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Introduction

In 2013 the Oncology Nursing Society published a Statement on the Scope and Standards of Oncology Nursing Practice – Generalist and Advanced Practice. Like the previous versions, it defines the roles of oncology nurses and reflects ONS’s mission statement (Brandt, and Wickham). The scope of oncology nursing care includes assessment, diagnosis, outcome identification, planning, implementation and evaluation (Brandt, and Wickham). This mirrors the ANA Standards of Professional Nursing Practice 2nd edition (2010). In Standard 5 (Implementation) of both the ANA and ONS documents it indicates that the registered nurse provides education to promote health.

ONS believes that oncology nurses have the responsibility of developing, assessing, implementing and evaluating educational programs for patients, their significant others, and the public. The nurse should provide teaching and anticipatory guidance regarding cancer and its treatment, including symptoms and side effects (APHON, 2009). Joint Commission (1992-2000) in the section on Education Standards identifies the facts that the patient’s learning needs, abilities, preferences and readiness to learn must be identified. They also emphasize the fact that
patient education is interactive, meaning that we must include the patient, significant other, and
the public and assure their interest in the programs. An important method of achieving this is by
incorporating “teach back” techniques into the educational process. In short the educator role is a
nursing responsibility (APHON, 2009; ANA, 2010; ONS, 2013; Home Health Nursing
Standards, 2007; Joint Commission 1992-2000) and a necessity for patients, their significant
others, and the public.

The Outcome Standards for Cancer Patient Education was first published by ONS in 1982,
followed by the Outcome Standards for Public Cancer Education in 1983. In 1989, the standards
were revised and consolidated into one document. These were again updated and revised in 1995
and 2004.

The purpose of this document is to provide comprehensive guidelines for nurses to:

- Develop, implement, and evaluate formal and informal patient/significant other education
  programs.
- Develop, implement, and evaluate formal and informal public education programs.

The intended outcomes of the Standards of Oncology Education: Patient/Significant Other
and Public are to:

- Enhance the quality of patient teaching.
- Exemplify the scope of teaching in all phases of cancer care, including prevention, early
detection, rehabilitation, survivorship, and supportive care.
- Improve health promotion and care for the public.

The standards in this document are descriptive statements designed to guide the achievement of
quality education for the patient, their significant others, and the public. The format is consistent
with the American Nurses Association (ANA) *Standards for Nursing Professional Development* and includes the following categories:

I. Oncology Nurse

II. Resources

III. Curriculum

IV. Teaching-Learning Process

V. Learner: The Patient/Significant Others and the Public

The following assumptions were made in the development of the *Standards of Oncology Education*:

1. All people are at risk for cancer.
2. All people have the right to information related to cancer and oncology care presented at the individual’s level of learning/comprehension.
3. Education is a component of the comprehensive nursing care of the patient/significant others experiencing cancer as well as the public.
4. Inappropriate responses to the potential or actual threat of cancer may be modified by enhancing knowledge, skills, and attitudes of the patient/significant others and the public.
5. Application of principles of adult education theory enhances learning.
6. Professional oncology nurses are role models in cancer education.
7. All educational activities reflect sensitivity to and respect for diverse cultural backgrounds and health belief systems of the patient and significant others experiencing cancer.
8. Professional oncology nurses provide care in a variety of settings, including hospitals, ambulatory settings, private practices, homes, and hospices.
This edition of *Standards of Oncology Education: Patient/Significant Other and Public* is designed to affirm nursing’s role as educator (ANA, 2015) and be reflective of current practice trends and evidence-based practice. Updated references are provided for practitioners to use in their role of educator for patients, significant others, and the public.
Changing Methods and Technology in Education

Lecture, verbal instruction, discussion, written materials both in hardcopy or digital format through short message system (SMS) text messaging and email, demonstration, teach-back, audio and visual (AV) aids – either hardcopy through discs or digitally through online audio and video files, “edutainment through gamification” (e.g. the use of games), and role-playing either in-person or virtually through programs such as Second Life – all of these are methods of current patient and public education. As technology has rapidly changed and continues to morph, so do the tools in which we use to fulfill the static principles of learning, utilizing the foundational nursing process. The Internet now provides instant evidence, resources, and tools, often well ahead of traditionally printed versions. In addition, mobile and televideo education methods are commonplace in today’s teaching environment with far-reaching effects (O’Connor & Andrews, 2015; Raman, 2015).

Teaching methods and “strategies [are only as] effective as their audience’s access to the necessary tools to use them” (Friedman, Cosby, Boyko, Hatton-Bauer, & Turnbull, 2011, p. 18). Demonstration and the teach-back method are most effective followed by written materials and AV tools, with verbal teaching and discussions least effective. While multiple education methods exist, there is no “one size fits all” to educate patients, families, or the public. A combination of education methods is preferred and proven to be more successful in producing enhanced patient outcomes (Friedman, et al., 2011).

The rise of the digital age has changed the way we teach and learn. Digital natives – those born after 1980 – are generally well-versed and comfortable with learning via digital methods; it is a natural language for Generation Y’ers and Generation Z’ers, a population currently totaling approximately 94 million people who will grow to surpass all prior generations combined
Conversely, digital immigrants – those born prior to 1980 – are often the educators, researchers, and the lions-share of the workforce teaching patients and the public, so a disparity in electronic/digital “first-language” teaching and learning styles may exist (Prensky, 2001; HRSA 2013).

The increase of e-patients, those who use electronic sources of health information to become empowered and engaged healthcare consumers has increased dramatically with widespread, public adoption of technology and social media (Nelson, Joos, & Wolf, 2013). There is now more horizontal information-sharing and crowdsourcing information using peoples’ “collective wisdom” as opposed to vertical information-sharing from face-to-face interactions with traditionally-thought experts (Nelson, Joos, & Wolf, 2013; Keller, Labrique, Jain, Pekosz, & Levine, 2014).

Eighty-one percent of adults use the Internet and email at least occasionally, and fifty-two percent of online adults use two or more social media (SM) sites. Contrary to popular belief, SM is not only for the young nor is it used solely for entertainment. Thirty-one percent of all seniors aged 65 and above have and use Facebook, and between one-third to one-half of adults using the Internet express utilizing SM for myriad healthcare information reasons (Duggan, Ellison, Lampe, Lenhart, & Madden, 2015; PricewaterhouseCoopers, 2012).

Social media such as blogs, Facebook, YouTube, Twitter, Instagram, LinkedIn, Pinterest, etc. garners the “collective wisdom” of its users, relationally connecting content. SM has been and continues to be used for various health reasons including broad engagement around clinical trials, increasing both targeted and wide-spread awareness of public health efforts, and connecting micro-populations for ongoing support (Thackery, Burton, Giraud-Carrier, Rollins, &
Draper, 2013). Social media’s effectiveness in educating clinicians as well as the public is just now beginning to be studied more fully and certainly needs more exploration.

This shift of information sharing and use clearly shows the movement from “Web 1.0” in which Internet content was static and passive to “Web 2.0” that includes engagement of large communities via SM applications and now our entry into “Web 3.0/Web 4.0” in which multiple networks and systems meld together and technology becomes a longitudinal, ubiquitous part of the human and health care experience (Nelson, Joos, & Wolf, 2013; Thompson, Younes, & Miller, 2012; Strickland, 2007).

<table>
<thead>
<tr>
<th>Web 1.0</th>
<th>Web 2.0</th>
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<td>• Content-focused</td>
<td>• Community-focused</td>
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<td>• Passive reading of static content</td>
<td>• Mobile connectivity</td>
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<td>• Single point of connectivity</td>
<td>• Group interaction around the content or generating the content</td>
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<td>• Information exclusivity</td>
<td>• Examples: Social media including patient/provider blogs, Twitter chats, Facebook or web-based diagnosis-specific support groups, mobile health applications</td>
<td>• Moving data to useful, meaningful information</td>
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<td>• Examples: government or organizational web pages</td>
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<td>• Intelligent search (e.g. technology that learns)</td>
<td>• Examples: synced home, business, health, and mobile networks; IBM’s Watson</td>
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As technology continues to shift and shape health, the U.S. government passed the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, setting Meaningful Use (MU) criteria to effectively provide safe, quality population health management through integrated electronic systems (U.S. Department of Health & Human Services [HHS], n.d.). Again, the shift to Web 4.0 is evident as multiple networks of information focus on
singular patients as well as large populations. MU stage 2 criteria includes sharing secure
electronic communications through the use of certified EHR technology, or CEHRT, which is
more commonly referred to as patient portal communication. As the number of organizations
compliant with MU criteria continues to increase, the number of patients who express feeling
more informed through EHRs and patient portal communications also continues to climb (Jones,

While patient portal use continues to become mainstream, direct mobile and digital
communication with patients outside of portals remains via SMS text messaging and email,
respectively. The majority of healthcare systems have protected servers to send encrypted, secure
email messages to those outside of the healthcare organization (e.g. patients, family members,
etc.), and many organizations also utilize encrypted text messaging services to allow secure texts
for both provider-provider communication and provider-patient communication. These safety
measures ensure compliance with the Health Insurance Portability and Accountability Act
(HIPAA) of 1996. Text messaging has proven to help increase clinical trial enrollment, improve
medication adherence, encourage tobacco or alcohol cessation, or increase screening uptake
(Lim, Wright, Hellard, 2014; Kannisto, Koivunen, & Välimäki, 2014). A 2015 literature review
(Nasi, Cucciniello, & Guerrazzi, 2015) found limited SMS text messaging use in cancer care,
however more evidence-based research and publication is needed in this area as text messaging
is a well-known method of communication in oncology nursing practice with head and neck
patients, for example, who may be unable to speak due to treatment effects. Evidence regarding
this practice is grossly missing from the health care literature.

Just as technologies are shifting to focus on longitudinal population health management, so
are public health and health accrediting agencies. Within oncology specifically, the American
College of Surgeons Commission on Cancer, which accredits more than 1,500 cancer programs throughout the United States, now requires all programs to focus on long-term patient care through cancer survivorship care plans (SCPs) via Standard 3.3. Treatment summaries and SCPs are provided to patients at the end of treatment to ease the transition into cancer survivorship, detailing necessary ongoing surveillance and care, which must be effectively communicated to the patient and care unit and reinforced throughout a lifetime (Commission on Cancer, 2012).

**Changing Roles of Oncology Nursing in Education**

The nursing process remains foundational, yet the implementation of the process varies with time. In order to effectively educate patients and the public, oncology nurses must assess the population first. This assessment, however, now expands beyond assessing readiness to learn and basic and health literacy to also encompass computer and digital literacy (Nelson, Joos, & Wolf, 2013). Without adequate literacy and fluency, nurses’ education methods may fail patients’ needs and lead to poor health outcomes.
Changing education methods and tools require the oncology nurse to adapt, as well. Just as there is no “one-size-fits-all” education intervention, nurses must remain competent with all patient and public teaching methods and the rapidly-growing technology to reach appropriate populations with effective information. This may be a significant barrier to oncology nurses as technologies used in education can easily outpace professionals’ use, especially among digital immigrants. Conversely, digital natives may have to work to remain competent with more
traditional education methods and hardcopy tools to also provide culturally- and age-appropriate education interventions.

While many health professionals express the value of social media tools, adoption and use of these resources are lagging (Keller, et al., 2014). Nurses must advocate and exhibit professional use of the changing tools, educating and empowering patients and the public to continue to use them for positive health outcomes (Tomsik & Briggs, 2013).

As electronic and social media tools are adopted for continued professional educational use, oncology nurses must remember they are tools of communication and apply the same rigor and professionalism as in traditional methods of education and communication, understanding body language and tone can be lost via certain education methods (Lim, Wright, Hellard, 2014). Oncology nurses should be mindful examples of all technology and social media ethical and professional principles, whether published nationally or at the healthcare organizational level, as in a social media policy, for example (Grajales, Sheps, Ho, Novak-Laucher, & Eysenbach, 2014; American Nurses Association, 2011). Just as in working to develop in-person rapport with patients, oncology nurses must also work to develop an online, caring presence for effective education (Mastel-Smith, Post, & Lake, 2015; Cox-Davenport, 2014).

Oncology nurses must continue to be able to discriminate between reliable sources of information and also be able to effectively educate patients and the public to do the same, especially with social media which blurs the lines between novice and expert (Garg, Venkatraman, Pandey, & Kumar, 2015; National Cancer Institute, 2012). As patients live longer and the majority of healthcare organizations shift toward population health, oncology nurses must broaden the inclusiveness of their education to extend to the entire care unit all throughout the continuum of care, spanning a single patient’s/family’s lifetime.
Contemporary Trends and Trends for the Future of Education

The future of education will continue to morph as technology shifts into Web 3.0/4.0 and the line between humans and technology blurs into one experience and everything and everyone is connected for instant, personalized information. Adoption of mobile and electronic education via smartphones, applications, social media, and EHR patient portals will exponentially grow (Cahill, Gilbert, & Armstrong, 2014; Jones, Weiner, Shaw, Stewart, 2015). This is true not only for patients but for the entire patient care unit as dyadic care (e.g., care of the caregiver in addition to the patient) and family proxy to patients’ individual health portals rises. The oncology nurse will educate the entire family, requiring maintained competence in all facets of patient and family education – assessing for the right communication style and excelling in its use (O’Malley, Cohen, Grossman, 2010).

As technology and connectivity becomes more ubiquitous, so will the education provided by oncology nurses. Federal legislation as well as healthcare accrediting agencies will continue to make large strides to patient-centered care and enhanced education throughout the course of a lifetime to improve overall health outcomes. Theories surrounding Web 3.0 and Web 4.0 include technologies mining patient/population health information to learn about the patient over time to individualize care as well as benefit the collective population’s health (Nelson, Joos, & Wolf, 2013). While it may seem far-fetched, this reality is already in its infancy. Oncology nurses must be prepared to take the foundation elements of the nursing process and shift its implementation in order to remain effective healthcare professionals.

And even as technology advances, “traditional” educational methods are changing to include more than the patient alone. Dyadic care and education – focusing on the patient and the primary caregiver – or the entire family, – continues to be researched and found to be an effective means
of providing holistic care to the patient/caregiver unit (Northouse, Mood, Schafenacker, Kalemkerian, Zalupski, et al., 2013). While educating a family unit together may not be a “new” concept to oncology nurses, many caregivers and family members desire to be educated alongside the patient, and this method may lead to improved and/or more desired health outcomes (Potter, Olsen, Kuhrik, Kuhrik, & Huntley, 2012; McCarthy, 2011).

The changing methods in technology and education that are reflected above should be kept in mind within the context of the next section which defines the standards, their rationales and methods for evaluation of outcomes.
Standards of Oncology Education - Patient/

Significant Other and Public

Standard I. Oncology Nurse

The oncology nurse at both the generalist and advanced practice level is responsible for meeting the educational needs of the patient/significant others related to cancer.

The oncology nurse provides formal and informal cancer-related public education commensurate with personal education and experience.

Rationale

Patients and their significant others have a wide variety of educational and informational needs in relation to a cancer diagnosis, treatment, side effect management and survivorship. This requires education work with the patients and their significant others to meet these needs at every point along the cancer care continuum. All oncology nurses provide education to meet these needs as they are both the most trusted health care professionals and the professionals who have the greatest amount of direct patient contact.

All oncology nurses also provide required or requested education to meet the specific needs of the public as they are educated regarding the promotion of health and are trusted as health care providers.

Measurement Criteria

The oncology nurse:
1. Practices health behaviors consistent with health promotion as a role model for the patient/significant other and public.

2. Promotes healthy lifestyles of individuals and groups through education.


4. Has a basic prerequisite understanding of the principles, practice and process of teaching and learning to carry out their professional responsibilities with efficiency and effectiveness.

5. Applies teaching-learning principles to the development, implementation, and evaluation of all educational offerings.

6. Functions as a facilitator of learning for patients, their significant others and the public.

7. Identifies educational strategies, technologies, and resources that support health promotion and cancer prevention, detection, treatment, and care.

8. Employs teach back and pictorial images to promote education in patients/significant others with low literacy and/or low health literacy.

9. Values potential outcomes of education on the knowledge, skills, and attitudes of patients/significant others and the public.

10. Assesses the accuracy and applicability of cancer information prior to endorsement and dissemination.

11. Critically appraises clinical recommendations for level of evidence prior to endorsement using reliable resource such as ONS PEP® Resources and NCCN Guidelines.

12. Demonstrates respect for the religious, social, cultural, and ethnic practices of patients/significant others and the public.
13. Identifies risk factors for the learner/target audience with special consideration to disproportionate risk.

14. Collaborates with community leaders, volunteers, and groups to advocate for, plan, and/or provide public education/cancer screening.

15. Incorporates and applies research findings into practice and into educational activities.

**Standard II. Resources**

Adequate resources to achieve the objectives of patient/significant other education related to cancer care are available and appropriate.

Resources for public education related to cancer prevention, detection, treatment, and care are adequate, current, accurate, and appropriate to achieve educational objectives.

**Rationale**

The literature supports the idea that patients want as much information as they can get about their illness and treatment plans. Individuals have different learning styles and abilities. Therefore a variety of resources must be available to meet the learning needs of each individual, including printed material with relevant pictures, the internet assuring trustworthy sites, computer assisted learning, audiotapes and videotapes. All materials must be culturally sensitive and address the various educational and reading levels of the population.

Public education resources must also be adapted to the learning styles and abilities of the individual.

**Measurement Criteria**

1. An environment conducive to learning is maintained
2. Current educational materials and supplies specific to health promotion, cancer prevention, detection treatment and care are available and easily accessed

3. Educational materials are appropriate for individuals of varied age, sex, race, creed, culture, education, physical and cognitive ability levels, health literacy and health beliefs

4. Personnel resources are sufficient to implement the process of education

5. Educational materials and information about community resources are reviewed for accuracy and relevance on a regular basis.

6. Educational materials are validated for use in culturally diverse populations.

Representative members of the population perform this validation

**Standard III. Curriculum**

Knowledge, skills, and attitudes related to the management of human responses to cancer are reflected in the educational activity for the patient and significant others experiencing cancer.

**Rationale**

The content of the education must address the unique educational needs of the patient/significant other and the public.

Individuals require information that assists them in making healthy lifestyle decisions, participate in health promotion activities, as well as making treatment decisions, manage treatment side effects and symptoms of their disease and coping with cancer.

**Measurement Criteria**

The educational activity designed for the patient/significant other includes:
1. Accurate, current, and credible information about cancer prevention, detection, diagnosis, treatment, rehabilitation, survivorship, and supportive care

2. Risk factors for cancer development including genetic, environmental, occupational, and lifestyle risks for cancer

3. Methods to modify health behaviors and practices for cancer prevention and health promotion

4. Recommended site-related self-examination and screening guidelines

5. Signs and symptoms that require follow-up by healthcare providers as well as information regarding contacting the provider.

6. Strategies to improve consumer accessibility to cancer prevention, detection, and treatment facilities

7. Strategies to modify health behaviors for health promotion and cancer prevention, detection, treatment, and care

8. Strategies to evaluate cancer prevention, detection, and treatment facilities.

9. Criteria to evaluate questionable information/cancer therapies and accurate, current, and credible information about treatment alternatives

10. Community resources for health promotion, early detection and cancer related information and services

11. Legal and ethical rights of people at risk for cancer and for those experiencing cancer.

12. Recognition and incorporation of religious, ethnic, and cultural values and beliefs that influence health practices

14. Signs and symptoms of potential physical and psychosocial responses related to cancer and/or treatment, including those that should be reported to the interdisciplinary healthcare team
15. Psychosocial strategies to facilitate adaptation to the cancer experience

**Standard IV. Teaching-Learning Process**

Teaching-learning theories are applied to the development, implementation, and evaluation of learning experiences related to cancer education. Given the ease of access to health information, the oncology nurse often plays the role of facilitator in the learning process and not so much the provider of information.

**Rationale**

Adult learning principles establish that adults are self-directed learners. The learning experiences provided must assist the learners in discovering and obtaining the appropriate resources, taking appropriate actions to maintain or regain health and empowering them in an independent approach to learning. Learners are provided with guidance and relevant information if they are struggling to understand or are incapable of comprehending.

**Criteria**

The oncology nurse:
1. Collects data systematically from the learner to assess literacy, learning needs, learning styles, readiness to learn, and situational and psychosocial factors influencing comprehension.
2. Analyzes assessment data to identify cognitive, psychomotor and affective learning needs.
3. Develops a teaching plan in collaboration with the patient/significant other or public that includes behavioral objectives, specific content to meet the identified objectives, teaching strategies/learning experiences that are appropriate for and promote active learner participation and criteria for evaluation of outcomes.

4. Implements the teaching plan in an environment conducive to learning. Provides material that is clear, well organized and in “plain language.”

5. Uses evidence-based practice to determine the best way to provide education on a specific topic.

6. Utilizes appropriate instructional methods, including the use of technology, based on an assessment of the learners’ preferences.

7. Collects data from the patient/significant other and public using teach-back techniques, to evaluate achievement of learning objectives, effectiveness and efficiency of instruction, and the need to revise the teaching plan.

8. Modifies the teaching-learning process based on evaluation data.

**Standard V. Learner: Patient/Significant Other and the Public**

The patient and/or significant other apply knowledge, skills, and attitudes to management of actual or potential human responses to the cancer experience.

Personal behaviors and public policy related to cancer prevention, detection, treatment, rehabilitation, and supportive care are influenced by formal and informal public education.

**Rationale**
Learners are the target of the education process. Individuals may learn in a variety of styles including visual, auditory, read-write, and kinesthetic. Using the learners’ predominant learning style will move the individual from passive to active learning.

Criteria

The patient/significant other:

1. Is able to verbalize an understanding of extent of disease and treatment plan at a level consistent with age, educational and cultural background.
2. Participates in decision making regarding the plan of care if desired and possible.
3. Utilizes appropriate community and personal resources to seek out information and services.
4. Describes self-care measures and verbalizes the appropriate action for common outcomes, oncologic emergencies, and problems associated with the disease, treatment and side effects.
5. Understands the planned treatment schedule and the instructions provided to them.
6. Participates in conversation regarding survivorship, advance care planning, and end-of-life care decisions as appropriate.
7. Identifies personal genetic risk factors and their implications when indicated.
8. Describes health promotion strategies and survivorship care plan when cancer treatment is complete.

The public that has been reached by cancer education:

1. Demonstrates realistic attitudes about cancer and cancer risk factors.
2. Describes lifestyle choices that minimize personal risks for cancer and promote health.
3. Participates in appropriate or recommended cancer screening activities.
4. Identifies a course of action for early detection when signs and symptoms of cancer are discovered.

5. Identifies sources of cancer information, care, rehabilitation, and supportive care in the community.

**Resources**

Printed and audiovisual materials related to patient/significant other and public education are available from numerous sources, including the following.

**American Cancer Society**

800-ACS-2345 [www.cancer.org](http://www.cancer.org)

ANA’s Social Networking Principles Toolkit:


**American Society of Clinical Oncology**

Patient information from the American Society of Clinical Oncology. Includes cancer types, treatments, survivorship, advocacy, resources, podcasts, and news.


**Leukemia and Lymphoma Society**

212-573-8484
http://www.lls.org/ LIVESTRONG Foundation

http://www.livestrong.org

National Cancer Institute (NCI)
800-4-CANCER
www.cancer.gov
Cancer and treatment information in multiple languages

NCI Clinical Trials Web site
http://www.cancer.gov/about-cancer/treatment/clinical-trials

NCI Complementary Therapies Web site
https://nccih.nih.gov/

NCI Office of Communications
Office of Communications and Public Liaison (OCPL)
National Cancer Institute
BG 9609 MSC 9760
9609 Medical Center Drive
Bethesda, MD 20892-9760
Phone: 240-276-6600
http://www.cancer.gov/about-nci/organization/ocpl
NCI’s *Evaluating Online Sources of Health Information*:

http://www.cancer.gov/about-cancer/managing-care/using-trusted-resources

**ONS Online**

https://www.ons.org/ ONS has an:

- Educator Resource Center, a subscription based database which encompasses information in all areas of oncology practice and includes power point presentations, case studies, test questions and competencies.
- http://erc.ons.org/
  - The website also contains practice resources such as the PEP (Putting Evidence into Practice) information which is reliable research based information to share with patients, fellow practitioners and the public. https://www.ons.org/practice-resources/pep

http://www.cancer.gov/publications/pdq

**Cancer Patient Education Network**

154 Hansen Rd, Suite 201
Charlottesville, VA 22911 USA
Tel: 434.284.4697 Fax: 434.977.1856
info@cancerpatienteducation.org
http://www.cancerpatienteducation.org/

Printed and online resources for the educator

**Cleveland Clinic Partnership with The Scott Hamilton CARES Initiative**
http://www.chemocare.com

Online site for information on chemotherapy including drug information, managing side effects, eating well during chemotherapy, what is chemotherapy?, before and after chemotherapy, survivor testimonials, frequently asked questions, educational videos, chemotherapy resources, complementary medicine and self-help. Information in English and Spanish.

Using What Works

Format: Web-based self-study

Time: Self-paced

Using What Works is a train-the-trainer course for health promoters and educators. It teaches users how to plan a health education program using evidence-based programs.

http://cancercontrol.cancer.gov/use_what_works/start.htm


http://www.cancerpatienteducation.org/publications.shtml


http://www.teachbacktraining.org/
**Terminology**

**Advanced Practice Level**—Level of practice for a nurse with a master’s, doctoral, or postdoctoral education who applies theoretical knowledge in a specialized field.

**Cancer Control**—A term including the entire spectrum of cancer care (i.e., prevention, screening and early detection, diagnosis, treatment, rehabilitation, survivorship and palliation).

**Cancer Detection**—Performance of tests to make a diagnosis of cancer in symptomatic clients.

**Cancer Eradication**—The obliteration of cancer and restoration of the client to a normal life expectancy.

**Cancer Prevention**—Strategies to minimize client exposure to substances known to increase the risk of cancer or to promote optimal client exposure to substances known to decrease the risk of cancer.

**Cancer Rehabilitation**—A process by which individuals within their environment are assisted to achieve optimal function within the limits imposed by cancer.

**Cancer Screening**—Strategies designed to detect cancer in asymptomatic clients.

**Carcinogenesis**—The production or origin of cancer.

**Complementary Therapy**—Scientifically accepted treatment options considered in clinical decision making.

**Cultural Competence**—Refers to being sensitive and responsive to issues related to culture, race, ethnicity, gender, age, socioeconomic status, and sexual orientation. Cultural competence indicates translation of cultural sensitivity and awareness into credible behaviors and actions.

**Culture**—A set of values, beliefs, and rules for behavior. Culture provides the structure for meaning and decision making.
Domains of Learning—Cognitive: Refers to rational thought, knowledge of the basic
concepts of identified topics

Psychomotor: Refers to the physical skills needed to perform a task

Affective: Refers to attitudes, values, and cultural beliefs regarding the subject being
presented

Education—The process of inducing measurable changes in knowledge, skills, and attitudes
through planned learning activities.

Generalist Level—Level of practice for a registered nurse who possesses general knowledge
and skills applicable to diversified health concerns of individuals.

Health Literacy - is the degree to which individuals have the capacity to obtain, process, and
understand basic health information and services needed to make appropriate health decisions.

Health Promotion—Strategies to achieve a dynamic state in which the well-being and
health potential of individuals are realized to the fullest extent.

Nursing Diagnosis—A description of an actual or potential health problem that nurses, by
virtue of their education and experience, are capable of diagnosing and licensed to treat.

Nursing—The diagnosis and treatment of human responses to actual or potential health
problems.

Oncology Nursing—Nursing care of people with an actual or potential diagnosis of cancer
ranging from prevention of disease to rehabilitation, survivorship, or terminal care.

Outcome Criteria—Descriptions of the desired end results of specific actions.

Palliation—Control of symptoms when disease is beyond cure.

Person at risk for or experiencing cancer—The individual, significant other, group, or
community for whom the oncology nurse provides formally specialized services.
Process Criteria—Descriptions of the major sequence of events and activities required to obtain desired outcomes.

Public—The people of an organized community.

Questionable Therapies—Cancer treatments or therapies that have not been shown to be active in tumor animal models or acceptable clinical trials and yet are promoted as effective methods for the cure, palliation, or control of cancer.

Significant Others—People who are related or who represent a significant support group for the person at risk for or experiencing cancer.

Standards—A norm that expresses an agreed-upon level of practice that has been developed to characterize, measure, and provide guidance for achieving excellence.

Structure Criteria—Descriptions of the environment and resources needed to achieve desired outcomes.
References


Coaching to Always Use Teach-back: http://www.teachbacktraining.org/


Jacobson et al (2012) Revision to the 2009 American Society of Clinical Oncology/Oncology Nursing Society chemotherapy administration safety standards: Expanding the scope to include inpatient settings. *Oncology Nursing Forum*, 39, 31-38. [http://dx.doi.org/10.1188/12.ONF.31-38](http://dx.doi.org/10.1188/12.ONF.31-38)


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**Recommended Reading**

Journal of Medical Internet Research - [http://www.jmir.org](http://www.jmir.org)

