

EAUN provides insightful training to Danish nurse

A fellowship exchange at UZ University Hospital Ghent, Belgium



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I visited the UZ University Hospital in Ghent last 24 to 27 November as part of a fellowship programme of the European Association for Urological Nurses (EAUN). The EAUN, which sponsors the travel, accommodation and daily allowances, offers two application rounds per year.

In my daily work at the Centre for Continence Disorders, we provide urological nursing to a diverse group of patients. We see men suffering from *Hypertrophica prostatae* who have an indwelling catheter following a period of urinary retention. We see the same group of patients for urodynamic examinations in order to establish which treatment is more suitable for each individual. Another large group are younger patients suffering from various continence disorders. It is particularly satisfactory when we succeed in helping this group of patients getting back to everyday life with "normal" urination, which many of them have never previously experienced.

Another group of patients which I am specifically interested in are those suffering from "Bladder Pain Syndrome." Sometimes it is possible to treat these patients with the instillation of Chondroitin sulphate, either by self-instillation or by receiving the treatment at the hospital. The so-called "neuro-patients" who are suffering from spinal cord injury, patients who have had a Clam operation and where the bladder is enlarged and with Mitrofanoff / Monti operations – are another important group of patients.

It is a great challenge to help these patients get competent care and assistance. In our small unit there is a very good collaboration with our secretary and the doctors in charge of the patients suffering from highly complex continence disorders and from spinal cord injury.

Urodynamic examinations

During my time at the Centre for Continence Disorders, I was interested in experiencing and learning how the nursing of comparable patients is conducted at another university hospital in Europe. I chose Ghent since the group of patients matched that of the Centre for Continence Disorders.

My contact point, Ronny Pieters, helped me find accommodation near the hospital, which was very comfortable. I spent a weekend as a tourist in Ghent with its historical centre and the many beautiful canals.

The first day of the week, I observed the daily routine of Ronny who is a clinical urological nursing specialist. He works full days at the hospital where

he supervises nurses in the outpatient clinic, the recovery room and the ward. In addition, staff from other departments called him for assistance such as providing training for clean intermittent catheterisation.

I was also present during several urodynamic examinations of children, men, women and "neuro-patients." Technically, the examination is conducted a bit differently from the way we do it in Denmark. A three-way catheter is used, with the urethral sphincter examined during filling. EMG (electrodes for measuring muscle activity) is not used and a profile is not established as we do it back home. An X-ray is made in order to control the position of the catheter and a picture is made of the urination to help improve diagnose and if the patient suffers from cystocele and reflux. Provided that the patient is sufficiently stable to stand up, both sitting and standing filling is made and "cough leaking" is also tested.

The bladder was not emptied in case of residual urine before the second filling; instead it was noted that the filling had started with X ml. The "neuro-patients" were examined in the same manner as we do it. All examinations were observed by a doctor and the patient got feedback and treatment was initiated immediately after the examination. Treatment with anticholinergics, Betmiga (Beta 3 agonist) and clean intermittent catheterisation training is initiated with the same indications as we use; however the approach is less pedagogical – often basic assessment has not been made prior to the urodynamic examination resulting to instances when patients are sent home to fill in liquid/urination scheme and, in rare instances, the use of diapers.

An annual subsidy of 150 euros for buying diapers etc. is provided for all patients suffering from continence disorder, including the period prior to the medical intervention. When the medical assessment has been finalized and diapers are established as one of the remedies to treat the condition, the patient will receive a 100% refund of the cost. As for catheters, the public funds will cover four catheters per day and in case of a need to extend the frequency, the patient must rely on the catheter manufacturer to donate the rest. To my understanding, it is possible for each individual patient to choose the best fit among available catheters.

At the operation ward I observed how test electrodes for InterStim Neurostimulation Therapy were placed by sacral nerves 2-3. This method is applied to different kinds of continence disorders, but the best results are observed with patients suffering from an overactive bladder. The test period is between one to four weeks and if the patient period is satisfactory to lessen the patient's symptoms, a small battery box is inserted into the right part of the loin. Once the box is adjusted, the patient should go to the toilet based on the need and the problem is solved. Later, when the patient is in the recovery room, Ronny Pieters – as part of his supervisory tasks – comes by and adjusts the intensity of the electricity with a small remote control.

Hexviz (Blue-light cystoscopy), instilled about one hour before trans resection of the bladder, is also used as well as the instillation of Mitomycin C in the bladder after resection. It is given when the urine is nearly clear, and the procedure as done in the recovery room by Ronny Pieters.

Catheter removal

Nephrostomy catheter removal is done in the outpatient clinic. The new catheter is guided by ultrasound and guidewire. A plaster is placed on the catheter where it meets the skin which makes it easy to detect if it is displaced; a thread fixed to the skin is also used. The bandage is placed over the catheter as we know it, but in order to avoid pulling and cracking of the hose, it does not cross the abdomen. The hose is placed over the hip and along the outer side of the leg which makes it impossible to lie on the side without irritation. The patient also has a supra-pubic catheter which was changed in the same session – the nurse made the necessary preparations, pulled out the old catheter and the doctor inserted the new one – a very smooth procedure.



Annette Hjuler and Ronny Pieters

Several unsuccessful attempts were made at changing a double J catheter via a urostomy, despite the involvement of several doctors. But fortunately we have an operation ward! Suprapubic catheters were placed as well; when the patient's bladder does not contain sufficient urine, salt water is instilled by catheter. The balloon contains 10 ml water and when there is a sufficient volume in the bladder, the nurse draws it to prevent the water from leaking in case of bladder cramps. At the same time, the bed was elevated at the feet end and the doctor placed the catheter easily and quickly.

At the ward, nurses are responsible for everything relating to patient care. The nurse has a mobile rack containing utensils that might be needed, the patients' medicine and a computer. One nurse is responsible for four to eight patients but depending on the demands of the individual patients.

The week concluded with a visit to the Rehabilitation Centre, comparable to Centres for Brain Damage and Centre for Spinal Cord Injuries in Denmark. Patients are admitted immediately following an accident/injury. The rehabilitation is conducted similar to our practice in Denmark and patients are hospitalised as long as necessary. The centre has "test" apartments where patients can live, including with family, one month prior to being discharged. If any aspects of managing everyday life requirements appear difficult for the patient to handle, there is time to address them. There is also a small garden with a greenhouse where training can take place as well as a car where patients can train how to get in and out and how to place the wheelchair, among others.

In conclusion, I benefited from a good and useful experience regarding specialised nursing practice in another country. I would encourage colleagues to take the same opportunity since it provides a great chance to reflect, learn and gain inspiration. And my thanks to Ronny Pieters who guided me during the wonderful fellowship in Ghent.



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This grant was made possible through an unrestricted educational grant from ASTELLAS.

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Beautiful houses and charming waterways

Improving follow-up care after nephrectomy

Experience from a Dutch cancer institute



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Similar to worldwide trends, renal cell carcinoma (RCC) in the Netherlands comprises 2% of all the malignancies¹. The Netherlands Cancer Institute is a specialised institute where many cases of nephrectomies and partial nephrectomies are performed in localised and locally advanced RCC.

The follow-up after surgery was until 2014 done by the urologists only. There were no common guidelines for the follow-up. In 2014 we decided to develop a standardised follow-up after partial and total nephrectomy where the clinical nurse specialist could play an important role. The goal was to have a standardised follow-up and to decrease the consultations by urologists.

We evaluated that performing the follow-up alternating with urologist and a clinical nurse specialist could generate a decrease of the urologist's consultations by about 58%. We decided to include the Leibovich prognosis score² which is dependent of the risk of recurrence in order to perform an adapted/ personalised follow-up after partial or radical nephrectomy. The score takes into account the pathological T stage, nodal status, tumour size,

nuclear grade and histological tumour necrosis. The Leibovich prognosis score gives a score ranging from 0 to 11 and is categorised into three groups dependent of the risk of recurrence after surgery: low- (0-2), intermediate- (3-5) or high-risk (≥6) groups (Table 1).

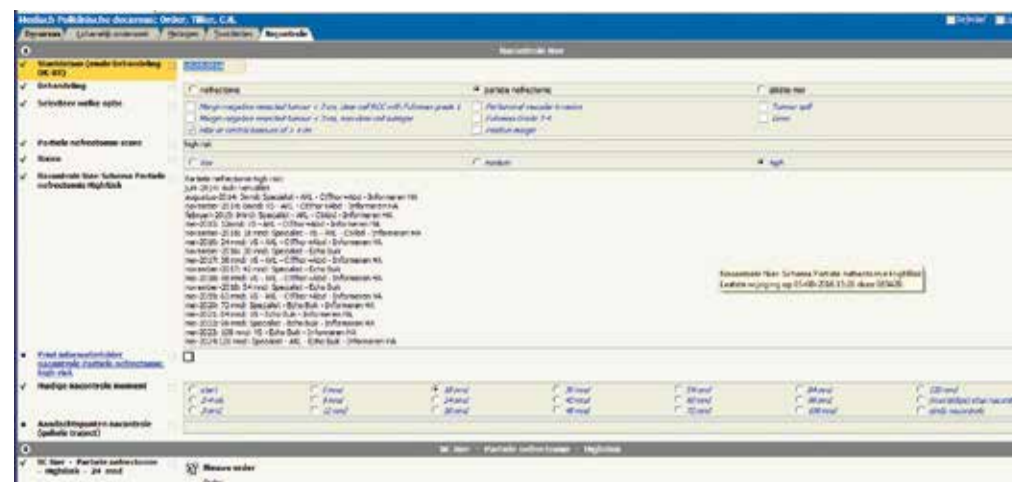
We implemented a standardised follow-up according to the evidence based in August 2015. We divided the patients into three groups depending on the risk of recurrence after partial/radical nephrectomy (low, intermediate and high-risk groups). The follow-up is alternately done by the urologist and the clinical nurse specialist urology. The follow-up after partial nephrectomy and nephrectomy is, respectively, five and nine years. Four weeks after the surgery, the patient has a consultation with the urologist who explains the risk of recurrence and reviews with the patient the medical issues one month after surgery. The patient receives from the urologist an overview of the follow-up for the next years. A few days after the clinical nurse specialist calls the patient and asks if everything is clear. The nurse explains his/her role in the follow-up as the permanent contact person who is accessible for the patient when needed.

A personalised follow-up depending on risk of recurrence is linked with the digital file of the patient (Table 2). This means that all the requests for CT scans, ultrasounds and blood tests are computerised. The urologist or the clinical nurse specialist has to fill at the time of the follow-up (for example month 42) and all the imaging tests and laboratory tests needed for the next consultation are automatically included and scheduled (Table 3). If the patient develops metastasis during the follow-up, we end the follow-up in the digital file and we refer the patient to the oncologist.

Preparing for the consultation (Self-Management)

During the follow-up, the patient has the opportunity to prepare the consultation with the urologist or clinical nurse specialist. The patient can log-in through his patient portal (www.mijnnavl.nl) and can ask questions or report physical/mental complaints after surgery. When the urologist/nurse clinical specialist prepares the consultation (a few days before), the questions/complaints appear in the

Table 3: Example of computerised orders



patient's digital file. The most common questions/complaints are: Is my cancer hereditary? Is it normal that I am still very tired? Do I have to follow a special diet after nephrectomy? Can I live with one kidney without health problems?

The patient is very satisfied to have the opportunity to prepare her/his consultation because in this way the patient will remember to ask a question to the urologist/clinical nurse specialist. We have to admit that we are also very satisfied since it makes the consultation easier. We can already prepare the answers to the questions/complaints. We have evaluated the follow-up after partial or radical nephrectomy (one year after implementation). The patient expressed satisfaction on the following:

- The alternating consultation urologist/clinical nurse specialist. They do not mind who is giving the results of CT Scans/ultrasounds/ laboratory results;
- Receiving a schedule of the visits for the next five to nine years;
- Having the same urologist/clinical nurse specialist; and
- Having the opportunity to prepare the consultation.

The urologist has fewer consultations after partial/ radical nephrectomy (for example 28% less consultations for low-risk after nephrectomy). We noticed that compared to the follow-up before the standardisation, we perform less CT scans. Moreover, the clinical nurse specialist appreciates providing counselling and support to the patients and is able to give the results of the CT scan or other exams.

Feasible scheme

The personalised follow-up after partial and radical nephrectomy based on the Leibovich prognosis score is feasible, efficient and can be alternatively done by the urologist and the clinical nurse specialist. It saves consultation time for the urologist and also reduces financial costs (less CT scans). The computerisation of the orders depending on the moment of the follow-up avoids unnecessary CT scans and allows a standardised follow-up.

References

1. Dutch Cancer Registration 2015: http://www.cijfersoverkanker.nl/selecties/Dataset_2/img578bcb8073d2d
2. Leibovich BC, Blute ML, Chevillet JC et al. Prediction of progression after radical nephrectomy for patients with clear cell renal cell carcinoma: a stratification tool -for prospective clinical trials. Cancer 2003; 97: 1663-71.

Table 1: Leibovich prognosis score after partial/ radical nephrectomy²

Characteristics		Points
Tumour	pT1a	0
	pT1b	2
	pT2	3
	pT3-pT4	4
Dimension	<10 cm	0
	>10 cm	1
Lymph node status	pNx/pN0	0
	pN1-pN2	2
Fuhrman	1-2	0
	3	1
Tumour necrosis	4	3
	absent	0
	present	1

Table 2: Schedule Follow-up after nephrectomy- intermediate risk

Nephrectomy: Intermediate risk	Follow-up	Year 1					Year 2		Year 3		Year 4		Year 5		Year 7		Year 9	
		4 w	3 m	6 m	9 m	12 m	18 m	24 m	30 m	36 m	42 m	48 m	54 m	60 m	84 m	108 m		
	Consultation																	
		Urologist	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Clinical Nurse Specialist	x (call)			x	x	x	x	x	x	x	x	x	x	x	x	x
	Laboratory test		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Imaging test	CT abdomen		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		CT lung		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
		Ultrasound						x	x	x	x	x	x	x	x	x	x	x
	Send a letter to the GP		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

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European Association of Urology Nurses

Monitoring patients on abiraterone

Experience of a regional cancer centre in New Zealand



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Prostate cancer is the most common cancer among men in New Zealand. In 2012, 3,129 men were diagnosed with prostate cancer and 607 died from metastatic or castration-resistant disease (MoH, 2015).

The Southern District Health Board (DHB) is a publicly funded regional health service covering the lower half of the South Island of New Zealand, servicing an estimated resident population of 304,260. It is the largest geographical area of any of the district health boards in New Zealand covering 62,000 km², which in itself can present barriers to care in terms of distance and accessibility for its large rural population (www.southerndhb.govt.nz). But perhaps, more significantly in the setting of prostate cancer, it has an aging population many of whom live in rural areas.

Introduction of abiraterone

In New Zealand, abiraterone was publicly funded for patients with metastatic resistant prostate cancer (mCRPC) in May 2015. Relatively intense monitoring of side effects is required at the start of abiraterone therapy. This includes potential for hepatic toxicity and hypokalaemia, hypertension or fluid retention due to mineralocorticoid excess caused by CYP17 enzyme inhibition (Pointer, 2016).

Within Southern DHB a joint decision was made to place the primary use of abiraterone after

bicalutamide and before taxanes for those patients who were chemotherapy naive. This was not a wholly clinical consideration but took into account societal and economic considerations (Pointer, 2016). Care of these patients was centralised within Radiation Oncology at the Dunedin Cancer Centre with a preference for managing patients at home in the primary care setting by making use of existing monitoring systems, including the Oncology-Haematology Assessment Unit (OHAU) and MOSAIQ, an electronic monitoring programme, both described below (Pointer, 2016).

Oncology Haematology Assessment Unit

The Oncology Haematology Assessment Unit is a nurse-led virtual clinic developed at the Southern District Health Board, just over two years ago with the primary aim of promoting appropriate use of services and resources and reducing avoidable hospital admissions. Secondary aims of this project included:

- Improving patient safety and care by monitoring symptoms and side effects of cancer treatment in a timely manner;
- Reducing avoidable treatment delays and dose reductions;
- Standardising the advice given to patients using evidence-based assessment tools;
- Providing a single point of contact for patients from throughout the region; and
- Ensuring calls are triaged safely and appropriately.

A 24-hour a day, free phoning number is given to all patients receiving oncology/haematology therapies when they first present for treatment. Incoming clinical enquiry's to this number are triaged according to a set protocol and patients are either given advice and education over the phone; the patient may be referred to another health care practitioner, including the patient's general practitioner, district nurse, emergency department or oncologist, or the patient can be brought into the unit for an advanced nursing assessment and appropriate treatment. Key to the success of OHAU is that nurses are able to proactively monitor high risk

patients on treatment; for example those with complex co-morbidities, elderly patients or those with mental health issues. Patients on oral cancer treatments such as abiraterone are also proactively monitored through the unit via scheduled phone calls.

MOSAIQ: Electronic monitoring programme

MOSAIQ is a comprehensive electronic information management system used within OHAU. It can be used to review, prescribe, dispense, treat, and document patient data in a single database solution. Customisable electronic records can be viewed online from multiple sites, with integration from external diagnostic laboratories and pharmacies. Appointments can be scheduled, and letters, reports and documents created (www.elekta.com/software-solutions/care-management/mosaiq-medical-oncology).

What happens when a patient is started on abiraterone?

Patients are seen in clinic by a radiation oncologist and abiraterone is electronically prescribed in MOSAIQ. Approval of the prescription automatically generates an electronic memo to OHAU nursing staff to prompt scheduling of abiraterone phone calls. MOSAIQ also automatically prompts the consultant to prescribe Lucrein (a gonadotropin releasing hormone agonist) if appropriate, to apply for a special authority for the abiraterone (required by the New Zealand drug funding agency PHARMAC) and an electronic request for a DEXA bone scan is generated.

Patients are educated either on-site or over the phone not long after they have seen the oncologist and the patient's general practice nurse is contacted to arrange for recordings of blood pressure, weight and blood tests. This is then followed up by the nursing staff in OHAU initially two weekly and then monthly at the time of phoning the patient, along with screening for other side effects, including oedema, diarrhoea, breathlessness and any other treatment or disease related complications. If the patient has any complex issues such as poor mobility or financial constraints, a

plan is individualised to their circumstances. Any concerns regarding a patient or their side effects are discussed with their oncologist as they arise.

Strengths and limits of the OHAU Abiraterone Monitoring Programme

It has been a pleasure working with men commencing on abiraterone. The number of patients reporting improved quality of life with reduction in pain and improved mobility is particularly satisfying. Many patients will be on opiates at the start of their treatment and within a few weeks have been able to wean themselves off. It also reassuring to know that a system is in place to ensure patients do not slip through the cracks in terms of follow up.

MOSAIQ has made this process all that much easier for nurses. The monitoring programme is reliant on the team, not an individual, with all patients' notes available electronically with no requirement for hand-over between staff. OHAU provides early identification of toxicities and has provided remarkable outcomes in providing supportive care to oncology and haematology patients; patients report that they feel well supported. The only real limitation is managing the high volume of patients, which has become easier over time as the process is refined.

I would like to acknowledge the fabulous oncology team I work with, in particular Jo Tuaine, Lynda Dagg and Simon Pointer, who were pivotal in the development of the abiraterone monitoring system.

References

- Ministry of Health, Cancer: New registrations and death 2012.
- Pointer, S. 2016. MOSAIQ to Manage Patients with Metastatic Castrate-Resistant Prostate Cancer. Unpublished Power Point Presentation.
- www.elekta.com/software-solutions/care-management/mosaiq-medical-oncology, retrieved 27 July 2016.
- <http://www.southerndhb.govt.nz/index.php?page=654>, retrieved 27 July 2016

European Association of Urology Nurses

18th International EAUN Meeting

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Abstract, Research Project, Difficult Case and Video Presentation deadline: 1 December 2016
Early registration deadline: 16 January 2017

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'London Calling' – 18th International EAUN Meeting, 25-27 March 2017

The planning for the anticipated 18th International EAUN Meeting is at its advanced stage! The Scientific Committee is hard at work putting together a relevant and informative scientific programme to support the practice of urological nursing in Europe.

Many of the features that give the EAUN meeting its distinctive flavour will be retained such as the Plenary Sessions, Thematic Sessions, European School of Urology courses, Difficult Cases, state-of-the-art lectures, and the increasingly popular Research Poster sessions. Full details of the programme will be available on the EAUN London website www.eaun17.org soon so please regularly check it for updates.

Patient-centred urological nursing care

The EAUN meeting will focus on patient-centred urological nursing care and sessions to analyse current issues such as uro-oncology in older people, the role of renal function in health, the emerging challenges in testicular cancer care, lymphedema following pelvic lymph node dissection, and the future trends in urodynamics, to name a few. Additionally, the critically important issue of the emergence of drug-resistant microorganisms in urology will be revisited in the "Is an Avalanche Coming?" session.

Recognising our role as educators to our patients, we will examine their health literacy to see how we can improve our effectiveness in communicating vital information and guidance to them. Furthermore, we will concentrate on the role of ethics in urological care through the interactive "House of Commons" session, which promises to be both interesting and enjoyable.

We, urology nurses, are increasingly required to demonstrate the value of the service we provide our patients, employers, and clinical colleagues. Therefore, we research and seek ways to persuade others about the importance of our role and clinical professionalism. To aid us in getting our message to a wider audience, there is also an EAUN session about the role of social media in urological nursing.

Advantages

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Location

London is truly an exciting city to visit. Despite its size, it is remarkably easy to travel around. The venue, *London ExCeL*, has two on-site rail stations and it is only five minutes away from the London City Airport. This year's EAUN Meeting is in the heart of London and our programme is in the heart of evidence-based, urological nursing care.

We look forward to seeing you in London and to sharing our future in European urological nursing!

Corinne Tillier
Chair SCO

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