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Using clinical competencies to underpin cancer and palliative care education for nurses

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Background: Developing clinical assessment tools for nursing education has been agonised over for many years without producing a tool that delivers rigor, objectivity and reliability. This problem becomes even more acute when applied to nurses undergoing post-registration training. An eighteen-month clinical rotation programme was developed in South East London that aimed to give nurses experience caring for patients across the spectrum of cancer and palliative care. A tool was required that could both direct nurses to seek exposure to all aspects of the patient's journey, and could demonstrate clinical knowledge and skill, that together can be seen to make up "competence". This paper will provide an overview of the process of development of clinical competencies and the domains which they were comprised. Examples of evidence produced by the students will be presented.

Development: Initial work was undertaken in developing competencies by using focus groups of clinical nurses from settings across the region. A smaller sub group then developed the competencies using regular consultation with clinical experts. Guiding principles for developing the competencies were that they should:

Reflect skills of good basic registered practitioners working in cancer and palliative care settings.

Be skills-based rather than aiming to directly measure knowledge

Be fulfilled by collecting evidence to demonstrate those skills.

Reflect all the specific phases of the cancer trajectory

Reflect role development of a qualified nurse

Outcomes: The competencies have been trialed by the first cohort of rotation nurses. Producing evidence and completion of the competencies has been time consuming, with some being difficult to meet. Much of the written evidence has been reflective and insightful and can be seen to illustrate high quality care.

Conclusions: As a tool to demonstrate consistent, competent clinical performance, proof remains elusive. However, the competencies have met their objective of directing learning across the patient's journey and helped nurses join the different facets of care together, helping them to support patients and families through their illness.

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A randomized trial with 1485 patients evaluating the importance of accelerated versus conventional fractionated radiotherapy in squamous cell carcinoma of the head and neck. Final results of the DAHANCA 6&7 study.

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Aim: The trial was initiated to examine whether reduction of the overall treatment time by increasing the number of weekly radiotherapy fractions from 5 to 6 (and maintaining same total dose and fraction number) did improve the tumor response, and were acceptable with regard to early and late morbidity.

Patients and methods: Pts. eligible for primary radiotherapy alone were randomized between 5 or 6 weekly fractions of radiotherapy (66-68 Gy in 33 to 34 fx). All patients, except those with glottic cancers, were also treated with the hypoxic radiosensitizer Nimorazole. Patients were recruited from all Danish institutions and from the Norwegian Radium Hospital in Oslo. Between January 1992 and December 1999, 1485 patients were randomized and 1476 eligible patients were included in the analysis. More than 97% received the planned total dose. The median treatment times were 46 and 39 days in the 5 and 6 fx/wk arm, respectively.

Results: Overall, the results showed a benefit in 5-year loco-regional control (58% vs 67% (p=0.001) for the 5 vs 6 fx/wk arm, respectively. The effect of overall treatment time appears especially to occur in the T-site (62% vs 73% for 5 vs 6 fx/wk respectively, p=0.0001), whereas the response in the neck nodes was not significant different. The benefit in T-control was also reflected in an improved conservation of larynx and voice in 908 patients with laryngeal cancer (68% vs 80% for 5 vs 6 fx/wk, p = 0.007) The benefit in tumor control resulted in a significant better overall disease-specific survival (66% vs 73% for 5 vs 6 fx/wk respectively. p=0.01), whereas there was no significant difference in overall survival. Acute morbidity in the form of severe mucositis was significantly more frequent in the 6 fx/wk group, but there were no difference in late radiation side effects.

Conclusion: The accelerated schedule was considered superior to conventional fractionation, and has now become a new standard baseline treatment for larynx and pharynx carcinoma in Denmark.

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Adjuvant chemotherapy in colorectal cancer: Joint analyses of randomised trials by the Nordic Gastrointestinal Tumour Adjuvant Therapy Group

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Background: The US NCI consensus conference recommended in 1990 adjuvant therapy for colon cancer stage III and rectal cancer stages II + III. The recommendations were not immediately accepted in the Nordic countries. Separate trials with a surgery alone group were initiated, first in western Denmark and Stockholm, Sweden and subsequently in the rest of Sweden and Norway. The aim of a joint analysis was to gain further insight into the benefits of adjuvant chemotherapy when used as in routine care at many hospitals in colon and rectal cancer stages II and III.

Patients and methods: Between 10/91 and 12/97, 2 225 patients with a curatively resected colorectal adenocarcinomas stage II and III below 76 years of age were randomised between surgery alone or chemotherapy. The chemotherapy varied between the trial, either the original Moertel scheme (n=445) for 12 months, a modified Mayo Clinic schedule alone (n=164) or with levamisole (n=95) for four months (4 courses) or the Nordic FLv schedule, alone (n=246) or with levamisole (n=152) for 4 and a half months (10 courses). Early randomisation and treatment initiation were emphasised but different time limits were set (4 to 10 weeks). Minimum follow-up was 4 years.

Results: Between 5 7% of patients randomised to surgery alone received adjuvant chemotherapy and a similar proportion randomised to chemotherapy did not receive any treatment. Treatment started after median 50 days (range 34 58 days in the separate trials). Between 46 and 73% of the patients received the treatment as intended in the various trials. In all randomised patients, there was no statistically significant survival benefit (p=0.1) according to an intent-to-treat analysis. Neither was there a statistically significant benefit in colon cancer stage III (n=760) with 5 year overall survival of 49% in the surgery alone group and 56% (p=0.2) in the chemotherapy group. There was no interaction between chemotherapy arms.

Conclusions: When several Nordic pragmatic trials totally including 2 225 patients were analysed together, no statistically significant overall survival benefit from adjuvant chemotherapy was detected, neither in the entire material nor in colon cancer stage III. The results for colon stage III in these trials do, however, not differ statistically from those in other trials