprint for the necessary competencies and educational programmes required to prepare and support the nurse at a particular level. Despite the continuing predominance of pre-degree diploma level education to prepare nurses for registration in England, Northern Ireland and Scotland (Wales offers graduate entry) many programmes are available at Masters degree level to support clinical nurse specialist posts in which nurses are working at a higher level of practice than that of the advanced nursing practice role. The Consultant Nurse role, introduced into the UK in 1999, requires nurses prepared at a minimum of Master’s level with additional research-related education or skills.

A fundamental component of the approach advocated in the RCN framework is the need to determine roles based on the patient and service needs. This provides some flexibility across Regions and Counties within the UK, but also essential commonalities in relation to structure and consistency at a National level by determining competencies and educational programmes. However, no approach to determine patient and service needs is discussed.
A need was identified (RCN, 2003) to develop lead cancer nursing positions as part of the career pathway approach, which was in line with the requirements of the National Cancer Programme (DoH., 2000). Consequently, the Lead Cancer Nurse role was developed to take forward key responsibilities in the following areas:

- Organisation, management and quality of care and services
- Workforce planning
- Education, training and continuing professional development
- Recruitment, retention and career pathways
- Leadership.

An evaluation of the Lead Cancer Nurse (LCN) roles was undertaken (Vaz & Small, 2007) which identified the diverse nature of such roles, and the variations noted in relation to achieving their key responsibilities. Of significance here is the large amount of work that was identified as still needing to be done on cancer care workforce planning and development; only half of the LCNs had completed some type of workforce analysis in their area or region of work and additionally, the approaches taken to this varied across the regions thereby making comparisons difficult.

It is evident from the literature that a substantial amount of work has been undertaken within the UK to support the various NHS Cancer plans in the different countries of England, Scotland, Wales and Northern Ireland. The relevant reports reflect the range of work that has been and is still being undertaken in an attempt to determine the scope of the cancer nursing workforce. The Cancer Care Group Workforce Team (DoH., 2003) considered the workforce implications of the key goals and objectives of the NHS Cancer Plan and, whilst the Team considered the entire workforce involved in Cancer Care and workforce supply and demand, it was unable to make specific recommendations about the number of nurses required since there was little of no data available at a national level. The Cancer Nursing Advisory Group (2003) considered three approaches to determine workforce planning and roles; the patient pathway, the managed care pathway and the competency framework for cancer nursing. However, there does not appear to be any data available in relation to these approaches and their outcomes for workforce planning, which suggests that no progress has been made to date. Instead, recommendations were made to develop practice nurses and community nurses skills and...
expertise in disease prevention. As most general nursing staff provide care to cancer patients, it was recommended that the clinical nurse specialist role would provide training and support to these nurses.

The clinical nurse specialist was seen as having a tumour-specific role working closely within multi-disciplinary teams and also within the community setting providing follow-up clinics (DoH., 2003) to support the patient pathway approach, despite an earlier recommended that tumour-specific cancer patients should be managed in a unit or centre (DoH. 2000). This variation may have arisen due to resource limitations and availability of beds in specialised units.

In Scotland, Regional Workforce Networks were established to link with Regional Cancer Advisory Groups and NHS Boards to conduct workforce modelling (S.E.H.D. 2004) to reflect the largely local needs of the population, and the incidence of cancer among older people. In 2004, however, the S.E.H.D. (2004) identified the lack of information on which to base decisions on the numbers of Clinical Nurse Specialists in Cancer. The situation does not appear to have changed despite the passage of time.

NGO service provision in the UK
Within the UK, the provision of specialist nursing services for cancer care is largely by the public sector, however a number of voluntary organisations, such as Macmillan Cancer Relief and Marie Curie, now provide nursing expertise at a specialist level. To date, however, there is no data available on numbers per patient, or any variations in role function.

The Canadian picture
The Canadian Association of Nurses in Oncology developed standards of care that have been used as the basis for new or advanced nursing roles, competencies and educational programmes. Three levels of nurse were identified which are very similar to those found in the UK:

- The Generalist Nurse who has completed a basic diploma or baccalaureate nursing programme. This nurse should be experienced in providing care for mixed populations of cancer and non-cancer patients in a variety of settings where cancer care is not the primary focus. This matches to the Registered General Nurse in the RCN (2003) framework.
• The Specialised Oncology Nurse who has a combination of oncology nursing experience and post basic oncology nursing education. This nurse should have a minimum of 2 years of experience in a cancer-focused setting and have completed an oncology nursing certificate, and have evidence of attending oncology-focused continuing education. This role matches to the Specialist Oncology Nurse in the RCN (2003) framework.

• The Advanced Oncology Nurse who has MSc (or equivalent) in a specific area of cancer control or aspect of nursing care. This person should be able to provide evidence of education in specialist areas such as Prevention, Palliative Care, Counselling and Coping. The five domains of the role are; clinical practice, education, research and professional and organisational leadership. This is similar to the Advanced Nursing Practitioner role in the RCN (2003) framework.

Data on the current number and roles of nurses in cancer care in Canada are currently unavailable and workforce projections for the future have not yet been published.

**USA picture**

In the USA, the Oncology Nursing Society has developed standards for Oncology nursing education for two different levels of practice; Generalist and Advanced Practice.

The Oncology Nursing Society offers five oncology nursing credentials from a basic oncology certificate in adult care, a basic oncology certificate in paediatric care, an advanced level for adult care and two higher levels for the oncology nurse practitioner and oncology clinical nurse specialist. However, data is only available on the nature of the roles for advanced practice and that is limited.

The report ‘Statement on the Scope and Standards of Advanced practice in Oncology Nursing’ (ONS 2003) provides a framework for the role, competencies and education of the Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP). The NP is a registered nurse who has completed a Master’s or Doctorate degree in their speciality. The standards incorporate structure, process and outcome criteria which can be used to evaluate the NP’s practice. Differences between the two roles are outlined as follows:

- Oncology Nurse Practitioners function primarily in the medical domain as clinical experts in oncology providing direct, episodic health care to prevent and meet the acute, symptomatic care needs of patients with cancer. The NPs’ scope of practice
includes comprehensive assessments; differential diagnosis; ordering, supervising and interpreting diagnostic tests, prescribing pharmacological and non-pharmacological treatments in collaboration with others and screening to prevent illness and promote wellness. NPs serve as researchers, consultants, educators and advocates in addressing patients’ needs and cancer care.

- Oncology Clinical Nurse Specialists function primarily in the oncology nursing domain as clinical experts, in subspecialty, special population, type of cancer, or comprehensive programmes. The CNS’ scope of practice can include providing clinical expertise in improving quality care across the cancer continuum; assisting patients and families in understanding navigating through cancer care; developing staff and healthcare programmes to promote evidence based, outcome-guided practice; and creating environments that empower nurses to act as patient advocates.

The US ONS acknowledge that, for some advanced nurse practitioners, a blend of roles occurs. Unfortunately, data on the current number and roles of nurses in cancer care and projections for the future are not currently available.

**Australian picture**
There is currently a major research project being undertaken in Australia, led by Peter Mac and supported by Australian Government funding, exploring cancer workforce education current and future needs. EdCaN is in its first of three years, and no data are currently available for informing the comparisons between New Zealand’s and Australia’s cancer nurses numbers and skill mix; links with these researchers have been made and so it is expected that data sharing will be possible within the next few months.

**Paediatric and Adolescent Oncology**
Both paediatric and adolescent oncology are sub-specialties of children’s nursing and with smaller numbers of participants and issues of local access this has impacted on the viability of educational courses (Langton 2007).

Within the U.K. the Paediatric Oncology Nurse Education group of the R.C.N. has developed an initiative with the charity Teenage Cancer Trust. This has led to an online nine month Postgraduate Certificate in Cancer Care for Teenagers and Young Adults. This certificate is a joint venture between the U.K., New Zealand and Australia. It has been designed as an
introduction with specific learning outcomes exploring the incidence of cancer in children and young adults, the major types of cancer and approaches to treatment and side effects, the psychosocial issues and the organisation of cancer services in participants' countries (Cancernursing.org, 2007).

Advanced nursing roles within paediatric oncology have tended to develop along similar pathways to that of adults, with a focus on tumour specific roles. Reducing length of stay in hospitals and the move to more outpatient/day care facilities has also meant the need for more specialist education for nurses working in these areas. There is also potential for development in the nurse practitioner and nurse specialist roles with regard to advanced assessment, decision-making and prescribing and more emphasis on community roles and outreach (Fallon and Sanderson 2007).

**Pre-Registration Education**

The identified need to prepare nurses for cancer care during pre-registration programmes is a consistent theme across the international literature. The RCN (2003) has put forward suggestions for core content which include prevention and screening through to treatments, rehabilitation and palliative care. They provide examples of what should be included as pre-registration nursing curricula for cancer care (see Table 3). It is unclear to what extent universities have addressed these recommendations, although they do comment that a few changes have already been made. The UK's registering body, the Nursing and Midwifery Council, are also considering making these subjects compulsory within the pre-registration curriculum. No other countries appear to be directing the pre-registration curricula content.
### Table 3 The pre-registration cancer-related nursing curriculum (RCN 2003 pp 25)

<table>
<thead>
<tr>
<th>Generic</th>
<th>Specific</th>
</tr>
</thead>
</table>
| Initial awareness in common foundation programmes building to more targeted knowledge in branch pathways | Primary focus  
Health promotion; primary prevention initiatives; screening; self-examination techniques; skills and abilities to improve personal poor self-health; cancer awareness in primary care, school nursing, community health, genetic counselling. |
| Cancers related to demographics: age, gender, sexual health, ethnicity, poor socio-economic indicators etc. | Secondary focus  
Primary and acute care settings: e.g. investigations for cancer; the patient's complete experience of cancer care service and support. |
| Mental health implications of: bad news, chronic illness, the worried well, coping with serious life changes. | Tertiary focus  
Managing difficult therapies; coping with chronic illness; body image changes; sexual and reproductive health problems; disability; rehabilitation; communication and counselling in loss and bereavement; supporting colleagues. |
| Counselling and communication skills: breaking bad news, listening and supporting people; reflective practice, mentorship support, psychological boundaries; multiprofessional collaboration and so on. |                                                                                              |

In Canada, the Canadian Registered Nurse Examination assesses competencies belonging to one of 5 domains including professional practice, nurse-person relationship, health and wellness, and alterations in health. Some competencies are particularly pertinent to good oncology nursing. For example, “NPR-10: provides care that is sensitive to the person experiencing loss (e.g., death, amputation, natural disaster)”, AH-74: “performs nursing interventions to meet spiritual needs (e.g., assesses for spiritual distress, provides time for prayer or meditation, appropriate referral, palliative care)” and AH-82: “provides supportive care throughout the dying process.”

It is advocated that cancer education be introduced early into the undergraduate curriculum in order to minimise stereotypical views about cancer (O’connor & Fitzsimmons 2005).

**Post-registration Education**

As discussed in the previous section, levels of practice that are underpinned by educational programmes have been proposed and accordingly, there are a range of graduate and master’s level programmes available in Australia, the UK, USA and Canada to support advanced nurse roles. Most are linked to competencies and are summarised below.
Canada

Canadian Oncology Nursing Certification requires nurses to meet a range of competency standards (Oncology Nursing Certification, 2003). These fit into one of 7 domains, most of which involve a considerable level of detail:

1. Prevention, early detection, and screening (4 competencies)
2. Diagnosis and staging of cancer (3 competencies)
3. Management of cancer diseases (3 competencies, each with a detailed list of elements representing cancer types)
4. Patient care related to treatment modalities (6 competencies representing treatment types, each with elements outlining necessary practices)
5. Supportive care (7 competencies relating to different forms of support, each with further detailed elements)
6. Rehabilitation and survivorship (4 competencies)
7. Palliative care (7 competencies).

Competencies are assessed through a multiple choice examination which comprises of approximately 170 questions. The questions provide a balance of question presentation (independent and case-based), level of cognitive ability required (knowledge/comprehension; application, critical thinking) across each of the domains (as above). Within this examination, there is a balance of contextual variables including client age, gender, culture, health situation, and health care environment. The aim here is to ensure holistic care that is free of prejudice and of a consistent standard across a variety of settings.

Australia

The Australian Nursing and Midwifery Council competency standards for registered nurses comprise 10 competencies that are organised into 4 domains: Professional practice; critical thinking and analysis; provision and coordination of care; and collaborative and therapeutic practice. A total of 45 elements contribute to the 10 competencies. The standards for enrolled nurses comprise 10 competencies organised into 4 domains: professional and ethics practice; critical thinking and analysis; management of care; and enabling. A total of 38 elements exist within the 10 competencies. There are 3 main standards for Nurse Practitioners. Together
these comprise a total of 9 competencies. Each competency has a detailed list of performance indicators to enable assessment of the practice against standards.

While detailed and comprehensive, Australian competency standards for registered nurses and nurse practitioners do not outline practices specifically related to cancer care. Therefore there are, currently, no specialist cancer nursing standards or competencies for Australia. The EDCaN project is currently carrying out work to develop these with web-links to the draft competencies available. The draft competencies are adapted from those set out for RNs, advanced RNs, and specialist breast nurses. They are organised into 4 domains, with between 2 and 7 competencies per domain and between 3 to 7 performance criteria (PC) per competency:

- Provision and coordination of care*
- Disease treatment and related care (2 competencies, 10 PC)
- Supportive care (2 competencies, 10 PC)
- Coordinated care (1 competency, 5 PC)
- Information provision and education (2 competencies, 12 PC)
- Collaborative and therapeutic practice (2 competencies, 10 PC)
- Development and maintenance of client-centred therapeutic relationships
- Collaboration with client and other health care team members
- Critical thinking and analysis (4 competencies, 12 PC)
- Quality improvement
- Developing evidence-base and applying it to practice
- Professional development
- Advising and mentoring colleagues
- Professional practice (3 competencies, 13 PC)
- Informed critique and influence of health and cancer care
- Appropriate self-monitoring of performance
- Practices within ethical, professional and legislative standards.

*Provision and coordination of care is a domain comprising 4 divisions, each containing up to 2 competencies.

The Cancer Nurses Society of Australia (CNSA) has developed outcome standards for practice (2002/3) to guide development of best practice guidelines and standards for specialist cancer nursing education program (1999). These can be ordered from their website.
There is also a position statement on chemotherapy developed with national input but again competencies have not been a part of this development and these have evolved at each local level.

**UK**

The Royal College of Nursing (RCN) has compiled a framework for adult cancer nursing (2003). This outlines the context of cancer nursing in the UK, service requirements; roles that cancer nurses play in cancer care, including those of health care support workers, registered nurse practitioners, specialist nurses and senior nurses; the required steps to developing and delivering cancer care education programmes, including the cancer-related content and assessment required in the pre-registration nursing curriculum; leadership and management in cancer nursing; and research and development. Nowhere, however, are specific standards or competencies described.

The National Institute for Health and Clinical Excellence (NICE) in the UK has issued guidance on Cancer Services (2004); Improving Supportive and Palliative Care for Adults with Cancer. This is discussed in more detail in the section on palliative care.

In many of the different region of the NHS in England, reviews have been undertaken in conjunction with the Nursing and Midwifery Council and the Workforce Development Confederation, and it has been identified in these that there is a growing demand for specialist cancer nurses and community based nurses with expertise in cancer care.

**Europe**

The European Oncology Nursing Society (2005) has documented a curriculum for post-basic cancer nursing which specifies practice competencies belonging to 8 domains including:

- The context of cancer nursing (4 competencies)
- Basic science and treatment of cancer (5 competencies)
- Nursing skills in assessing people with cancer (4 competencies)
- Decision making and communication (4 competencies)
- Impact of cancer on the individual and carer (3 competencies)
- Nursing interventions in the management of cancer (6 competencies)
- Clinical leadership and managing nursing resources (6 competencies)
- Informatics and applied research in cancer care (5 competencies).
The document aligns the competencies with the curriculum learning outcomes, and details content and its evidence base, assessments, and processes of quality control and evaluation of the curriculum. At the start of the module students complete a learning agreement determining their development needs and how these are going to be achieved. With the emphasis on practice-based competencies a range of assessment methods are described but there is a strong emphasis on practice based skill assessments. As a pre-requisite a nurse must have a first level qualification and at least one year’s post-registration experience. If studying part time the nurse needs to be involved in the care of people with cancer.

There is no discussion of levels of practice with the EONS curriculum, although they state it has been used as the basis of developing Bachelors and Masters Degrees across Europe, and in doing so meets the European Credit Transfer System.
Appendix 4: Palliative Care - Levels of Practice and Nursing Roles, Education and Competencies

UK

In the UK, the Specialist Nurse Role in palliative care has been well established, initially developing as a hospital based role. In 2005/6 the National Council for Palliative Care carried out a survey of all regions in England and identified that there were a total of 5100 FTE nurses working in Palliative Care across the voluntary and NHS sectors. The majority of these were registered nurses working at sub-specialist levels (staff nurses in NZ equivalent levels of 2-4) working within the voluntary sector. There were more senior nurses (NZ equivalent) in the NHS sector than voluntary but no specific details of numbers can be provided to date.

The NICE (2004) guidance does state that there should be sufficient specialist palliative care staff to provide 24-hour care, 7 days per week. However, no details are provided on numbers and mix of staff. NICE refers to specialist palliative care teams, which consist of palliative medical consultants, palliative care nurse specialists but again no numerical data are provided, however the minimum level of service is suggested as the following:

“The team should be staffed to a level sufficient to undertake face-to-face assessments of all people with cancer at home or in hospital, 0900-1700, seven days a week. In addition, there should be access to telephone advice at all times (24 hours, seven days a week). Provision for bed-side consultations in exceptional cases outside the hours of 0900-1700, seven days a week is also desirable” (NICE 2004 pp 129).

For in-patients, the same level of service would apply but the team would also be supported by additional nursing staff that have received education at an introductory level on the principles and practice of palliative care.

In one region of England (Cumbria & Lancashire), figures have been included in their investment plan for the community and hospital palliative care services to match the recommendations of NICE; nursing numbers are cited as being 3.2 FTE Community Specialist Palliative Care Nurses, and 3 Hospital Specialist Palliative Care Nurses with admin support. This is for a population size of 1.5 million people.

(http://www.cancercumbria.org.uk/cancer_network_investment_plan.doc)
There is an expectation that the Workforce development confederations should work with their respective Cancer Networks to determine workforce capacity planning. The Department of Health, in partnership with the Nursing and Midwifery Council, the Health Professions Council and the Workforce Development Confederations Strategic Health Authorities contracted with the Quality Assurance Agency for Higher Education (the Agency) to carry out reviews of all NHS-funded healthcare programmes in England during the period 2003-06. However, there does not appear to be a consistent approach taken to workforce capacity planning across the different Regions and no further data is available at this stage in this project.

Australia
The Palliative Care Workforce Supply and Demand Study (Victorian Government 2006) aimed to develop:

1. Workforce supply and demand projections for Victoria
2. An evidence base for program and sector decision making workforce issues

The study found that 45% of the palliative care workforce was community based and the remaining 55% in-patient based. This workforce was split into two divisions of nursing roles. Nurse division 1 roles encompass the nurse practitioner, clinical nurse specialist and clinical nurse consultant roles. Nurse division 2 roles encompass registered nurses. No detailed information is provided on the differences between the Nurse division 1 roles but the register of the Nurses Board of Victoria has been used to develop summarise the distribution of these roles across settings (see Table 4).

<table>
<thead>
<tr>
<th>Nurse division</th>
<th>Inpatient</th>
<th>Community</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Head count</td>
<td>FTE</td>
<td>Head count</td>
</tr>
<tr>
<td>Nurse division 1</td>
<td>264</td>
<td>178.1</td>
<td>215</td>
</tr>
<tr>
<td>Nurse division 2</td>
<td>67</td>
<td>41.9</td>
<td>7</td>
</tr>
<tr>
<td>Totals</td>
<td>331</td>
<td>220</td>
<td>222</td>
</tr>
</tbody>
</table>

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In determining workforce demand, projections were made for the years 2006-2011 using number of in-patient episodes at a growth rate per annum of 4% and number of community contacts with a growth rate of 4%. The study also broke this data down further into metropolitan and regional or rural areas.

Workforce capacity measures were developed so that FTEs for nurse division 1 and nurse division 2 could be calculated for inpatient and community services. The study worked on the premise that in palliative care health professionals will have a relative level of input. For nurses this was calculated at .60 FTE nurse division 1, and 0.14 FTE nurse division 2 for inpatient (Metropolitan); and .67 FTE nurse division 1, and 0.19 FTE nurse division 2 for inpatient (Regional or rural). For community services this was calculated at 0.58 FTE nurse division 1, and 0.02 FTE nurse division 2 in Metropolitan; and 0.75 FTE nurse division 1 and 0.01 FTE nurse division 2 in Regional or rural. Based on these calculations the projected workforce requirements were determined for 2006-2011, and this data may be useful as a benchmark for New Zealand.

Canada
In 2005, a significant increase in the palliative care nursing workforce in Canada was announced. However, no specific data appears to be available for the numbers of palliative care nurses in Canada.

Education for Palliative Care
As discussed in the previous section, levels of practice that are underpinned by educational programmes have been proposed and accordingly, there are a range of graduate and master’s level programmes available in Australia, the UK, USA and Canada to support advanced nurse roles. Most are linked to competencies and are summarised below.

UK
As part of a national education programme to up-skill primary health care teams, funding was made available to assist district and community nurses to understand the principles and practice of palliative care (NHS Cancer Plan 2001b). A regional approach was taken to reflect local needs but the principles and practice of palliative care that needed to be reflected in the programmes had already been identified as:

- Assessment of patient and carer needs
• Planning ahead, to anticipate issues that may arise
• Management of symptoms
• Recognition of the need for specialist support and advice
• Recognition of the need for appropriate admission to hospital.

34 projects were funded across 8 regions with variations in the programmes and mode of delivery. Six million pounds was made available over a three-year period and an external evaluation conducted by King’s College London (Addington-Hall et al, 2006). The findings revealed that a national programme did improve confidence levels for palliative care provision within the primary care sectors, but that more education was still needed, specifically at the more advanced levels. However, it has also been recognised that research is still required to ascertain the most cost-effective approach to developing district nurses, and hospital and care home staff in Palliative Care (NICE 2004).

The National Institute of Clinical Excellence Guidance (2004) on Improving Supportive and Palliative Care for Adults with Cancer considered workforce development in a number of areas and these are linked to levels of practice. As a baseline it was identified that health professionals who contribute to supportive and palliative care should have skills training to enable assessment of patient, families and carers needs in the following areas:

• Information needs and preferences
• Psychological care
• Social care
• Spiritual care
• Rehabilitation
• Cultural diversity (NICE, 2004 pp 183).

Additional educational requirements were also identified in the following areas:

• Completion of accredited communication courses
• General palliative care services, including best practice guidelines in the care of dying patients and some examples of these include the Liverpool Care Pathway for the Dying Patient (Ellershaw and Wilkinson 2003) and the Gold Standards Framework (Thomas 2003)
• Rehabilitation is also viewed as an additional educational requirement as a component of supportive care.

The 2004 NICE guidance recommended that all patients with advanced cancer should have at least one care team member who has completed post-registration education and training in palliative care.

The Royal College of Nursing (RCN) defines competence as “the skills, knowledge, experience, attributes and behaviours required by an individual in order to perform the job effectively”. The RCN has specified knowledge areas, competency skills, and behaviour across 7 domains for specialist palliative care nursing practice. Within each domain the knowledge areas, skills, and behaviours required are categorised according to one of 4 levels of nursing (Level 1: support worker or health care assistant; level 2: qualified nurse; level 3 senior qualified nurse; level 4: specialist nurse). Domains include:

• Communication skills
• Quality assurance
• Clinical practice, job knowledge and skill
• Education
• Management and Leadership
• Research and development
• Grief, loss and bereavement.

Europe
The European Association for Palliative Care (2004) have produced a guide for the development of palliative education. The levels are determined by the degree to which the health care professional is involved in palliative care. Table 5 represents the levels and degree of involvement they would expect.
### Table 5 Levels of Palliative Education

<table>
<thead>
<tr>
<th>Level</th>
<th>Basic (undergraduate)</th>
<th>Future health care professionals during their initial training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level A</td>
<td>Basic (postgraduate)</td>
<td>Qualified health care professionals working in a general health care setting who may be confronted with situations requiring a palliative care approach.</td>
</tr>
<tr>
<td>Level B</td>
<td>Advanced (postgraduate)</td>
<td>Qualified health care professionals who either work in specialist palliative care, or in a general setting where they fulfil the role of resource person. Qualified health care professionals who are frequently confronted by palliative care situations (e.g. oncology, community care, paediatrics and elderly care).</td>
</tr>
<tr>
<td>Level C</td>
<td>Specialist (postgraduate)</td>
<td>Qualified health care professionals who are responsible for palliative care units, or who offer a consultancy service and/or who actively contribute to palliative education and research</td>
</tr>
</tbody>
</table>

It is evident from the EAPC (2004) report that they see the educational programmes being delivered as an interdisciplinary approach. They have identified what they refer to as dimensions of the palliative care learning process:

- With patient
- With family/carer
- With team
- With society
- With health care system.

Each of these dimensions is mapped against the three levels to provide more detailed content. EAPC (2004) provide statements for clinical practice for nurses at Level A through to Level C noting that the statements reflect expectations of the minimum requirements. These statements could be viewed as competencies.

Although the EAPC (2004) report does not refer to undergraduate education, it states how countries should be developing nurse training programmes that incorporate dying as a core concept and this would include best practices for dying patients and their families, carers. This is similar to recommendations in the NICE (2004) report.
Spruyt, Macleod and Hudson (2006) noted the developments in Australia supported by the Australian government to foster training initiatives for health professionals. However, they also note that there is no consistency in palliative care content within undergraduate nursing programmes in Australia or New Zealand. There is also a lack of research specifically examining cancer care and palliative care in the undergraduate nursing programmes in New Zealand.

Some initiatives might be considered in the context of the competencies outlined for specialist palliative care nursing (Canning et al, 2005) and the 13 Standards for providing palliative care outlined by Palliative Care Australia, relevant to service providers (Palliative Care Australia 2005). These Standards comprise specific levels which delineate the roles of primary care and specialist palliative care services and are relevant to consumers as well as a range of health care professionals including community and specialist palliative care nurses.

The Residential Aged Care Palliative Approach Network (RACPAN) has successfully introduced guidelines for providing appropriate palliative care to those in residential aged care facilities (Dept. of Health and Ageing 2006a). Self-directed educational packages are available for those providing palliative care to promote awareness and competence among service providers, including nurses and assistant nurses. For example, guidelines have recently been developed to help health care professionals discuss end-of-life issues with patients and families (Dept. of Health and Ageing 2006b). These resources are available online and have relevance beyond residential aged care. The packages have been evaluated using forms, phone interviews, and focus groups.

Australia has a government funded National Palliative Care Programme (NPCP). Another initiative was also discussed by Spruyt, Macleod and Hudson (2006); The Program in Experience in the Palliative Care Approach (PEPA). This is open to all health professionals in primary care so that they can gain experience in specialist palliative care practice. Primary care providers are supported not only with an educational programme but with the use of backfilling so that they can be released from their workplace. To date there is no information available on the evaluation of this programme undertaken by Queensland University of Technology. Spruyt,
Macleod and Hudson (2006) state that there is evidence of improvements in relationships and liaisons across boundaries such as primary care and specialist practices.

The Palliative Care Curriculum for Undergraduates (PCC4U) was established to determine the level of palliative care education in the undergraduate curricula for health professionals and also to develop educational resources to support programmes. It commenced in 2003 and previous phases of the project involved:

- Consultation with members of the palliative care community about undergraduate educational needs regarding palliative care for students in all health-related disciplines
- Development of core principles for including palliative care in undergraduate curricula and
- Development of palliative care curriculum resources and conducted a preliminary evaluation of these resources.

The fourth phase of the project that is currently underway aims to implement and comprehensively evaluate these resources, and incorporate them into the curricula of a number of units in undergraduate health courses from seven universities from rural and metropolitan areas of Australia in 2006. The project will also implement and evaluate Principles for Including a Palliative Approach to Aged Care in Undergraduate Nursing Curricula, which were developed in a separate project funded by the Department of Health and Ageing.

In Australia, the Centre for Palliative Care Research and Education has specified competency standards for specialist palliative care nursing practice. These consist of 12 competencies across 5 domains. Measurable cues are specified for each competency to allow assessment of practice. Domains, standards and cues are as follows:

1. Therapeutic Relationships (4 standards, 8 cues)
2. Complex supportive care (1 standard, 6 cues)
3. Collaborative practice (2 standards, 7 cues)
4. Leadership (3 standards, 7 cues)
5. Improving practice (2 standards, 8 cues).

The Australian Nursing and Midwifery Council competency standards for registered nurses comprise 10 competencies that are organised into 4 domains: Professional practice; critical thinking and analysis; provision and coordination of care; and collaborative and therapeutic
practice. A total of 45 elements contribute to the 10 competencies. The standards for enrolled nurses comprise 10 competencies organised into 4 domains: professional and ethics practice; critical thinking and analysis; management of care; and enabling. A total of 38 elements exist within the 10 competencies. There are 3 main standards for Nurse Practitioners. Together these comprise a total of 9 competencies. Each competency has a detailed list of performance indicators to enable assessment of the practice against standards. While detailed and comprehensive, Australian competency standards for registered nurses and nurse practitioners do not outline practices specifically related to palliative care.

Monash University’s School of Nursing and Midwifery in Melbourne includes palliative care as one of its 8 major streams of study towards a graduate certificate, diploma or Master of nursing. It also has a palliative care research team that actively promotes opportunities for postgraduate students to undertake research projects in palliative care (Monash University School of Nursing and Midwifery Palliative Care Research Team, 2006).

Calvary Palliative Care provides a range of professional development opportunities for nurses, including a speciality certificate in palliative care nursing; 2 courses which credit towards competencies in several qualifications at levels relevant to those studying (i.e., nurses, nurse assistants, allied health workers and support workers); and 4 short courses including: communication; grief and bereavement; ethics; and advanced palliative care skills (Calvary Health Care, not dated).

The Centre for Palliative Care Education and Research (CPCER) is an academic unit in St Vincent’s Hospital affiliated with the University of Melbourne. Its educational initiatives include specialist certificate in palliative care; a postgraduate certificate, diploma and masters in cancer and palliative care nursing; continuing education programmes; and provides supervision for postgraduate research students (St Vincent’s Hospital and the University of Melbourne Centre for Cancer and Palliative Care, not dated).

As part of the Strengthening Cancer Care initiative the Australian Government Department of Health and Aging is funding The Australian National Cancer Nursing Education Project (EdCaN). In order to prepare the nursing workforce to meet the needs of people with cancer, this 4-year project (2005-2009) aims to develop a range of standards for national education in cancer nursing across levels from undergraduate to specialist cancer nursing. The goal is a
nationally recognised curriculum that can be customised to meet the specific requirements of the context in which the nursing is to take place (EdCaN).

USA

Within the USA, a national initiative, The End of Life Nursing Education Consortium (ELNEC) developed specialised nurse educators using the train-the-trainer approach (Ferrell, Virani, Grant, Rome, Malloy, Bednash and Grimm 2005).

The curriculum consists of 9 core areas themes in end of life care and adopts a modular approach:

- Nursing care at the end of Life
- Pain Management
- Symptom Management
- Ethical and Legal issues
- Cultural considerations in End of Life Care
- Communication
- Loss, Grief and Bereavement
- Achieving Quality at the End of Life
- Preparation for care at the time of death.

The evaluation of the project identified positive outcomes associated with increasing knowledge and effectiveness of new graduates (Ferrel et al 2005).

Paediatric palliative care

Within the United States, The Initiative for Paediatric Palliative Care (Solomon, Dokken, Fleischman et al 2002) has developed web based educational material to support health practitioners working with children in palliative care. The initiative recognises there are three distinct groups of children:

- Those who are born without an expectation of survival to adulthood but who may live a long time with substantial suffering
- Those who acquire illnesses such as cancer
- Those who suffer relatively sudden death due to trauma.
In responding to their needs five curriculum models have been developed:

- Engaging with children and families
- Relieving pain and other symptoms
- Analysing ethical challenges in Paediatric End of Life Decision Making
- Responding to suffering and bereavement
- Improving communication and strengthening relationships.

As well as providing educational materials IPPC has set goals that they believe hospitals and other institutions involved in paediatric palliative care should achieve, such as, developing strategies for enhancing the palliative care clinical competence of staff (Solomon, Dokken, Fleischman et al 2002). There is no information about the numbers of hospitals and other institutions that IPPC is working with and what the uptake by these organisations has been.

Canada
The Canadian Hospice Palliative Care Nursing Certification requires a detailed range of competencies from nurses at post-registration level. Competencies are arranged into 8 domains including:

- Care of the person and family (23 competencies)
- Pain management (29 competencies)
- Other symptom management (11 competencies)
- End of life planning/dying and death management (14 competencies)
- Loss, grief, and bereavement support (9 competencies)
- Interdisciplinary/ collaborative practice (10 competencies)
- Education (3 competencies).

Some competencies, particularly other symptom management, have a series of elements within them, ensuring that the standard is met across the range of relevant contexts or situations. Competencies are assessed in a multiple choice examination comprising 170 questions. The questions provide a balance of question presentation (independent and case-based), level of cognitive ability required (knowledge/comprehension; application, critical thinking) across each of the domains (as above). Within this examination, there is a balance of contextual variables including client age, gender, culture, health situation, and health care
environment. This tests a candidate’s ability to provide holistic care that is free of prejudice and of a consistent standard across a variety of settings.

In addition to the Hospice Palliative Nursing Certification, the Canadian Registered Nurse Examination assesses competencies belonging to one of 5 domains including professional practice, nurse-person relationship, health and wellness, and alterations in health. Some competencies are particularly pertinent to good palliative care nursing. For example, “NPR-10: provides care that is sensitive to the person experiencing loss (e.g., death, amputation, natural disaster)”, AH-74: “performs nursing interventions to meet spiritual needs (e.g., assesses for spiritual distress, provides time for prayer or meditation, appropriate referral, palliative care)” and AH-82: provides supportive care throughout the dying process.”

Israel
In Israel, all general nursing courses include a unit of palliative care nursing. Several inpatient hospice units offer placements for student nurses for training in palliative care.
Appendix 5: Example of Feedback from one DHB (Canterbury)

Phase 1 of a national report on Palliative Care and Cancer Nurses Educational Needs

Canterbury

Name of person completing this Form:
Nanette Ainge on behalf of Mary Gordon, Executive Director of Nursing, CDHB.

Canterbury DHB plays an important role in tertiary health services for the South Island. Please refer to the map showing the DHB’s catchment area. To learn more, go to our website: www.cdhb.govt.nz ▶ Communications ▶ Publications ▶ Annual Plan for the 2007/2008 financial year (CDHB’s District Annual Plan), Our Disease Priorities see Section 6.3.1 Cancer pp 55, 56.

The growing needs of Canterbury’s aging population are addressed in numerous reports on our website. Population growth projections and associated workforce growth are part of the Cancer Control Strategy.

Approach to postgraduate nursing workforce planning
Canterbury DHB is keen to see a synergistic process to postgraduate nursing workforce planning which avoids duplication, enhances local capability, without any diluent effect on viability1. This will require co-operation from educational providers. Planning must take account of the continuum of professional development. Nursing services in tertiary hospitals are becoming more and more specialised and the rapidity of change is unprecedented. Specialty knowledge is expanding at a very rapid rate in Cancer Nursing. While technology is making dissemination of new knowledge easier, RNs adapt to the knowledge explosion in various ways, so a multifaceted educational strategy is required.

Method of data collection for this information request [+].
These key service areas were identified. Under each section of the questionnaire, individual responses are set out in box format.

<table>
<thead>
<tr>
<th>Christchurch Hospital</th>
<th>Information provided by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children: Haematology Oncology</td>
<td>Clinical Nurse Manager, Childrens Haematology Oncology Centre (CHOC)</td>
</tr>
<tr>
<td>Haematology, Oncology Ward Oncology Dept (Outpatients)</td>
<td>Nursing Director(Haematology/ Oncology)</td>
</tr>
<tr>
<td>Surgery</td>
<td>Nursing Director (Surgery)</td>
</tr>
<tr>
<td>Womens Health: Gynaecology</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Ashburton Hospital</td>
<td>Director of Nursing</td>
</tr>
</tbody>
</table>

[+ This is a limited response. A tertiary DHB caring for patients from across the region means that there are cancer patients in all of our institutions. Most wards and departments provide some services to patients with cancer or requiring palliative care. For example, oncology patients often undergo phases of their illness in surgical or intensive care or diagnostic setting. District Nursing services are contracted out for Christchurch metropolitan area, so their response is not included. Ashburton does provide some district nursing services.

1 Discussion Paper, presented at CDHB Postgraduate Nursing Education Strategic Planning Forum meeting on 12 April, 2005.
Current Palliative Care & Cancer Nurse Workforce - Numbers, Skills, Future Needs?

CDHB numbers and skill-mix data are presented on the Spreadsheet CDHB Summary Data.xls
See also MoH Cancer Control Workforce Stocktake and Needs Assessment.

### 1A Area specific needs for Cancer Nursing

<table>
<thead>
<tr>
<th>Area</th>
<th>Description and Workforce Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Christchurch Hospital</strong></td>
<td>Major South Island Centre - major tertiary &amp; teaching hospital,</td>
</tr>
<tr>
<td><strong>Child Cancer</strong></td>
<td>This is a global workforce. Paediatric cancer nursing can have a higher through-put of nurses often due to overseas nurses working in the specialty on short term contracts while travelling. This can impact on team building and consistency.</td>
</tr>
<tr>
<td><strong>Haematology</strong></td>
<td>There are 2 areas that deliver care to Haematology patients within Christchurch Hospital, (including a proportion with non-malignant conditions). Clinical Nurse Specialist + 0.5 FTE Nurse Educator (shared) Bone Marrow Transplant Unit 15 Bed Unit; Haematology Day Unit 2 beds/7 chairs An increasing number of patients receive transplant as a treatment option. Some chemotherapy treatments are now being offered as a day case. In the next 5 years, these trends will have a significant impact on nursing resources and workforce planning is required to meet the changing needs of treatment options.</td>
</tr>
<tr>
<td><strong>Oncology Ward</strong></td>
<td>As the main Oncology Ward, keeping up to date is a priority, and helps with staff recruitment and retention. Ward based Clinical Nurse Specialist and 0.5 FTE Nurse Educator (shared)</td>
</tr>
<tr>
<td><strong>Oncology Outpatients (major treatment centre)</strong></td>
<td>An increasing amount of cancer treatments is being offered within a day case scenario. Modelling and a workforce plan will be needed around configuring the amount of nursing staff and facilities to respond to this and the potential impact on IP beds and flow on to community. A new CNS role in Radiation Therapy is proposed - to deliver some nurse led initiatives. 0.5 FTE Nurse Educator (shared)</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>There are dedicated Nurse Specialists working with the Breast Cancer patients and a Colorectal Nurse Specialist who 70% of the time, deals with patients whose diagnosis is colorectal cancer. All surgical specialties have oncology patients requiring nursing expertise egg Sarcoma (Orthopaedics), Brain tumours (Neurosciences), Head and Neck cancers (ENT).</td>
</tr>
</tbody>
</table>
**Womens Health: Gynaecology**

Gynaecology / oncology surgical services is provided for the women of Canterbury and other South Island DHBs. The following data Information Analyst:

<table>
<thead>
<tr>
<th>Year</th>
<th>Avg CWD for year</th>
<th>No. of Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003-2004</td>
<td>255.818</td>
<td>255</td>
</tr>
<tr>
<td>2004-2005</td>
<td>296.971</td>
<td>194</td>
</tr>
<tr>
<td>2005-2006</td>
<td>320.299</td>
<td>142</td>
</tr>
<tr>
<td>2006-2007</td>
<td>321.561</td>
<td>122</td>
</tr>
</tbody>
</table>

While the data shows the number of women presenting has reduced, the caseweights indicate the complexity of the surgery being performed has increased.

One Clinical Gynae/Oncology Nurse Specialist (0.4FTE) currently works in the Gynaecology Ward. Her role is to provide education to nursing staff, provide mentorship and support to nurses within the ward and referring DHBs, strengthen the primary/secondary interface and provides information for women who require surgery. An increase in the FTE of the Clinical Gynae/Oncology Nurse Specialist from 0.4FTE to 0.8FTE will enable the role to be developed and expanded to meet future needs.

**Consideration of Workforce in other South Island DHBs**

As women who require our service are also from outside the CDHB region, skills and expertise of nursing staff from referring DHBs needs to be developed. This will enable women to be well prepared for their procedure and post operative care and management. The strength of the Nurse Specialist role is to develop excellent communication within the multi-disciplinary team, to act as a mentor and resource person for the nurses from the referring DHBs. With the complexity of surgery, these nurses skills need to be maintained and kept current.

Very few women receive palliative care on the ward.

One NP In training (Womens Health & Colposcopy)

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**Ashburton Hospital**

80 Km from Christchurch, this hospital also serves a rural population.

Most cancer care is provided in Christchurch; a limited chemotherapy service for ambulatory patients is offered in Ashburton. (Also some diagnostics like colonoscopy etc which are not included in this response.)

Chemotherapy service runs from the Day Unit in Ward 3. Currently, 4 chemotherapy certified RNs across the site. 4 RN’s (3.6 FTE across both pm and day duties and also offer some on call work case by case) – 2 with BN and others RGON or Diploma.

All have completed 700 level work, one has Postgraduate papers. Average age is 50 years.

Future needs more user-friendly chemotherapy certification to increase RN confidence. (We have trouble retaining staff certification because it is seen as such a major responsibility by some.) Our patient volumes for chemotherapy are also episodic and small overall. This can make skill retention a challenge.
### 1B Palliative Care

**Christchurch Hospital**

Community care is provided by the “non-provider arm.” As District Nursing in Christchurch is non CDHB, please advise if you require information from that sector.

**Adults**

Currently 2 FTE nursing staff at Clinical Nurse Specialist Level.

Increased treatment options and an aging population have significantly increased the workload as cancer becomes a ‘chronic illness’. There will be a need to increase nursing levels by 1 FTE to meet the projected demand over the next 2 years within CDHB hospitals.

Internationally areas involved in Chronic Disease Management are implementing the ‘Liverpool Care Pathway’. This is a quality initiative that has already been taken up by some NZ hospitals. It is a nurse lead initiative and implementation will require a project person.

**Children**

CNS offers Outreach Palliative Care to children. (1 FTE, jobshared)

A component of another CNS role provides palliative care to children with life limiting conditions.

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**Ashburton Hospital**

Palliative care is managed by an inter-professional palliative care team, with hospital and community team members. Key nursing input is via district and open admission to the base ward (Gen med/ surg/palliative care).

Inpatients usually number 2-4 at one time and community care can number up to 30 or 40.

Community care is via district nurses – 2-3 RN and 1 EN on days and 1 RN on evenings and weekends augmented from a pool of district nurses PRN. 2 key RNs – 1 graduate study and 1 masters, ave age 57. Other staff largely graduate level study at 700 level and RGONs. 2 ENs.

Average age is 45.

Inpatient care provided by collaborative team model where only 18% of nurses work full time. 15 RNs (3BNs and a mix of RGON and Diploma). 5 PG Certs currently in progress (2 of which major in palliative care) and 1 palliative care PG Cert completed. Average age RN -46 and EN -52.

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**Educational Needs of Current Palliative Care & Cancer Nurse Workforce**

Educational Levels are presented on the Spreadsheet CDHB Summary Data.xls

Postgraduate qualifications may be under reported. Over 20% of cancer nurses have PG qualifications.

**2A Cancer Nursing – additional comments**

| Christchurch Hospital | Chemotherapy certification is required and is provided currently by the Nurse Educator, Oncology. See Appendix B for articulation with CPIT at level 7. Postgraduate studies are supported via CTA funding. Our main educational provider is the University of Otago. |
| Child Cancer | CPIT Paediatric Oncology (GCPO700) Paediatric Palliative Care (GCPP700) ✓ Coventry programme ✓ |
| Haematology | There is a robust preceptor program in Haematology introducing staff to the specialty. Ongoing education is support by the Nurse Educator and Clinical Nurse Specialists meeting the needs of the unit. CPIT short courses in haematology nursing & Leukaemia. Currently plans include looking at pathway development with nurse initiated care. Workforce development for future responsiveness to the increasing numbers of patients receiving this treatment in the near future. Bone Marrow Transplantation for malignant disease is an increasing treatment option. It is complex and is high dependency. |
| Oncology | A comprehensive preceptor program orientates staff to the specialty with ongoing regular in-service education responding to the needs of the unit. Nurses access tertiary educational opportunities at graduate and postgraduate level with the support of the Department of Nursing, and CTA funding for postgraduate study. |
| - Surgery | CNSs have Postgraduate Qualifications. (minimum PG Cert) |
| Womens Health: Gynaecology | Graduate Level education papers (NZQA) appropriate to the specialty cancer i.e. gynaecology/breast cancer. See CPIT Matrix. Advanced Health Assessment and other postgraduate education papers (NZQA level 8) are accessed. (Some with an inter-disciplinary focus.) |
| Ashburton Hospital | Graduate level education (NZQA Level 7) is supported for staff nearing the end of their careers who do not wish to invest in Postgraduate study. For many, understanding the nursing care associated with cancer treatment regimes is really helpful and is possible via the CPIT level 7 courses. Also, generic topics around communication skills, support, hope, cultural safety and other key nursing skills are very valuable at all levels in relation to cancer care. We plan: Better organizational structures to support advanced skills of PG Clinical Masters study that reduce risk of isolation and burn out as roles expand in the CNS area where greater clinical responsibility is undertaken. To review our internal CDHB certification programmes (especially chemotherapy and Graseby processes which are very intensive for regular users) |

In the community, we need to continue developing a workforce with the skills and expertise for palliative care and symptom management. Even with CTA funding, within smaller services,
there is limited facility to release staff over and above class time because of staff shortages. Full time staff have difficulty fitting in the demands of study especially in isolated practice roles.

Nursing expertise in Palliative Care is needed in many settings, and is a key part of the Aged Care strategy. While recognising that there is some role overlap, particularly in smaller centres, the historical tendency to associate Palliative Care nursing with Cancer nursing must be discarded. Palliative Care nursing services are provided in contexts as varied as intensive care, to patients at home or in rest homes, residential care. Curriculum design must accommodate the interface between Gerontological Nursing and Palliative Care for papers to articulate smoothly.

<table>
<thead>
<tr>
<th>2B Palliative Care</th>
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<tbody>
<tr>
<td>The Palliative Care team provides continuing education running a year long Palliative Care Resource Group Programme. Approximately 80 members attend the Group, participants coming from within the CDHB and from NGOs. One CNS is Masters prepared, the others have PG qualifications towards Masters.</td>
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<table>
<thead>
<tr>
<th>Ashburton Hospital</th>
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<tbody>
<tr>
<td>Our staff can attend the regular Palliative Care group meeting that provides opportunity for inservice learning from an experienced team discussing individual patient needs. A CNS or NP would be great but the patient numbers do not currently support this. With the addition of a Chronic Care Team in 2008 this may change over the next 5 years.</td>
<td></td>
</tr>
<tr>
<td>Continued support for PG study. We support a wide scope of study rather than a lot of narrow focus specialty degrees and while a specific cancer qualification would not be discouraged support it is not a priority in this setting due to our small numbers. Palliative care study is more suited to our workplace allied with chronic care specialty and symptom control papers. There is substantial similarity in the core competencies of advanced practice across specialties and given the diversity of rural areas a specialty paper/s within a framework of advanced care core skills is most useful to us.</td>
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</table>

Educational Availability: What is Available, Access, Future Needs

Our main provider of postgraduate nursing education
Postgraduate studies are supported via CTA funding. Our main educational provider is the University of Otago. (60% of CTA funding). Each year, more RNs are completing Clinical Masters.

Postgraduate Studies in Cancer Nursing
Auckland University has excellent several specialty papers in Oncology Nursing, and Child Cancer Nursing, which our staff access. CTA Funding has enabled this support to grow.

Victoria University of Wellington has a paper NURS 538 People in Life – challenging Situations – Cancer Nursing
Recently the Royal Marsden developed a MSc in Cancer Care. There are similar programmes in Australia. Assessing the need to develop a Masters programme in New Zealand or to link a well regarded international programme must include financial viability. TEC changes are affecting some postgraduate nursing schools. (Eg recent demise of a South Island Masters programme.)

Postgraduate Studies in Palliative Care Nursing **
CTA reviewed Victoria University of Wellington’s postgraduate certificate in Palliative Care in 2005. That report may be helpful.
Whitiriea / Hospice NZ Postgraduate Certificate is very popular and well reviewed by participants, especially RGNs, some of whom have continued to Postgraduate Diploma. (We are discussing a forward articulation pathway with our local colleagues at the University of Otago.) As these nurses may have leadership roles, their exposure to postgraduate studies is vital, but some have been reluctant to start at a University, so this course is valued. A CNS accessed University of Auckland’s paper in Palliative Care - Child & Adolescent, and found it very worthwhile.

Graduate Studies in Cancer Nursing at CPIT
Graduate Certificate in Nursing Practice (Cancer Nursing). Please see Appendix A. Ten short courses have been designed in partnership between CPIT and CDHB, in recognition of our role in supporting South Island secondary care hospitals and other regional needs. Our staff contribute to the teaching. Dr Daphne Manderson at CPIT could provide up-to-date curriculum information.

Coventry University, Post Graduate Certificate
Cancer Care for Teenagers/Adolescents and Young Adults
The CNM advises that “this web based course is available to NZ students. Currently there are grants available for overseas students and Canteen are very supportive of this course in offering assistance with fees. If these subsidies were unavailable the course fees would be unmanageable for NZ students. The first year is almost completed and while there have been some on line teething problems these have since been addressed.”

Chemotherapy Training & Competency – inhouse at CDHB
It would be good if DHBs could agree a nationally recognised programme, with a RPL mechanism for Overseas trained nurses. This would save duplication of effort and cumbersome processes when nurses transfer between organisations. CPIT has recognised the CDHB course as 5 credits on the NZQA Framework. (Locally, a review of our course is planned – see comments from Ashburton)

Nursing Entry To Practice Programme (NETP)
Newly registered nurses are inducted into a professional/career development process from day one of the NETP. The NETP provides a platform to go on to develop specialty and advanced practice within an operational clinical context. The programme is fully aligned to our PDRP.

Undergraduate Preparation
Palliative care nursing content must be explicit in the BN curriculum.
3 Additional comments

<table>
<thead>
<tr>
<th>Location</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>Christchurch Hospital</td>
<td>Graduate and Postgraduate level study is actively supported by the Department of Nursing. CNSs require postgraduate qualifications at least to a Certificate level.</td>
</tr>
<tr>
<td>Children</td>
<td>Paediatric cancer and palliative care nursing needs differ slightly from the adult nursing needs. A much smaller population means that courses and educational opportunities are limited and this would be the main barrier for these nurses.</td>
</tr>
<tr>
<td>Womens Health: Gynaecology</td>
<td>CPIT for level 700 papers. Staff have a choice to undertake their post-graduate studies from a variety of education agencies.</td>
</tr>
<tr>
<td>Ashburton Hospital</td>
<td>There is a wide range of options for Postgraduate study, and I think overall the cover is good. At Postgraduate level, we fully support the palliative and chronic care options especially with rural versions. Increased distance study would be good. Attendance at weekly tutorials is difficult for rural staff from small practices. Many of the inter-professional options at local university still require attendance for three hours a week, although teleconferencing is increasingly an option. For staff here, three hours on a teleconference is no better than having to attend in terms of release time and classes are often at peak times of the day. The size of our workforce at Ashburton would not support a cancer-specific PG qualification.</td>
</tr>
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</table>

1. Characteristics of Population Served (including ethnicity) and Cultural Competence of Palliative Care & Cancer Nurse Workforce (include needs for nurses from those ethnicities)

All nurses demonstrate cultural safety as part of their performance reviews and nursing competencies. This is a Nursing Council requirement and component of the PDRP. Nevertheless, the CDHB data return shows a predominately female (in some cases entirely female) workforce, mainly of New Zealand European descent. While the Payroll data sourced was incomplete, other Canterbury APC data suggests under 4% of our nurses are Maori, with similar under-representation of Pacific peoples.

An increasing number of minority groups are relocating to the South Island. This provides an ongoing requirement that we provide culturally appropriate services to all members of our community. Like all areas, the CDHB provides care to an aging population.

4 Additional comments

<table>
<thead>
<tr>
<th>Location</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Christchurch Hospital</td>
<td>We have access to a Maori Health Unit and various community supports to ensure that our services are culturally responsive. However, health statistics continue to indicate that the uptake of services by our Maori is not</td>
</tr>
</tbody>
</table>
optimal. There is a requirement for our services to incorporate more cultural requirements into service planning.

<table>
<thead>
<tr>
<th>Womens Health: Gynaecology</th>
<th>Currently the RN workforce on the Gynaecology Unit is female, NZ/European who are aware of the cultural needs of the various cultural needs of women. The population group we serve ranges from age 30-90.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashburton Hospital</td>
<td>Ashburton District has a growing population with a high number of older adults in the urban area. There is a growing Pacific and Maori population; also African, Asian and other groups. We have also recently appointed an excellent Maori Health Advisor and have access to a Pacific health worker. Both are excellent teachers.</td>
</tr>
</tbody>
</table>

The Palliative Care team is expected to demonstrate cultural responsiveness at all times. The Maori Health Team and Community agencies support them when required.

2. Comments on Key Findings of Palliative Care & Cancer Nurse Survey and Related Findings (pp 9-11 in Summary attached)

The low response rate to the survey probably affects validity of any findings.

- Need to consider wide range of options across continuum, including levels 700 and 800 plus study to support a workforce with a range of previous study qualifications and workplace needs.

- Need to retain a generalist option for advancement in nursing practice.

- In a long narrow country, minimizing isolation is important, especially to regions in the South Island. In rural areas, some would like to see cancer considered more as a chronic disease and linked to that field of study than a specialty but would support a specialty branch to an existing paper.

- Key findings seem in line with what is experienced in our institution. CTA funding has overcome the barrier of cost but time constraints when undertaking study is a major disincentive. Access to computers in the workplace can be limited, especially access to the internet. (Nurse Specialists and other senior nurses have full access.)

- PhD study options should be supported as it is there that new nursing work is created in the field. This is also a good option for furthering inter-professional research and collaborative work.

3. Any other input you would like to make to be incorporated into the final report? Nurses are often very keen to advance their knowledge, however often family commitments make this difficult. Not all nurses wish to proceed to level 800 education papers. Level 700 education papers with specialty focus assists in building a robust skill base and competency for the nursing staff delivering day to day care. The ten
short courses in Cancer Nursing offered by CPIT as part of the Graduate Certificate are fulfilling a valuable need.

Palliative Care nursing is a growing field expanding to people with chronic illness. This requires considerable workforce development.

In Paediatric Oncology, an issue pertains to registration of UK “Childrens Nurses”. In NZ this can create problems within a team particularly in general hospitals. There is an expectation that NZ nurses are generalist nurses and therefore their skills can be transferred in times of need to other areas. However this practice is not encouraged in some other countries and so creates a two tier system of nursing internationally.

Thank you for the opportunity to participate in the survey.

If you have any questions about this response, please contact
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Canterbury DHB
c/o Dept of Nursing
Christchurch Hospital
PO Box 4710
CHRISTCHURCH
tele 03 3641495 (Mon - Thurs) Email nanette.ainge@cdhb.govt.nz