

IRISH ASSOCIATION FOR NURSES IN ONCOLOGY



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Introduction

Dear Members,

Welcome to the Autumn/Winter edition of the IANO newsletter. In this edition we feature the winning essay in our essay competition and the two runner-up essays. The winning essay was submitted by Teresa Slevin and is entitled “The Role of Parents in bone marrow transplant using Casey’s partnership model (1988) as a framework to discuss issues”. The runner-up essays are “Does the nursing diagnosis ‘nausea and vomiting’ have any relevance in the area of paediatric oncology nursing practise” by Maria Ryan and “The optimal environment to nurse the adolescent with cancer” by Lorna Hampson.

At this time of the year we are looking forward to our annual general conference which is being held on the 25th November 2000 in the Corrib Great Southern Hotel Galway. The title of this year’s conference is “Recent Innovations in Cancer Care” which should be of interest to a large number of our members. The speakers at the conference are:

- Opening Address - Senator Margaret Cox
- Dr Maccon Keane - *consultant medical oncologist UCH Galway*
- Dr John Armstrong - *radiation oncologist St. Luke’s Hospital*
- Nora Kearney - *lecturer University of Glasgow*
- Wilma Ormiston - *genetics nurse St. James’s Hospital Dublin*
- Emer O’Keane - *research nurse St. Vincent’s Hospital*
- Professor Paul Redmond - *consultant surgeon Cork University Hospital*
- Kathy Redmond - *oncology nurse consultant*

The programme for this year’s conference is printed further on in this edition.

Looking forward to seeing you in Galway at the annual conference and in particular at our AGM which is being held on Friday 24th November in the Great Southern Hotel Galway. If you have any queries regarding the conference please don’t hesitate to contact *Mary Kennedy* at (01)231 0529 10am - 2pm Monday - Friday.

**The Role of Parents in bone marrow transplant
using Casey's Partnership Model (1988) as a
framework to discuss issues.**

by

Teresa Slevin

Bone marrow transplant is a last resort for many children with malignant and non-malignant conditions. It is a treatment filled with hope, but unfortunately, it is also plagued by uncertainty (Wochna 1997). Parents play a major role in caring for their child during the transplant and the case that follows highlights just one of the many problems that may be encountered, during that time.

Ann is an eleven years old girl who has acute lymphoblastic leukaemia since she was four years old. She relapsed twice in the last year and as a result is having an allogenic bone marrow transplant. Her older sister is her donor. Ann's main carer is her dad (John), who has taken three months off work to care for her. Ann's mum visits during the weekend, which gives dad a chance to go home and spend some time with the other three children. Since Ann's first diagnosis her parents have always participated in her care, which is, promoted by our oncology unit. The parents main responsibilities throughout Ann's treatment were care of her broviac dressing, mouth care and administration of her oral medication and nasogastric feeds. Dad is anxious that he will be allowed to continue with these responsibilities while Ann is in transplant.

Prior to the transplant Ann and her family met with the transplant team and discussed what the transplant entailed and their role during this time. It was welcomed and accepted by members of the team that the parents could continue with their usual routine in relation to the broviac dressing, mouth care and the administration of medication and nasogastric feeds, with the assistance of the nurses. "The care of children, well or sick, is best carried out by their families, with varying degrees of assistance from members of a suitably qualified health care team whenever necessary" (Casey, 1988 p.8).

For this assignment some of the problems that developed as a result of allowing parental participation, and how these problems were overcome will be discussed. The main problem that arose, especially as Ann got sicker, was Dad and Ann's non-compliance with care. Dad disagreed with enforcing mouth care, delayed in giving her medication and at times refused to adhere to her feeding regime if he thought Ann was too unwell or if she was uncooperative. These specific areas were chosen for discussion as they were very important chores for John. In being allowed to provide this care he felt that he had some control over a little of Ann's care and more importantly it made him feel he was needed, and that he hadn't to depend or relinquish all care to the nurses. However in allowing John to retain control over these areas, created, certain challenges for the nurses and this emphasises the important of good negotiation skills and a trusting nurse/parent partnership in order for Ann to receive optimum care.

Casey's partnership model (1988) comprises of five concepts: the child, health, environment, family and the nurse. The philosophy of this flexible care model identifies the important contribution that parents make to the care of the sick child and the role of parental empowerment. Partnership nursing tries to create a relationship of equality between the parents and the professional carers (Farrell 1992), but this may not always be the case. Casey's partnership model (1988) will be used as a framework in this assignment to discuss Ann's care, using a holistic approach rather than discussing each individual concept. However, the concept of the nurse and parents will be discussed in more detail than the other three concepts.

Preventing and treating infection in bone marrow transplant patients presents a complex challenge for nurses and the type of isolation to use during a transplant is controversial (Dunleavy 1996). Due to the restrictions created by isolation, Ann was limited to only three people to participate in her care. As stated earlier, Dad was her main carer, with assistance from mum at the weekends. They didn't have a third person. During the initial period in transplant John and Ann continued their usual routines of care, which appeared to help them settle in to their new environment. Parent participation provides parents with a feeling of control and positivism, but also gives them something to focus on and helps alleviate their fears (Evans 1994). Allowing dad to perform tasks for Ann helped alleviate some of her stress and it provided a sense of normality amongst all the abnormality. This point was also cited by Knafl et al. (1988) in their research of the hospitalised child.

Two weeks in to her transplant, Ann developed bad mucositis and this is where problems began. She became uncooperative and began to refuse to adhere to her mouth regime. Initially her dad tried to persuade her to perform her oral care, but unfortunately as the condition of the mouth deteriorated and the more difficult Ann became the less attempts were made by dad to enforce this vital task. The nurses, initially didn't notice the omission of mouth care, because they had become very busy with the administration of intravenous medication and blood products, which were time consuming, but a vital part of Ann's care and the nurses assumed that he was in control of the situation.

Non compliance is seen as a manifestation of patients asserting control in a situation (Haberman 1988, Perry 1992), and some transplant patients feel that they have complied with the regimen of transplant for long enough. At this stage Ann was becoming fed up with the restrictions that were imposed on her and was feeling miserable. Gardner et al. (1987) claims that non-compliance among paediatric bone marrow transplant patients is attributed to a desire to achieve mastery and control. Phipps et al. (1990) in their research on compliance in bone marrow transplant

patients found that the highest rates of non-compliance were found in pre-school and school age children and not adolescents and it was usually in relation to oral care regimens. It was felt that Ann was not adhering to her oral care, as this was her only form of retaliation. The nurses had become in control of most of her care, which left Ann that she had little say in decisions about her care or treatment. After identifying, and in trying to overcome this problem the team negotiated with Ann and offered her as much choice as reasonably possible in relation to her care. For example, the time she would prefer for mouth care, and the choice of the nurse or her dad to implement this care.

The physical risks associated with stomatitis due to immunosuppression and infection is responsible for some of the morbidity that occurs in bone marrow transplant patients (Ezzone et al 1993), and may even be fatal (Zerbe 1992). The importance of adherence to her mouth care was emphasised to both Ann and her dad in the hope that this knowledge would promote compliance. There is no dispute that regular oral care is essential in reducing the detrimental effects of a compromised oral cavity (Gibson et al. 1997). Ann requested to allow dad to perform her mouth care, even though the staff had some reservations about dad's ability to overcome his daughter's manipulative ways.

Tesno (1995) recommends that the family should be aware of the development of non-adherence problems and have the nurse assume the responsibility for these problems which will be emotionally less draining for the family. This may prevent the breakdown of the parent/child relationship that is so important at this stage of their illness. Handing over the difficult tasks to the nurse allows the family to do the 'nice things' such as providing comfort, support and play with the child, but in this case, Dad refused to relinquish these tasks. Following the discussion on mouth care it was noticed dad had become stricter with Ann in performing her oral care. This new effort by day to comply with the mouth care regime emphasised to the staff that he had obtained the necessary knowledge to empower him to ensure that Ann's oral care would be adhered to.

In order to achieve parental empowerment the nurse has to be willing to relinquish some of her role to the parents. This empowerment allows the parents to become their child's advocate and therefore make decisions on their child's behalf (Valentine 1997). As Ann's condition worsens, the more anxious and upset her dad became, and this affected the decisions he made in relation to Ann's care. Not only was he not adhering to the mouth care regiment now he refused to comply with the nasogastric, feeding regime. As soon as Ann complained of feeling nauseated, he would immediately stop the feed, despite numerous explanations as to why it was

so important to continue the feed, even at a very slow rate. This non-compliance with instructions created conflict between the staff and John. Ann realised that the more uncooperative and upset she became the more her dad would get upset and give in to her requests, which usually was not to disturb her. This created a situation where the nurses had to confront both Ann and John each time a task had to be performed.

It was noticed that as Ann's condition deteriorated and the lack of "cures" and the uncertainty of the transplant process the more anxious and angry John became. Despite giving explanations for the various problems that Ann encountered and informing him of Ann's day to day progress, John remained very anxious and angry towards the staff. Martocchio (1990) states that many family members feel that they are helpless and can do little for their sick child during the transplant process and at times question their decision to have allowed their child to have undergone the bone marrow transplant. As John's fear and anxiety began to overwhelm him, it interfered with his coping and his ability to offer support to Ann. Part of the problem may have been that he did not have an appropriate vent to voice his frustration or concerns. Initially the staff were too concerned about Ann's condition that dad's concerns were overlooked and the more anxious he became, he got labelled as being "difficult". As a result the staff avoided him which added to his anxiety.

It was noticed that John's anxiety levels corresponded to the amount of hope he had in relation to Ann's progress. The longer Ann's problems existed, John's hope for improvement or cure diminished and his anxiety levels increased. Hope played a major role in Ann's treatment. Thorne (1985) states that promoting a positive attitude and maintaining hope is very important for both patient and family. Throughout Ann's treatment it was necessary that the team conveyed an attitude of hopefulness and it appeared to help alleviate some of the stress. The team promoted this attitude of hopefulness by focusing on the positive aspect of Ann's condition e.g. her improved mouth condition, the improved blood count and Ann's own psychological well being. At the same time it was important not to ignore the negative side of things but to emphasise to her parents how things may improve. Fortunately it was common for the nurses caring for Ann to be optimistic as all in all she was progressing well despite some complications.

Brack et al (1988) claims that hope cannot be emphasised enough during bone marrow transplant. By informing John of Ann's daily progress immediately the results were available rather than having him to ask appeared to reduce his stress and increased his faith in the nurses and medical team.

Supplying John with the daily progress allowed him to be more hopeful about Ann's treatment. This enhanced hope encourages compliance with treatment, as John realised that adherence to policies were producing the appropriate results.

Part of dad's anger and frustration was fuelled by his exhaustion. Because he had taken three months off work to care for Ann he felt that he had to be present all the time. Even though his wife came up at weekends, John didn't take a break because he felt he was more in tune with what was going on than mum.

This attitude of his created tension between himself and mum. It took a lot of persuasion to encourage John to change their arrangement so that he could have a change of scenery and more importantly spend some time with his other children. The diagnosis and treatment of childhood cancer in a family changes a siblings life, including exposing a sibling to the side effects of treatment, feeling of being displaced, and a possible misunderstanding of what is happening (Lehna 1998). The siblings of bone marrow transplant patients experience similar problems as those mentioned in the previous statement. The feelings of being displaced and of isolation were worse for Ann's siblings, due to the long period of separation and the fact that the parents were more engrossed than ever before in Ann's treatment. Dad felt that the time he spent with the rest of his children, when they visited Ann on a Sunday was sufficient. He felt that they didn't need him as much as Ann did. Ann's mum was in agreement with the staff that dad needed a break away from the hospital for a short while. She also felt it would benefit the other children as they were taking their frustration and annoyance out on her because they missed their dad and they didn't fully understand why he spent all his time with Ann.

John had become so involved in Ann's care that he was oblivious to the stress and strain that had enveloped him and the effects it was having on his family and the staff. His non-compliance was mainly as a result of his stress and exhaustion, which was discussed earlier and this was creating conflict with those around him. This conflict was preventing the progression of the healthy parent/nurse relationship that had developed at the beginning of Ann's transplant. As a result, Ann's nursing care was affected as the staff found dad's assertive and demanding ways difficult to deal with, especially the more junior the staff or the staff who hadn't cared for Ann before. Valentine (1997) in her discussion on family-centred care identified the fact it was the less experienced staff that had the greatest difficulty in coping with parental conflict, which was mainly due to their lack of negotiation skills. To overcome this problem in Ann's case it was decided that the nurses who had a good rapport with John and the more experienced nurses were allocated to Ann's care. It took a lot of discussion and negotiation with John to

highlight the benefits of him going home for a few days, without him feeling that the team were dismissing him. John took it very personally and felt that the nurses thought that he wasn't coping and this upset him greatly. It was emphasised to him that everybody needs time out and the other parents in transplant were used as an example to demonstrate how they share their time between home and the unit.

Another option, which the unit promotes, was the involvement of a third person in Ann's care but John was completely against this. Just as John was beginning to think about going home, Ann began to 'play up' pleading with him not to go and this made the situation more difficult, as Ann blamed the nurses for wanting to send her dad home. After spending a lot of time with Ann, dad and mum and discussing the importance of dad going home, a compromise was reached.

Reluctantly John agreed to adhere to the initial plan arranged prior to Ann having her transplant. He would go home for at least two nights every week and the nights were to be chosen by himself and Ann. Initially John didn't want to admit that he had a renewed energy on his return visits to the unit after being away for awhile. John's break also benefited Ann in that she and mum had quality time together alone, and the change of shift between mum and dad helped to break the monotony of the transplant regime. The other children gained in that they were able to spend time with both parents.

It took a lot of negotiating and compromise on the staff's behalf in order to reach an agreement that would provide Ann with the best care. This negotiating allowed all parties involved to voice their grievances and as a result promoted honest and open discussion. This degree of openness and honesty ensures optimum trust, between the family and nurse and this leads to greater compliance (Macleod Clarke and Latte 1992). In the transplant environment the difficulty for parents to negotiate is further aggravated by the stress and the uncertainty of the transplant process. Negotiation may be seen as a learned skill, from which the continuum of confrontation, change and adaptation allows both parties involved to win and grow from the experience (Ganlett-Beare 1989) cited by Soanes (1997). In Ann's case the negotiation that took place allowed the nursing staff to develop negotiating skills, which empowered them to deal with conflict without feeling threatened by the parents or endangering the care Ann received.

In this assignment the role of parents in bone marrow transplantation was discussed in relation to non-compliance, using the Casey's Partnership Model (1988). Non-compliance is common among young children and pre-adolescents as they retaliate against the restrictions of the transplant. Parental participation plays a major role

in promoting compliance, but it is vital that the parents are empowered to deal with their child's non-compliance and realise that they have the support of the staff to enable them to achieve this goal. This assignment also highlights the need for nurses to learn and to be confident in developing negotiating and conflict skills in order to maintain a successful nurse/family relationship. An effective two way communication system and frequent evaluation of the nurse/family relationship is important to enhance the success of family centred care during a bone marrow transplant.

APPENDIX

Rationale for either continuation or changing the care given in the future, should a similar situation arise again.

Parental Participation: This is a vital role for the parents as it includes them in the decision making, giving them some control over the situation. This provides a sense of satisfaction and a small degree of power. It is essential that prior to participation the degree to which parents want to participate is identified and negotiated. The nurses should frequently evaluate the situation and be aware of the risk of non-compliance and use measures to prevent it i.e. encourage parents to relinquish their role temporarily if difficulties arise.

The involvement of a third person should be promoted and parents encouraged to use this person to relieve for breaks and allow the rest of the family to spend a little time together.

To set aside a specific time so that parents can discuss their fears and anxieties.

Nurses: Prior to transplant it should be emphasised to parents the importance of adhering to transplant regime. The nurses should develop a good relationship with the family from the start and be able to negotiate decisions without conflict arising. Promote the use of nurses that have cared for the child previously or are more experienced in relation to more assertive and demanding parents.

Nurses should have training in interpersonal, communication skills and managing conflict to work in such a stressful area as bone marrow transplant.

Child: Include the child in decision making as far as possible to provide the child with some control and involvement.

A play specialist is a necessity to provide an opportunity for the child to express their fears and frustration through play. In Ann's case due to the lack of a play therapist, Ann was restricted to the resources that were available to deal with her anxieties.

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**DOES THE NURSING DIAGNOSIS “NAUSEA AND
VOMITING” HAVE ANY RELEVANCE IN THE AREA
OF PAEDIATRIC ONCOLOGY NURSING PRACTISE?.**

by

Maria Ryan

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Introduction

This essay aims to discuss whether the nursing diagnosis “nausea and vomiting” is relevant to the area of paediatric oncology nursing practise. If a nursing diagnosis is to be valid and credible then it must be flexible enough to be applied to real clients in the clinical area (Cox, 1993). The majority of useful diagnoses can be applied to almost any individual in any area by a skilled, knowledgeable practitioner and those that cannot be applied may be too abstract or may not be true nursing diagnoses (Gordon, 1994). In nursing, theory must be applied to practice in order for learning to occur and the use of nursing diagnosis in the clinical area provides a valuable focus for decisions to be made about the nursing care a client may need or desire (Iyer and Taptich, 1995). This author will initially discuss the history of and the background to nursing diagnosis, the problem of nausea and vomiting for the client will be explored briefly as an introduction to the discussion of nausea and vomiting as a nursing diagnosis and finally the relevance of the diagnosis in the clinical area of paediatric oncology will be explored. As a paediatric nurse with oncology experience this author has experienced the many benefits of using nursing diagnosis in this area in the United States especially with regards to the issues of accountability and professional recognition by other healthcare colleagues and feels that the establishment of validated nursing diagnosis criteria in Ireland would enhance nursing image and professionalism.

Section 1.1: History of and background to Nursing Diagnosis

The term nursing diagnosis was first used in the 1950's as part of the process necessary in developing a careplan. In the early 1970's prominent nurse leaders recognised the need for a comprehensive language to describe health problems diagnosed and treated by nurses (Carpenito, 1997). The first meeting to make this process formal was held in 1973 in the USA and since that time work has continued in the development of many nursing diagnosis. The American Nurses Association endorsed the diagnostic process and the term "nursing diagnosis" in 1973 and within a short period of time made it a legal right and a professional obligation for nurses to use the diagnostic process. By the fifth conference NANDA was formed and in 1990 they announced an official definition of nursing diagnosis, the rationale being to clarify what nurses can diagnosis, as there was little question that nurses could diagnose but the traditional nurse training encouraged nurses to act defensively when diagnosing so it was felt that guidelines would be useful (Gordon, 1994). NANDA described nursing diagnosis as follows: "Nursing diagnosis is a clinical judgement about individual, family or community responses to actual or potential health problems/life processes. Nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable" (Carpenito, 1997, p84). Nursing diagnosis makes it possible for nursing expertise to be clarified and hopefully measured. Both NANDA and Marjory Gordon (Gordon, 1994) have developed frameworks for nursing diagnoses. NANDA bases its framework on 9 human responses and Gordon bases hers on 11 functional health patterns.

The term diagnosis is currently used in three different contexts as the second step of the nursing process, which can lead to confusion, as a list of diagnostic labels or titles or as a two or three part statement. After every conference NANDA produces a list which is then further developed by authors such as Carpenito, Gordon and Ackley and Ladwig to name but a few, to be more easily applied to clinical situations. Due to changes in the NANDA list these authors may retain some diagnosis, which are very significant in the clinical area (Ackley and Ladwig, 1997). An actual nursing diagnosis consists of four components a label, definition, defining characteristics and related factors and thoughtful and precise assessment will ensure that the correct diagnoses and related factors are chosen as interventions will depend upon this process (Carpenito, 1997). It is important to remember that nursing diagnoses do not describe everything that nursing does and in an ideal world they would include only interventions that nurses can perform independently or interdependently but they do include dependent ones, as without good assessment by the nurse then the doctor would be unable to care for the patient.

Summary: The development of nursing diagnosis is a continuous evolving process which aims to increase accountability and autonomy for nursing but in order for this to benefit the profession and the clients each diagnosis must be relevant and applicable to the clinical setting.

Section 1.2: Nausea and vomiting in Paediatric Oncology patients a major nursing issue!

Almost all nurses at some point in their careers will come across patients suffering from nausea and/or vomiting yet this important area is often neglected in nurse education (Hawthorn, 1995). Many childhood malignancies once regarded as fatal are now more curable with intense therapy regimes but the side effects can cause much distress to the patient and family. The distress is often described as symptom distress - physical and mental suffering that results from the experience of symptom occurrence (Wong, 1995). Nausea and/or vomiting associated with cancer therapy in children and teenagers can be very distressing and debilitating leading to low morale, poor compliance with treatment and even refusal of therapy but with correct and thoughtful nursing intervention it is a problem that can be tackled resulting in major benefits for affect patients. Newly diagnosed patients, especially adolescent patients and their families generally perceive that “feeling sick” and “being sick” will be the most distressing problem of cancer therapy (Hawthorn. 1995). One of the major reasons in adolescent non-compliance with treatment is nausea and /vomiting with figures as high as 59% being quoted in some studies (Hogan and Grant, 1997).

Nausea can be thought of as an aversion stimulus with the aim of stopping the person from eating. It is a subjective experience that is difficult to describe and may be perceived as unpleasant due to messages being sent from the vomit centre in the brain to the cortical and limbic areas of the brain, but not usually painful (Wong, 1995). Nausea is associated with changes in gut mobility and the patient feels that vomiting is imminent which unfortunately is not always true in chemotherapy induced nausea which leaves the patient feeling very uncomfortable and anxious (Quinton, 1998). Vomiting can be described as the forceful expulsion of gastric contents through the mouth and/nose due to the painful contraction of abdominal muscles. The vomiting reflex involves detectors that identify the need to vomit, effectors, which cause the vomiting, and a co-ordinating centre.

Chemotherapy causes release of 5HT from enterochromaffin cells of the gut mucosa which begins the nausea/and vomiting cycle and a vicious circle is set up as the process of vomiting itself causes more 5HT to be released (Hawthorn, 1995). Emetic stimuli are cumulative and many children undergoing therapy will be fearful and anxious before starting any treatment, which will contribute, to their risk of experiencing nausea and vomiting. Nausea and vomiting must be assessed separately to ensure correct interventions, as they are separate entities.

Anticipatory nausea and vomiting is a conditioned response and is a major problem in paediatric patients undergoing chemotherapy with figures ranging from 11-50% being reported (Hockenberry-Eaton and Benner, 1990) and its prevention is a primary nursing responsibility that involves in-depth understanding of physiology and risk factors as well as the ability to apply knowledge to clinical situations but correct intervention will have major benefits for the patient and family (Scanlon-Fessele 1996).

Summary: As discussed above, nausea and vomiting in paediatric oncology patients is a major problem with many implications for the nurse, patient and family yet it is an area where knowledgeable nursing assessment, diagnosis and planning can change the course and outcome of the treatment and prevent distress and suffering.

Section .13: Nausea and Vomiting - A Nursing Diagnosis?

There is no question that nausea and vomiting is a major nursing issue and area of nursing responsibility but can it be seen as a true nursing diagnosis? Different authors categorise nausea and vomiting differently but it does not or has never appeared on the official NANDA list. Wong (1995) places it with the nursing diagnosis, high risk for fluid volume deficit related to nausea and /vomiting, when discussing children receiving chemotherapy and appears to feel that it is a very significant diagnosis with correct interventions making a positive difference to these patients care. Carpenito (1997) on the other hand mentions vomiting only briefly under the fluid volume deficit and altered nutrition diagnostic labels as collaborative and potential complication diagnoses and not as a pure nursing diagnosis. The main heading under which Carpenito (1997) and Ackley and Ladwig (1995) discuss nausea and /vomiting is under the nursing diagnosis Altered Comfort. Altered Comfort was accepted by NANDA in 1973 and retained in 1975 but in 1978, 1980, 1982, 1984 and 1986 it was exclusively related to pain (Gordon, 1994). In 1988 it appeared again as a diagnosis in its own right but was dropped in 1990 and has not been use again (Gordon, 1994). Carpenito (1997), Gordon (1994) and Ackley and Ladwig (1995) consider it to be a very important and significant problem for patients and because comfort has always been an important goal for nursing, altered comfort should continue to be addressed they continue to retain it as a nursing diagnosis in their work while acknowledging that it is no longer on the NANDA list.

NANDA described altered comfort in terms of a state in which a person experiences an uncomfortable sensation in response to a noxious stimulus with the major defining characteristic being the person reporting or demonstrating discomfort and nausea and /vomiting would be seen as one of the minor defining symptoms (Carpenito, 1997). The altered comfort could also be related to nausea and vomiting secondary to chemotherapy.

Carpenito argues that nausea and /vomiting represent signs and symptoms of an altered comfort state and are not a contributing factor, something which this author disagrees with and feels that both definitions can apply equally. Carpenito would prefer the statement to say that altered comfort is related to the effects of chemotherapy as shown by nausea and /vomiting and feels that this diagnosis is very appropriate in patients undergoing chemotherapy (Carpenito, 1997). Ackley and Ladwig (1995) use Carpenito's definition of altered comfort and mention retching with chemical irritants discussed under related factors. Their outcome statement specifically mentions relief of the discomfort of nausea as a nursing goal (Ackley and Ladwig, 1995).

Summary: Although a degree of confusion exists around the exact categorisation of nausea and vomiting in patients receiving chemotherapy in relation to it being seen as a nursing diagnosis, it is evident that the many renowned authors quoted above feel that it is a significant nursing issue and should be included for its usefulness and appropriateness in the clinical area, a decision this author would agree with based on clinical experience.

Section 1.4: The relevance of the Nursing Diagnosis “Nausea and Vomiting” to Paediatric Oncology nursing practise

Having already discussed the fact that nausea and vomiting are major nursing issues in paediatric oncology practise and are a valid and useful nursing diagnosis for paediatric and adolescent patients receiving chemotherapy, it is now necessary to discuss the relevance of the diagnosis for the area of paediatric oncology. Many studies have shown that assessment of the patient prior to starting chemotherapy for risk factors; anxiety and pain could prevent any nausea or/vomiting occurring during the treatment and prevent anticipatory nausea and /vomiting developing. Goodman (1997) found that 50% of recovered adolescents who had received treatment for Hodgkin’s disease still have anticipatory nausea and /vomiting two years after completing treatment. The use of the nursing diagnosis nausea and vomiting - either actual or high risk provides a structure and framework for assessment, intervention and evaluation of what is essentially a nursing problem. The only medical intervention in nausea and vomiting is the prescription of the anti-emetic and the nurse should be heavily involved as the anti-emetic needs to be based on the emetogenicity and dose of the chemotherapy being given along with individual patient needs and problems. Nurses are the only consistent care providers and the use of the nursing diagnosis allows for accurate assessment, prompt intervention and documentation of the care given to promote quality and continuity of care.

In order to show relevance to the area of practise the writings of Carpenito (1997), Wong (1995) and Ackley and Ladwigh (1995) will be used to examine the application of the diagnosis to the clinical area. Carpenito (1997) mentions the need to assess the onset, duration and frequency of nausea and /vomiting and to be aware of the patients environment and the relationship of the nausea and vomiting to meals. The use of medication to relieve nausea and /vomiting can be useful but the efficacy must be assessed. Hawthorn (1995) suggests the use of either a Visual Analogue Scale or a Semantic scale to assess nausea initially and then to assess the effects of the medication given and this certainly could be used by children and parent in the area of paediatric oncology where the assessment can be quite difficult. Carpenito (1997) does not mention anything about assessing for risk factors such as sex, age, motion sickness, anxiety, pain or menstruation which have been identified as increasing the risk for chemotherapy induced nausea and / vomiting in children and adolescents (Foley, Fochtman and Hardin-Mooney, 1993). She also fails to stress the need for individualised and in-depth pre-treatment assessment. The identified outcome suggest the reduction of symptoms when in fact the aim should be the prevention of any nausea and /vomiting. In relation to assessment Wong

(1995) stresses the need for full pre-treatment assessment and identification of risk factors with the goal that the patient will experience no nausea and/ vomiting. Ackley and Ladwig (1995) stress the need to determine the cause of the nausea and/ vomiting as the cause can often determine the treatment and discuss the role of environmental assessment in preventing nausea and/ vomiting. Stimuli such as sights, sound and smells can trigger acute nausea and/ vomiting in patients and can also elicit anticipatory reactions (Quinton, 1998). Their goal for the patient is similar to Carpenito's.

In the area of intervention some very good guidelines are given which again prove the relevance of the diagnosis to the area being studied. Carpenito suggests the need for the nurse to provide comfort for the patient during the episode by holding their hand, holding the emesis bowl and rubbing the back, which can easily be applied to paediatric oncology. The need for good mouthcare is stressed to prevent dental damage but also to prevent further vomiting due to a bad taste in the mouth, which can start a vicious circle. (Scanlon-Fessele, 1996). Carpenito places fewer onuses on management with drugs and emphasises the nurse's role in manipulating the environment to reduce noxious stimuli such as the odours of cooked food; the smell of strong perfume and the unpleasant smells associated with a ward area. These interventions may appear simple but in the quest for skills acquisition are often ignored by nurses to the detriment of the patient (Hawthorn, 1993). Wong (1995) suggests interventions that are child specific and easily put into practise. She suggests administering the initial dose on anti-emetic before chemotherapy with the first treatment being the critical one, to prevent the child from experiencing any nausea and /vomiting thus preventing an anticipatory response. Woodgate (1998) supports this plan and recommends individualised assessment when picking anti-emetics and the need to consider both physiological and psychological issues in the management of this problem. Wong (1995) also suggest administering the chosen drug around the clock for as long as nausea and/ vomiting could be expected to last to prevent any episodes from occurring. Hawthorn (1995) also stresses the need to assess for delayed nausea and /vomiting which can last for up to seven days after the end of treatment and is experienced by 30-60% of patients receiving chemotherapy. She suggests the use of a diary by the patient and parent to help record the incidence of these problems and thus assist with interventions. Wong (1995) also stresses the need for ongoing evaluation of both pharmacological and nonpharmacological methods to ensure that the child is benefiting from the interventions. She also discusses issues about the management of smells and the reduction of noxious stimuli and gives guidelines similar to Carpenito (1997). Ackley and Ladwig (1995) discuss the use of medications and environmental stimuli reduction but also include the use of nonpharmacological methods such as

distraction, therapeutic touch, muscle relaxation and guided imagery all of which can be taught by nurse who have obtained the necessary skills. Tyc, Mulhern, Jayawarlene and Fairclough (1995) found that children and adolescents undergoing chemotherapy benefited from instruction in guided imagery and the use of distraction such as videos and music with a reduction in nausea and /vomiting and thus better compliance with treatment. Relaxation exercises have been shown to reduce anxiety in children undergoing chemotherapy and thus take away one of the major risk factors (Foley, et al, 1993). It is necessary to remember that the above authors only provide guidance in using a nursing diagnosis in the clinical area and in the case of nausea and vomiting they help to show its relevance to the area of paediatric oncology.

Summary: Overall the use of a framework such as nursing diagnosis helps nurses in clinical areas to assess and plan care and this author firmly believes that the nursing diagnosis “nausea and vomiting” is very relevant to the area of paediatric oncology.

Conclusion

As nursing strives to become a profession and to be more accountable and autonomous then it needs a structure and language of its own so other professionals will know exactly what nursing involves. Nursing diagnosis can provide a way for nurses to claim and document problems and interventions that are the sole responsibility of nursing and where nursing intervention will improve patient care and outcomes. In the rush for professionalism it is important to realise that nursing involves real people and if a nursing diagnosis is not relevant in the clinical area then it is a purely theoretical exercise. For a diagnosis to be relevant it must be useful and the assessment and intervention must be of benefit to the patient (Gordon, 1994). This author believes that the nursing diagnosis “nausea and vomiting”, although not NANDA approved, is relevant in the area of paediatric oncology because it identifies ways of assessing and managing a problem that nursing can really solve and recommends that nurses working with all patients who experience nausea and /vomiting should become more active in gathering data to validate clinical findings.

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THE OPTIMAL ENVIRONMENT TO NURSE THE ADOLESCENT WITH CANCER

by Lorna Hampson

Introduction

Adolescence is a period of great change and ambivalence. At present adolescents in the Republic of Ireland who need hospital care are admitted to either adult or children's hospitals or wards. There is not one hospital in Ireland with a specific adolescent ward despite their individual needs (Fitzgerald 1998).

Working in the National Oncology / Paediatric Bone Marrow Transplant unit within the Republic of Ireland, which caters for children from infancy to adolescence, I have a particular recognition for the unique needs and problems faced by adolescents with cancer here in Ireland. Since the advent of the Teenage Cancer Trust within the U.K. there have been a surge of literature pertaining to adolescent oncology within the U.K. Since academia is a relatively new phenomena within nursing in Ireland, there is a dearth of nursing literature capturing the Irish perspective.

This essay attempts to define adolescence and discusses the slow development of specific adolescent health care facilities within Ireland. I will discuss the unique needs of adolescents with cancer and the creation of an optimal environment to meet their needs. I will highlight the benefits of meeting these complex needs using a multidisciplinary partnership approach and make recommendations for the future of adolescent oncology care within Ireland.

Defining Adolescence

Although health care professionals have largely ignored adolescence as a separate entity, it is interesting to note that within a historical construct this stage of development was indeed recognised. Classical literature identified many of the characteristics of the modern day adolescent;

‘Our youth love luxury; they have bad manners and contempt for authority, they show disrespect for elders, and love chatter in place of exercise’ (Plato quoting Socrates 5th Century B.C. cited by Evans, m. 1996 p.251).

Throughout time various theorists have highlighted adolescence as an identifiable and unique stage within human development. Havighurst (1972) identified developmental tasks necessary for adolescents to achieve before progression into adulthood. Piaget & Inhelder (1969) described a final stage of cognitive development that is achieved during this phase. Finally theories of social cognition pertaining to adolescents were developed by Selman (1977) and Elkind (1967) (cited by Rechner, 1990).

There is a general consensus that adolescence can be described as the ‘transition between carefree childhood and responsible adulthood’. It is a time marked by distinct changes in physical, social, and cognitive developments. The adolescent is faced with conflicts regarding political and religious values, social concepts and questions his/her identity. They are expected by parents and society to adopt responsible behaviour and to develop a life philosophy and moral ideology (Evans, 1993, White et al 1997). Adolescence is divided into early, middle, and late sub-phases each with major developmental tasks (Sharp 1980). The litany of varying interpretations and the age ranges within the term ‘adolescence’ causes great confusion as highlighted by Kelly (1991), Lewis (1996), and Whyte & Smith (1997).

Although I believe that chronological age is a poor indicator of maturity, the majority of adolescents nursed on the unit on which I work are aged between twelve and eighteen years. This age range is in keeping with my own beliefs of what constitutes the age range of adolescence. There were ninety adolescents with cancer in the above age category in the Republic of Ireland in 1996 (National Cancer Registry, 1998). Thirty patients (from a total of one hundred and forty four patients) were admitted to the unit in 1998. We must remember that biological, emotional, social and cognitive maturity occurs at different rates and in irregular spurts within and between individuals. Therefore, adolescence must be viewed as a flexible concept reflecting specific development tasks and broadly encompassing

those individuals in their teens and early twenties.

Slow Developments Of Adolescent Services

Despite recommendations laid down forty years ago that encouraged the provision of separate accommodation for adolescents within the UK (The Platt Report, 1959) Burr (1993) highlights that no studies have been performed within the UK to identify available services, evaluate provision of adolescent care or formulate strategies to meet the needs of these individuals. The heightened awareness of this “often forgotten” group within the U.K. has been clearly demonstrated in recent publications such as ‘*Youth Matters, Evidence-based best practice for the care of young people in hospital*’ (Caring for Children in the Health Services, 1998) that recognises the different needs of adolescents and call for separate services designed to meet what they see as their concerns. The overwhelming representation of adolescent related issues and research being undertaken on this population displayed at the International R.C.N. Paediatric Conference last year, further accentuated the lack of recognition the health needs of these individuals get within the Republic of Ireland and prompted me to write this essay to heighten their profile.

McAuliffe and Joyce (1988) feel that the document ‘*Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990’s*’ (Department of Health (Ireland) 1994) is perhaps the most significant for the Irish health services (p.1). Although not specifically addressing hospitalised adolescents, it questions two very important issues;

- 1 The focus of healthcare and
- 2 The system through which healthcare is delivered.

It places great emphasis on the “consumers in healthcare” participation and in improving links to provide the most appropriate care. It emphasises accountability as a key principle within the strategy with emphasis on accountability to the consumers of the service. In 1996 the Department of Health (Ireland) provided a cancer strategy which once again did not focus on the specific needs of the adolescent with cancer. It made an important contribution by promoting the provision of specialists working in multidisciplinary teams with an adequate annual throughput of new cancer cases. The full implementation of the National Cancer Strategy (1996) should therefore help to improve both the care and the caretakers for treatment of cancer patients in Ireland. In Ireland there have been many

initiatives requesting active consumer feedback and input (Department of Health 1986, 1990, 1991, 1992). Although much is being done to obtain feedback from healthcare consumers there appears to be no recognition of the specific views of adolescent patients. In assessing the current facilities available for adolescents in Irish hospitals, a study was carried out in 1996 by sending out questionnaires to all consultant Paediatricians practising in the Republic of Ireland (Greaney, 1996). Although recognising that the needs of adolescents in hospital are indeed unique, once again the views of adolescents and their needs in the provision of care was not established.

It is interesting to note that following the publication of a recent Department of Health report (1999) entitled ‘Cancer Support Services in Ireland Priorities for Action’, adolescent cancer services are reported on separately from other issues. This highlights a changing climate in recognition of the specific needs of these individuals. Respondents to the study (including consumers, health care providers and support groups) strongly recommended the development of a specific haematology and oncology unit for adolescents.

Needham (1997) highlights how adolescent service within a U.K. hospital were canvassed through a focus group setting, before the inception of a Teenage Quality Group. The underlying principle in this development was

“the need for a way in which to obtain the opinions of adolescent patients... It was the concept of the Teenager’s individuality and his or her right, under article 12 of the teenager’s individuality and his or her right, under article 12 of the United Nations Convention on the rights of the child, to have an opportunity to express an opinion” (Needham, 1997 p.15)

It is my opinion that the Department of Health, acting with the health care providers needs to turn its attention to their participants where future health may be influenced by their changes. In relation to specific adolescent oncology units, it is only when governing bodies and staff who care for these adolescent are aware of their unique needs that advancements can be made in the development of specific adolescent oncology units. In explaining the slow development of such units, Evans (1996) suggests that staff catering for this age group may not have sufficient training for recognition of their individual needs. Hence, the increase in availability of specific nursing courses in relation to care of the adolescents within the UK. Adolescents with cancer may be seen to be a small group and the financial implications necessary for the creation of specialist accommodation may be unattractive to health care providers.

The Teenage Cancer Trust, funds the capital cost for the specialist adolescent oncology units within the UK. Each unit costs £500,000. The Trust works in collaboration with the National Health Service Trusts which largely funds the day to day operations of the units. Evans (1996) claims that the Trust “*cannot be expected to pick up running cost which should be the responsibility of the provider unit*” (p.259). She suggests that research is needed to demonstrate that meeting the emotional and social requirements of adolescents will improve their long-term outlook and, although difficult to prove, they will more importantly in the eyes of the providers reduce costs.

The recent recommendation to set up “separate adolescent units with appropriate staffing and facilities” by the organisation Children in Hospital Ireland (1999) may prove a turning point with regard to the recognition and development of such facilities within Ireland. Likewise the establishment of a working group by the Department of Health and Children to make recommendations for the development and provision of cancer support services has prompted interest amongst adolescents with cancer. “CanTeen” (a support group for teenagers with cancer run by teenagers with cancer) currently making a submission to the Department strongly endorsing the need for a specific adolescent oncology unit in Ireland. This is the first active demonstration by adolescents to air their views in service provision.

“A special adolescent unit is what we need. It could have a hang-out area and couches. Our friends could come in and hang out with us. People would have to knock on the door and give you a little privacy”

and

“The facilities for treating teenagers are crap”.

These quotes from the CanTeen submission highlight the lived experience of adolescents with cancer in Ireland in relation to inadequate facilities.

The impact of cancer on the adolescent

Even when health and vigour prevail, adolescence has been highlighted as a difficult time of life. It has been described as a period of emotional upheaval (Freud, 1969) and as a time of ‘*storm and stress*’ characterised by inner turmoil, rebellion and moodiness (Atkinson et al, 1990). The adolescents normally needs (e.g. accepting a new body image and developing relationships) as highlighted by Blunden (1989) are threatened by any illness affecting this group. The dramatic

effect of cancer on the difficult tasks of adolescence highlights the impact of its diagnosis as perhaps the most challenging of diseases in this age group. In reviewing the literature on adolescents and cancer several themes emerge incorporating psychological issues, social life, information and support, families, body image, sexuality and hopefulness. Evans (1993) highlights the adaptation necessary for the adolescent with cancer to make referring to;

1. The effects of the disease and treatment
2. The loss of personal control
3. Changes in social relationships
4. Uncertainty about the future

The common themes identified in the literature will be examined under the above headings. This will highlight that only when these issues are recognised can proper management of the adolescent's malignancy take place.

There appears to be no consensus as to the long-term effects of survivors of childhood cancer. Limitations to studies on this issue are the American focus and the fact that many were conducted over a decade ago. They are retrospective in design with a lack of consideration given to the development point at which adolescents are studied. I feel there is a need for future studies to examine this population separately from other childhood cancer survivors. Especially important is the effect of cancer as the adolescents make the transition into young adulthood. Longitudinal data would be more advantageous in understanding complex processes occurring over time. Finally the implementation of a common research tool that assesses "quality of life" issues would illuminate measures for preventative intervention.

The effects of the disease and treatment

As well as the normal bodily changes associated with puberty, the adolescent has to come to terms with both direct and indirect altered body image, due to the effects of treatment. Bloating and acne development from steroid therapy, dramatic weight changes, altered skin integrity and presence of naso-gastric tubes and central lines, can all be seen as having a direct impact on altering body image. Impaired sexuality and fatigue, which permeate every aspect of altered body image, are examples of phenomena with a more indirect impact. Adolescents may have a dual perception of their body image as described by Gross (1991);

1. the way he/she looks and;

2. the way he/she would like to look.

Threats to body image such as puberty and the effects of cancer and its treatment will increase the distance between adolescent's own and ideal body image which may lead to overwhelming psychological consequences (Evans 1997).

Sexuality encompasses not only sexual activity and the ability to procreate but also self-esteem and relationships. Adolescents with cancer are confronted with sexual and reproductive issues at diagnosis, during the treatment period and as long-term survivors (Heiney, 1989). The sexual implications of cancers and their treatment have been clearly documented (Thompson, 1990). However most of the literature relates to the adult population. Adolescents with cancer appear to have been ignored as "sexual beings". The whole issue of sexuality is usually encompassed under the umbrella headings "self image" and "body image" in the literature. In order to assist the adolescent to overcome a serious illness with minimal social and psychosexual scarring, there is a responsibility for the healthcare professionals to educate themselves on the necessary knowledge and skills to handle this sensitive topic.

There have been dramatic improvements in reducing mortality rates in children and adolescents over the last thirty years (Triche, 1992). As the survival rate improves, the prevention of psychosocial problems will assume increasing importance. A diagnosis of cancer can evoke feelings of anxiety, fear, helplessness, uncertainty and depression in adolescents as they attempt to cope, by coming to terms with the disease, treatment and their uncertain future (Whyte & Smith, 1997).

Loss of personal control

During adolescence the relationships between adolescents and their peers, parents and other adults change. The adolescent negotiates the changing responsibilities and privileges of this unique stage culminating in autonomy (Bee & Mitchell, 1984). The diagnosis of cancer can pose a threat to autonomy. This is due to the effects of cancer and its treatment and the increased dependence of the adolescent on parents, family and medical staff and other health care professionals. The adolescent's information priorities are similar to those of adult cancer patients i.e. information about diagnosis, treatment, and prognosis (Hooker, 1997). In realising that a "tailor made information package developed to meet the needs of every adolescent oncology patient should be used" (Palmer, 1994 p.2) the unit in which I work has introduced "patient held records" in the form of "Passport" in recent months.

Adolescents can maintain a feeling of personal power through being informed and by being offered options whenever they exists e.g. appointment times. The likelihood of acting out behaviours that may jeopardise their chance of long term survival (such as non-compliance with treatment plans) can be reduced where such a philosophy of care is adopted (Broome et al, 1994).

Changes in social relationships

The adolescent peer group is very important. Fear of rejection and social isolation become very real problems in the adolescent with cancer. In on study, 61.5% of adolescent cancer amputee's reported that friends drifted away after the initial crisis of diagnosis was passed (Tebbi, 1985). A considerable component of normal socialisation for adolescents takes place at school. Absence may lead to social isolation and a failure to develop normal skills. Noll et al (1990) discovered in their study that relative to their matched controls, children with cancer aged eight to eighteen years were perceived by their teachers as less sociable and less responsive to leadership as well as being more withdrawn and more socially isolated. With advances in treatment and care of these individuals it may be argued that it is neither acceptable not necessary for teachers and/or healthcare professionals to "write off" these adolescents once diagnosis is confirmed.

Uncertainty about the future

Adolescence heralds new beginnings, with dreams of future life, money, cars, sex and eventual intimacy, marriage and family. A diagnosis of cancer threatens this. In investigating the future goal expectations of adolescent survivors of childhood cancer, adolescents saw themselves successful in achieving concrete tasks such as graduating from school. They were less definite about having children and raising a family (Overbaugh & Sawin, 1992).

Optimal environment

As well as the difficulty in defining this unique period of development, there has also been difficulty in selecting the most appropriate hospital setting within which to care for them. There has been a paucity of research asking sick adolescents where and how they want to be cared for (Farrelly, 1994: Gibson 1997). The UK experience would appear to be more progressive in providing specific adolescents units. The Teenage Cancer Trust was the first national initiative within the UK to appreciate the very special needs of adolescents with cancer. The trust initially set

out to open just one unit for young cancer patients. This was achieved when the first purpose built Teenage Cancer Trust Unit - designed with young people in mind was opened in 1995 in the Middlesex Hospital, London.

The Calman Report (Department of Health (London) 1995) set out seven guiding principles for developing services providing high - quality care for people with cancer. It stated that twenty such units would be required throughout the United Kingdom. Progress has been very positive with six specific adolescent oncology units established and plans to expand the service (Teenage Cancer Trust, 1998). The advantages of having specialist units for adolescents with cancer is built upon two major premises:

Firstly the perceived benefits of centralisation of care should lead to greater treatment and survival. There is clear evidence that centralisation of care leads to better survival especially for childhood cancer. This finding is still somewhat controversial for adult cancers (Stiller, 1988 : Lewis, 1996). The notable progress made in childhood cancer treatment can also largely be ascribed to the achievement of extensive multi-institutional clinical trials. These trials are performed far more widely in the paediatric sector to that of the adult sector (Selby et al, 1996). The unit in which I work is one of the specialist paediatric centres currently affiliated with the United Kingdom Children's Cancer Study Group (UK CCSG). As we're the only such unit within the Republic of Ireland it highlights how the development of an adolescent unit would encourage central registration and the development of specific clinical trials for all groups of individuals.

Secondly, the special physical, psychological, educational, and social needs of adolescents can be best served by geographically centralised expertise within a single multi-disciplinary team (Lewis 1996).

Authors Hooker and Williams (1997) document disadvantages of being treated in specific adolescent oncology units as:

1. The emotional upheaval when a fellow adolescent relapses or dies and;
2. The possible inconvenience and travelling expenses along with the physical and emotional dependence on the unit arising from the units distance from the family home.

The Benefits of a Multidisciplinary Approach

Having highlighted advantages and disadvantages in the development of specific

adolescent oncology units, it poses the question whether it is the location of philosophy of care that matters when dealing with this emotionally challenging group of young people. Much literature states that adolescents have an intense desire to be normal and the threat of being abnormal is often greater than the threat of a potentially fatal illness (Heiney et al 1989 : McCarthy, 1998). *“The human desire is to be normal”* is a view that is incorporated into Orem’s (1985) model of nursing. This identifies the patient’s need to be in control. In the care of adolescents this philosophy should be encouraged in partnership with family, friends and members of the multidisciplinary team. The concept of the multidisciplinary team has always been central to the philosophy of oncology care (Randell et al 1996).

Vachon (1996) describes a team as *“group of individuals who must work interdependently to attain individual; and organisational objectives”* (p.34). She identifies the characteristics of a team as;

1. A charter or reason for working together.
2. Interdependence the recognition that the members of the group need each other’s expertise and abilities.
3. Commitment to the idea of working together as a team.
4. Accountability within the organisational context.

Lauria et al (1996) highlighted how the complex medical and psychological needs of children and families are served best when the collective knowledge and practice skills of professional of several disciplines can be used.

It is widely thought that a multidisciplinary approach is imperative when dealing with adolescents with cancer. In order for adolescents to achieve autonomy in care and decision making during their treatment, a process of empowerment is seen as fundamental in reaching a true partnership. This partnership process describes how the promotion and enhancement of people’s abilities to meet their own needs, solve their own problems and feel in control of their own lives is reached (Gibson, 1997). This approach is imperative for the adolescent with cancer whose autonomy has been threatened at a vital stage in their development.

Stower (1992) and Soanes (1997) highlight effective communication and co-ordination of a multidisciplinary team in which a common goal is pursued is crucial to the development of this *“partnership model”* (Casey, 1988). Negotiation is a key process in both forming partnerships and allowing parental/adolescent control as endorsed by Casey. Successful negotiation does not occur in a vacuum. It is

dependent on the social environment in which it occurs. I endorse the opinion that *“although much can be achieved by skilled and dedicated men and women in unsympathetic conditions, treatment in units designed to be user friendly and sensitive to patient, their families and staff maximises their efficacy”* (Whiteson & Whiteson, 1996 p.ix).

Conclusion

The basis of good clinical practice is research (Allen, 1997). Several limitations in studies of adolescents with cancer exist. These include their UK/American focus, retrospective design, their small sample sizes and the numerous variables considered. The relevance of these study findings may not reflect the experiences of Irish adolescents with cancer. It is my intention to capture this experience by interviewing adolescents and members of the multidisciplinary team to ascertain their perception of the ideal environment in which to meet the needs of these unique individuals.

Establishing a specific adolescent oncology unit would not be without difficulties or controversy. While we are waiting for the development of such a unit, (if proven to be economically viable) adequate supportive care for adolescents wherever they are treated is needed. Social, financial and educational factors need to be taken into account as well as the direct medical and psychological needs of the adolescents and the philosophy of care. I believe that in the absence of specific adolescent oncology units here in Ireland, this unique group of individuals will continue to benefit from all the additional support that is normally available in a paediatric oncology unit. In addition, I feel that many adult oncology departments would benefit from adopting the ‘partnership’ approach to caring and by incorporating roles available in paediatric oncology e.g. patient educators, liaison nurses. The current climate of patient empowerment, changed service demands and partnership caring demands active listening to the views and wishes of adolescent patients with cancer in relation to their own care.

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IRISH ASSOCIATION FOR NURSES IN ONCOLOGY

18th ANNUAL CONFERENCE



**Recent Innovations
in
Cancer Care**

in

Corrib Great Southern Hotel, Galway

on

Saturday 25th November, 2000

AN BORD ALTRANAIS CATEGORY 1 APPROVAL

For details and further information
please write to:

President,
Irish Association for Nurses in Oncology
P.O. Box 1499,
Dublin 4

Annual General Meeting

on Friday 24th November 2000 to be held in Corrib Great Southern Hotel, Galway.

Programme of Annual Conference

Saturday 25th November 2000

- 8.30/9.15 am **Registration/Coffee**
- 9.15 am **Opening address**
Senator Margaret Cox *Fianna Fáil, Galway*
- 9.30 am **Chairperson**
Mary Courtney *Director of Nursing & Midwifery
Planning & Development Unit Western Health Board*
- 9.40/10.15 am **New agents in cancer**
Dr Maccon Keane *Consultant Medical Oncologist
University College Hospital Galway*
- 10.15/10.45 am **Stereotatic Guided Radiotherapy**
Dr. John Armstrong *Radiation Oncologist, St. Luke's Hospital*
- 10.45/11.30 am **Coffee and viewing of exhibition stands**
- 11.30/12.15 pm **The future of clinical practice: The WISECARE experience**
Nora Kearney, *Lecturer, University of Glasgow*
- 12.15/12.45 pm **Genetics & Nursing**
Wilma Ormiston, *Genetics Nurse St. James's Hospital*
- 12.45/2.00 pm **Lunch**
- 2.00/2.30 pm **The Role of the Clinical Trials Research Nurse**
Emer O'Keane, *Research Nurse St. Vincent's Hospital*
- 2.30/3.15 pm **Vaccines in the treatment of Melanoma**
Professor Paul Redmond, *consultant surgeon Cork University
Hospital*
- 3.15/4.00 pm **The NICCI Project - An Innovative Way to Improve
Colorectal Cancer Nursing**
Kathy Redmond, *Oncology Nurse Consultant*

For further details: Tel: Mary Kennedy 01-2310529 10 am to 2 pm Monday - Friday

THIS IS A NON-SMOKING SEMINAR