McGrath Foundation

ABOUT THE MODEL

HOW TO USE THIS DOCUMENT

FIRST CONTACT

DIAGNOSIS, STAGING & TREATMENT PLANNING

WAITING FOR TREATMENT

TREATMENT

POST TREATMENT RECOVERY

SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION

PALLIATIVE CARE END OF LIFE CARE

RESOURCES & LINKS

OPTIMAL CARE PATHWAYS

GLOSSARY

SKILLS & KNOWLEDGE

ASSESSMENT TOOLS

McGrath Model of Care

January 2026

Acknowledgment of Country

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

We acknowledge the Traditional Custodians of the land on which we work and come together.

As a Foundation built on care, connection, and community, we honour the strength, wisdom, and enduring custodianship of the First Nations people, who have cared for this beautiful Country for thousands of years.

Standing on this Country reminds us that caring for one another is not new – it is a value long upheld and preserved and protected by First Nations communities across generations.

We commit to deep listening, learning humbly, and strengthening meaningful relationships with First Nations peoples.
May we contribute to a future grounded in care, respect, understanding and genuine connection.

About the McGrath Model of Care

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

The McGrath Model of Care is an initiative of the Australian Cancer Nursing and Navigation Program (ACNNP), funded by the Commonwealth Government. This initiative builds on partnerships founded in sharing care and resources among ACNNP members. A key goal of the McGrath Model of Care is to improve equity across cancer types and promote continued collaboration in the cancer care sector.

The McGrath Model of Care is a framework designed to assist **McGrath Cancer Care Nurses (MCCN)** deliver support to people with any type of cancer and their families across Australia. It's built on one clear goal – to make sure everyone receives high-quality, person-centred care, wherever they live and for whatever type of cancer they have.

The McGrath Model of Care sets out the core principles that guide our nurses – compassion, clinical excellence, respect, and partnership. These principles are the same for every MCCN, no matter the location or the type of cancer the people they are caring for are experiencing.

Because healthcare systems and services differ between hospitals, public and private services, communities, and states and territories, the way the **McGrath Model of Care** is applied can look slightly different from place to place. These variations aren't inconsistencies, they're how McGrath make sure the MCCN fits the local health system and meets the unique needs of each person and community.

What doesn't change is our commitment to:

- Providing expert, evidence-based nursing care.
- Supporting patients and their support people throughout their treatments with an emphasis on living well, at whatever stage of care that they are in.
- Working with the broader multidisciplinary cancer care team to ensure timely and accurate information sharing, and to coordinate appropriate referrals that support patients and their support people.

Wherever you meet a McGrath Cancer Care Nurse, you can be confident that care is guided by the same national standards – delivered with understanding, clinical expertise, local knowledge and kindness.

Australian Cancer Nursing and Navigation Program

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

McGrath Cancer Care Nurse referral considerations for the McGrath Model of Care

The ACNNP aims to improve access to high quality, culturally safe care for anyone impacted by cancer, regardless of where they live or their type of cancer.

The ACNNP funds many MCCNs to deliver supportive cancer care nursing services.

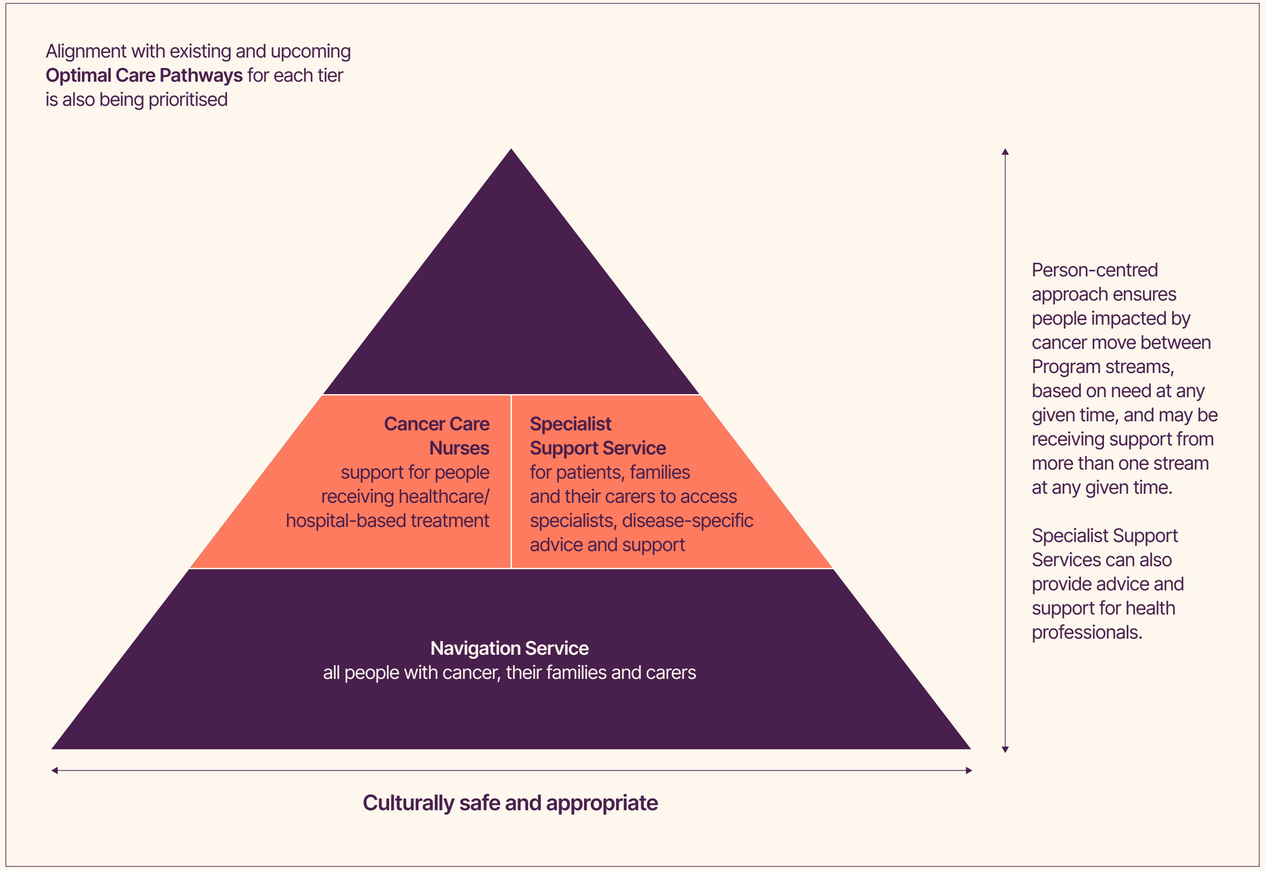
The ACNNP is being delivered through three integrated service streams:

- Cancer Navigation Services
- Cancer Nursing Services
- Specialist Support Services

Services are free for anyone to access – the individual, support people, families, carers or friends. Health professionals can also access the Cancer Navigation and Specialist Support Service streams for advice to support people.

Figure 2:

Tiered model of support



About the McGrath Model of Care

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

In November 2023, the Commonwealth Government announced the Australian Cancer Nursing and Navigation Program (ACNNP) in response to the Australian Cancer Plan. As part of this initiative, the Government invited the McGrath Foundation to lead the all-cancer nurse service due to its reputation for delivering high quality cancer nursing care. The expansion of the McGrath Foundation reach to all cancers will improve equity in cancer care in Australia by providing supportive cancer nursing care for people affected by any type of cancer.

To ensure the McGrath cancer nursing program meets the unique needs of people in Australia, the McGrath Foundation partnered with Ethicol to lead a collaborative co-design process for the development of the McGrath Model of Care.

To support the co-design process, three expert advisory groups established a strong governance structure:

- **Cancer Experience Advisory Group** – ensured the McGrath Model of Care remained person-centred and that the process was psychologically safe, inclusive and respectful for people with lived cancer experience.
- **Provider Advisory Group** – brought together a wide range of clinicians to confirm nursing interventions were contemporary, in scope and evidence based.
- **Research Advisory Group** – comprised of leading cancer care academics in nursing and allied health to ensure the model reflected the latest academic evidence.

The Co.Design4All Framework[1] was applied to support a robust and collaborative co-design process. This resulted in over 960 interactions across people with an experience of cancer, clinicians, academics, and Non-Government Organisations (NGOs). The process also built on the previous work to develop the McGrath Model of Care – Breast. Figure 3 outlines the five-stage co-design process.

Figure 1:

Melbourne Cancer Experience Focus Group attendees

[1] The co-design process has been adapted from the Co.Design4. All Framework, this can be found at www.codesign4all.com

Co-design process

The design of the McGrath Model of Care was informed by the Co.Design4All Framework[2], beginning in April 2024 and concluding in November 2025.

Figure 3:

The five-stage co-design process

1. Planning

During the first stage the critical elements for success were mapped out. This included undertaking a stakeholder mapping exercise and reviewing strategic documents across the cancer continuum. Flinders University commenced a systematic literature review which was used in the Design stage of the project.

2. Discovery

During this stage, the team sought to understand the current state of supportive cancer nursing across Australia. Co-design principles underpinned consultation with people that have an experience of cancer, along with clinicians, representatives from the NGO sector and government departments. An experience map was developed in this stage.

3. Design

A series of workshops were held with people who have experienced cancer, carers, clinicians, priority populations and representatives from the NGO sector to design the ideal nurse led supportive cancer care experience map. The results from the academic literature were leveraged.

4. Decide

An online consensus survey was undertaken to obtain agreement from Specialist Cancer Nurses on inclusions in the McGrath Model of Care. Two feasibility workshops were held to discuss and iterate the model.

5. Debrief

The final McGrath Model of Care was presented to stakeholders. An implementation plan was designed, and educational requirements considered. A debrief survey was also distributed to all stakeholders.

533

Interactions with people who have a lived experience of cancer

405

Interactions with clinicians from across the cancer continuum

18

NGOs involved from the cancer sector

[2] The co-design process has been adapted from the Co.Design4. All Framework, this can be found at www.codesign4all.com

About the McGrath Model of Care

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

The McGrath Model of Care was informed by Fitch's Supportive Care Framework for Cancer Care[3], which outlines seven domains of supportive care. These domains are outlined in Figure 4. To create a contemporary, standardised model of care, principles of the Optimal Care Pathways were incorporated. Feedback from people with lived cancer experience, and clinicians further refined the model. A literature review undertaken by Finders University underpins the evidence base of the McGrath Model of Care (Refer to Appendix 1).

The McGrath Model of Care is designed for use by the MCCNs working across Australia to improve outcomes for people with all cancer types. By making the McGrath Model of Care publicly available, the team also aim to enable other Cancer Nurses to learn from, build on, and benefit from the McGrath Model of Care.

The McGrath Foundation and Ethicol would like to thank the participants involved in designing the McGrath Model of Care, and for generously sharing their stories, insights and clinical expertise with us. Your open and honest contributions are the cornerstone of the co-design process, and we deeply appreciate the richness and quality they have brought to this work.

The role of the McGrath Cancer Care Nurse (MCCN)

The role of the MCCN is to support the individual and their support people following a diagnosis of cancer, to promote self-efficacy and the ability to live well throughout all stages of care. This includes the assessment, management and escalation of care for the symptoms of their disease and side effects of treatment, the provision of timely information and guidance and support with a coordinated multi-disciplinary team approach.

[3] Fitch, M.I., 2008. Supportive care framework. *Canadian Oncology Nursing Journal*, 18(1), pp.6–24. https://doi.org/10.5737/1181912×181624

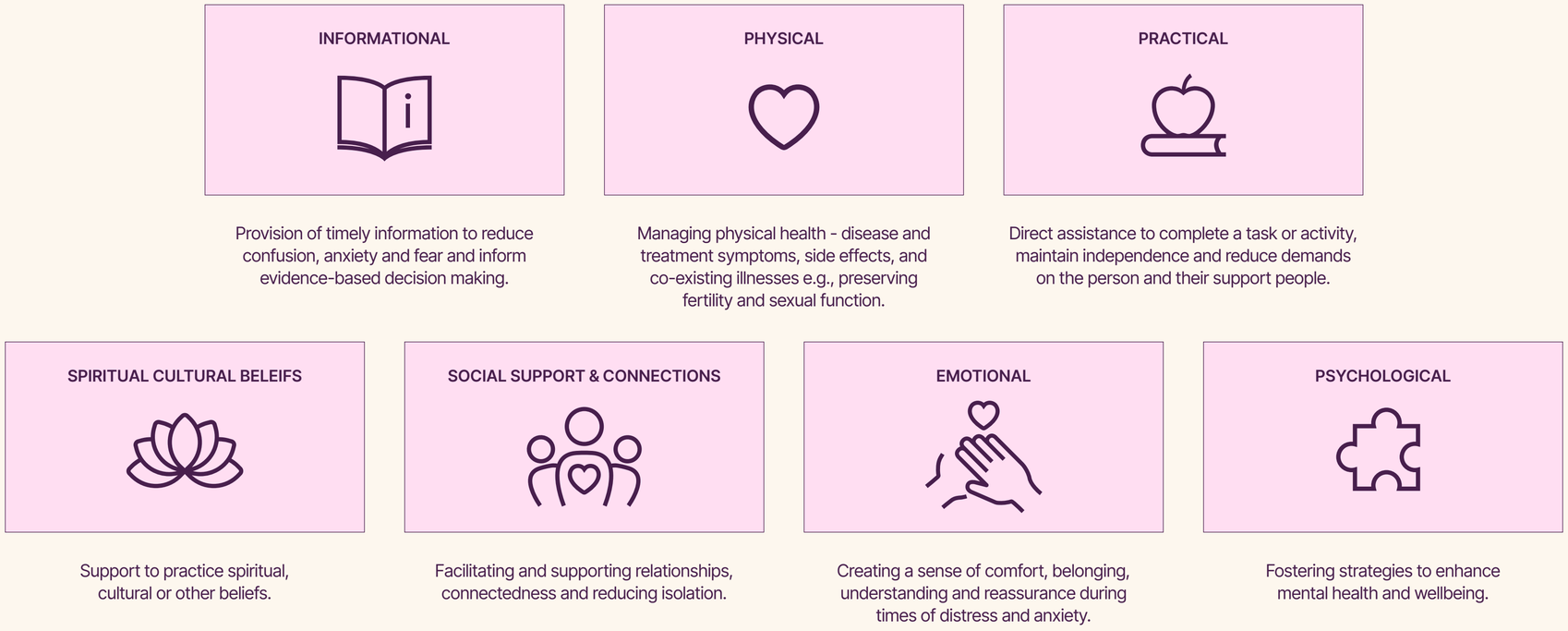
About the McGrath Model of Care

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Fitch's Supportive Care Framework for Cancer Care guides nursing assessment and clinical decision making to meet an individual's needs throughout various stages of care and treatment modalities.

Figure 4:

Supportive Care Framework for Cancer Care



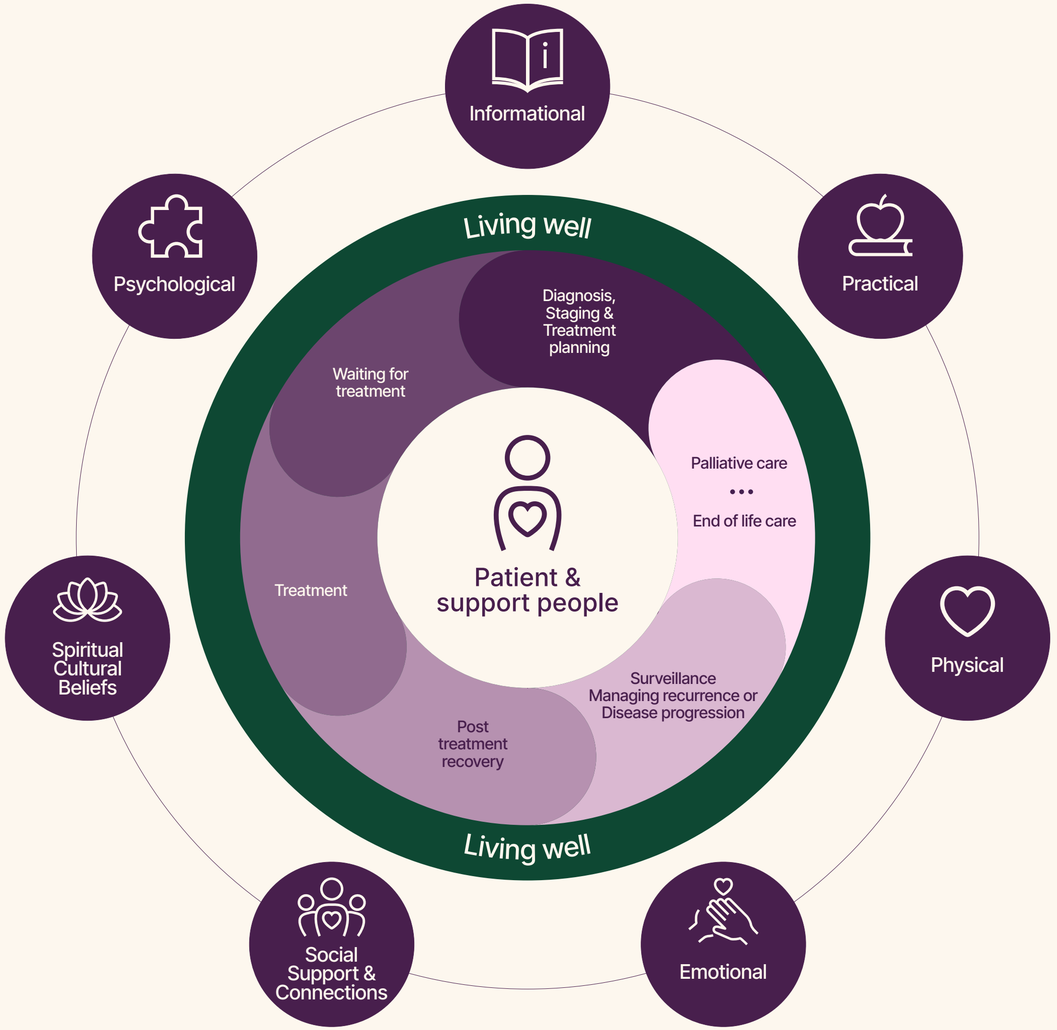
Adapted from Fitch, M.I., 2008. Supportive care framework. *Canadian Oncology Nursing Journal*, 18(1), pp.6–24. https://doi.org/10.5737/1181912×181624

About the McGrath Model of Care

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Figure 5:

Overview of the McGrath Model of Care



About the McGrath Model of Care

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Principles of the McGrath Model of Care

The following points describe the key design principles of the McGrath Model of Care:

- **Central focus on person and support people** – Emphasises the importance of designing care around the individual needs of the person. Throughout the McGrath Model of Care the patient is referred to as the person or individual. The schematic of the McGrath Model of Care uses the term patient to align with the system of care
- **Blended circular stages** – Key stages of care are presented as a continuous, blended circle to reflect that the cancer experience is not linear
- **Deliberate anticlockwise flow** – The McGrath Model of Care intentionally moves anticlockwise indicating there isn't a standard flow across the stages of care and people can be in multiple stages at any one time
- **Living well as a consistent goal** – "Living well" is embedded as a goal at every stage, as well as the overarching aim of the McGrath Model of Care
- **Dynamic supportive care domains** – Supportive care domains encompass the stages, with some domains becoming more significant at different stages of care
- **Expanded spiritual domain** – Now incorporates cultural and other beliefs to reflect the diversity of beliefs within the Australian population

How to use this document

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

The McGrath Model of Care is designed as a reference guide for MCCNs to support the delivery of supportive cancer care and should be used in conjunction with the MCCN's clinical judgement. It can be printed for reference or navigated digitally using the menu on the left and bottom of the document.

Throughout the document, activities are listed under each stage of the McGrath Model of Care. These are intended as a guide and should be adjusted to suit the person's circumstances and MCCN's clinical judgement. Some activities may be undertaken in collaboration with the multidisciplinary care team.

The McGrath Foundation is also developing a Model of Care for haematological cancers. References and resources associated with nursing care for people with haematological cancers do not appear in this model.

Key components of the McGrath Model of Care have been explained in Figure 6 below and 7 and on the subsequent page.

Figure 6:

Key components of the McGrath Model of Care

KEY ACTIVITIES	The activities for the MCCN to consider in the delivery of supportive cancer care, in conjunction with the person's need and their clinical judgement. They may be delivered across multiple points of contact in the same stage of care
DELIVERY CONSIDERATIONS	The method of contact (e.g., face-to-face or telephone). This is determined by the stage of care, type of information, contact frequency, and the person's needs
RESOURCES FOR INDIVIDUALS AND SUPPORT PEOPLE	Information and services that an individual and/or their support people can access, relevant to each stage of care
RESOURCES FOR NURSES	Clinical or other resources that can be used by MCCNs to provide information and support aligned with key activities, the stage of care and the person's needs
ASSESSMENT TOOLS	Assessment tools that are recommended for use at each stage of care, in alignment with the person's needs and clinical judgement

Hyperlinked text to external resources.

How to use this document

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Priority populations

Priority populations defined in the Australian Cancer Plan have been considered in the McGrath Model of Care. Tailored resources and activities are suggested for incorporation into each of stage of care. People may identify with one or more of these cohorts.

Figure 7:

Priority populations

AGE	Provides guidance and resources to support younger and older people
CULTURALLY & LINGUISTICALLY DIVERSE	Provides guidance and support to individuals who identify as having diverse languages, ethnic backgrounds, nationalities, traditions, societal structures, religions and beliefs
FIRST NATIONS	Provides guidance and support for First Nations people
HEALTH STATUS	Provides guidance and support for people with disability, mental illness or other comorbidities
LGBTIQA+	Provides guidance and support to lesbian, gay, bisexual, transgender, intersex, queer, asexual, and other sexually or gender diverse people (LGBTIQA+)
RURAL & REMOTE	Provides guidance and support for people living in regional, rural or remote parts of Australia
SOCIAL CHALLENGES	Provides guidance and support to people experiencing complex social situations

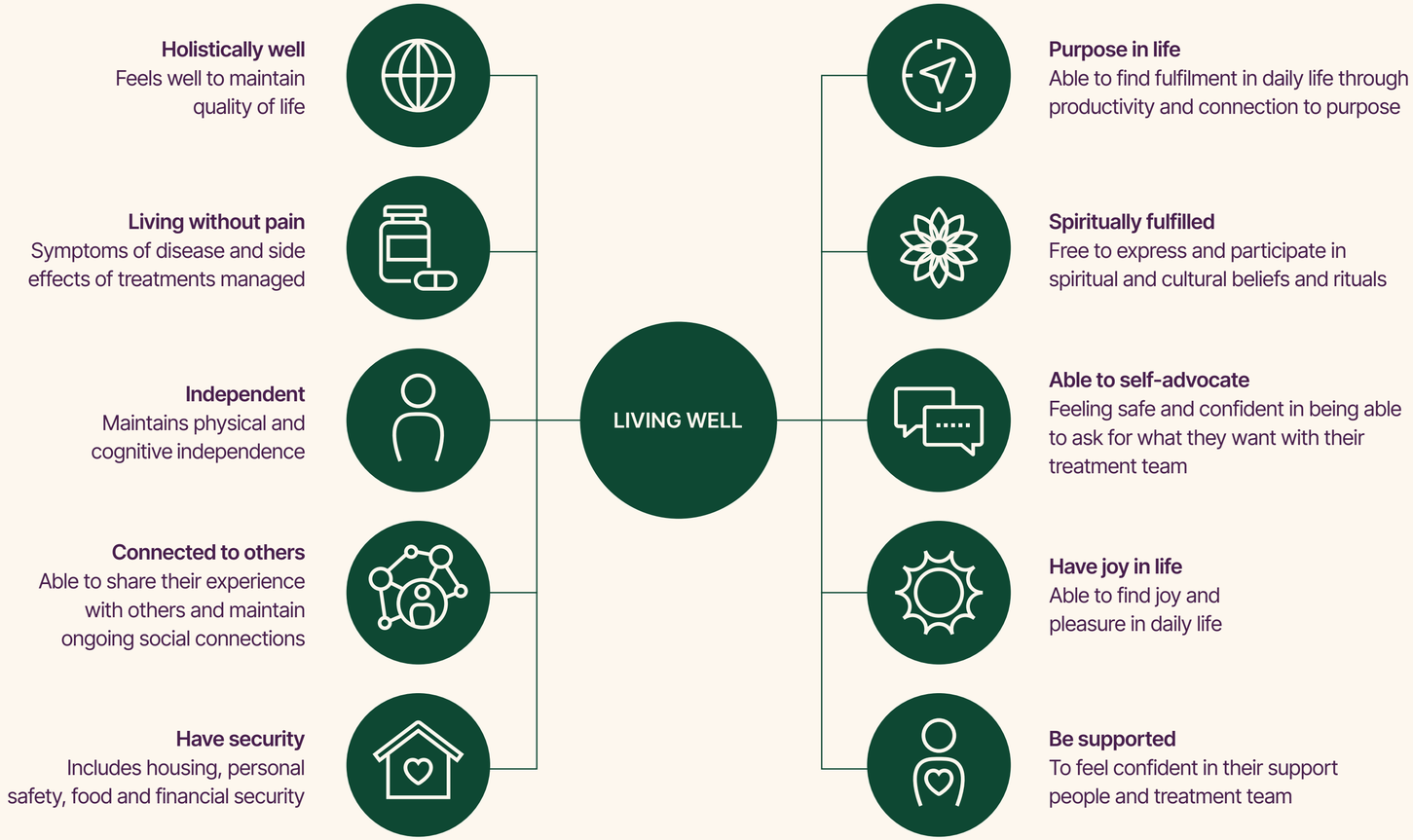
How to use this document: Living well

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Living well is unique to each individual. Figure 8 outlines elements that may be considered for Living well. The Living well component of the McGrath Model of Care encompasses all stages of care and is designed to ensure a focus on achieving the wellbeing goals of the person you are caring for. Refer to this section at every stage of care to check in with the person on their wellness goals.

Figure 8:

Elements of Living well



First contact

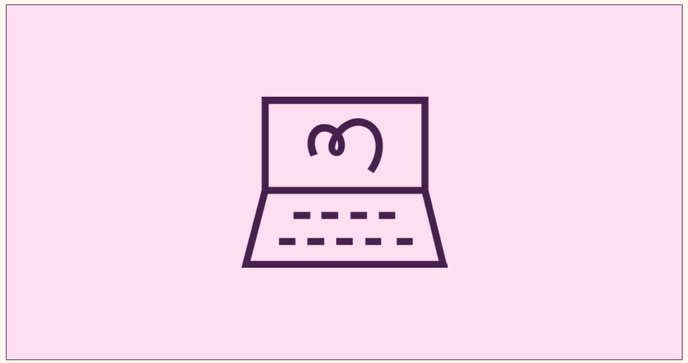
People may enter MCCN care within any stage of the McGrath Model of Care. Key considerations for the First MCCN contact include:

Has the person had contact with another Cancer Nurse or agency?

- Is there a local or close to home Cancer Care Nurse or agency involved in the person's care. If so, provide timely clinical updates.
- Identify and refer to appropriate NGOs to access additional resources and support.
- If the person is new to you and is located within your area, establish contact and maintain continuity of care.
- If the person is receiving care outside of their local health area, refer to the MCCN service or agency closest to place of residence.

What stage is the person entering the McGrath Model of Care?

- If the first contact with the person is after the Diagnosis, Staging and Treatment planning stage, consider delivering the key activities, resources, referrals and supports from previous stages of care in the McGrath Model of Care.



What services and information has the person already been provided?

- The person should receive services and information that meet their needs relative to their stage of care.
- Provide the person with MCCN days of work and alternative contacts.
- Encourage them to initiate contact with the MCCN about any concerns.
- Information may need to be reinforced to enhance the person's understanding and retention.
- If referrals to support services are declined by the individual or their support people, offer information on how to self-navigate to support and connections. Regularly repeat offers of referral through all stages of care.

First contact: Referral

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

MCCN referral considerations for the McGrath Model of Care

MCCNs can refer to other cancer care organisations at any point in care including:

- On admission
- During treatment
- On completion of active treatment and/or discharge from nursing service

Referral processes to be explored by cancer type, cancer stage and residential locality (e.g., State/Territory based versus national services).

Referrals will be dependent on the person's needs and should consider:

- Individual consents to referral
- The person's health status (determined through validated assessment tools)
- Location (metro, regional, rural, remote)
- Services available within the treatment centre that the person and their support people are accessing
- Services already accessed
- Priority population status, including health beliefs and language needs
- Co-morbidities, including other treating teams and services
- Needs of support people

If referrals are declined by the person, information on how to access services independently should be provided with offer of referral revisited in future MCCN care episodes.

Information on support services for support people should also be provided and offered throughout the stages of care.

Specialist support service delivery partners:

Leukaemia Foundation
Ovarian Cancer Australia
Brain Tumour Alliance Australia Inc 1800 857 221
BEAT Bladder Cancer Australia
Head & Neck Cancer Australia
Cancer Hub
Myeloma Australia
Cancer Council
Lung Foundation Australia
Pancare Foundation
Liver Foundation
melanoma. patients australia
Lymphoma Australia
NeuroEndocrine Cancer Australia
Bowel Cancer Australia
Breast Cancer Network Australia
rare cancers Australia
Prostate Cancer Foundation of Australia

Diagnosis, Staging & Treatment planning

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Key Activities

First steps

- Contact the person as soon as possible after they have learned of their diagnosis
- Check individual's understanding of their diagnosis and treatment plan and provide tailored information as required e.g., verbal and written
- Encourage the person to ask questions and allow adequate time for discussion
- Use therapeutic conversations to provide emotional support
- Respect and include the individual's support people
- Assess supportive care needs using a validated assessment tool
- Assess performance score with a validated assessment tool
- Assess the person's needs related to gender at birth, gender identity and sexual preferences
- Assess the person's needs related to their culture and beliefs
- Assess the person's needs related to their age, mental health, presence of a disability, geographical location and socioeconomic status

Clinical roles & multidisciplinary care

- MCCN collaborates and communicates within the Multidisciplinary Team (MDT), inclusive of the person's General Practitioner (GP)
- MCCN role and scope of practice is clear among cancer care team
- Document the cancer staging using TNM or relevant cancer classification
- Discuss clinical trial options with person and support people
- Assess sexual function and oncofertility needs, facilitate referrals appropriately
- Assess indications for genetic testing (e.g., family history) or genomic profiling (e.g., targeted treatment options) and facilitate referral where appropriate

Clinical roles & multidisciplinary care (continued)

- Provide evidence-based information on self-care strategies to manage symptoms of disease and side-effects of treatment
- Provide information on who and when to contact for non-urgent, urgent and emergency events e.g., Emergency Department or Symptom and Urgent Review Clinic (SURC)

Treatment planning

- Foster empowerment and self-advocacy and support informed decision making and consent by providing evidence-based education and information in varied formats (e.g., written translated into first language and verbal using an interpreter)
- Assess, manage and escalate symptoms of disease
- Discuss oral and dental health and facilitate referral to a dental service if appropriate
- Encourage the person to record and report symptoms of disease
- Provide information on the treatment and treatment schedule including the timing of supportive pathology or investigations and communicate the next steps
- Ask the person if they are using any complementary or alternative therapies and explore for contraindications
- Provide culturally safe and inclusive care to people of priority populations.

Practical assistance

- Provide information and facilitate appropriate referrals to meet practical needs e.g., travel, accommodation and parking
- Assess for the risk of financial distress e.g., current employment type and access to sick leave, income protection or trauma insurance

Supportive Care Needs

Significant supportive care needs during this stage are:

- Informational
- Emotional
- Psychological

Delivery Considerations

- During this stage, the individual may prefer support to be given in a private setting and may want support people to be present
- Information overload is common during this stage. Gradual information provision with regular reiteration during multiple appointments and phone calls is required

Diagnosis, Staging & Treatment planning

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Key Activities

Practical assistance (continued)

- Provide referrals for financial support, guidance and counselling where appropriate e.g., Social Work, Centrelink, Cancer Council Pro Bono Financial Counselling
- Provide evidence-based information and resources for the individual and their employer about employment during cancer treatment if relevant
- Provide evidence-based information and resources for the individual about studying during cancer treatment if relevant

Common referrals & information provision

- **Refer to specialist cancer support through ACNNP and other partner organisations. Consider if referral assistance is required during any stage of treatment.**
- Provide information on MDT referral pathways and expected timing of contact
- Provide guidance on where to find reliable sources of information
- Facilitate navigation of the broader health system and access to services closer to place of residence e.g., pathology collection, medical imaging and medication dispensing
- Provide information and appropriate referrals to support services and peer support groups for the individual and their support people
- Provide information and appropriate referrals for psychological support e.g. health service Psychologist or GP for referral to psychology services as part of a Mental Health Care Plan
- Provide information and referrals to locally available allied health support or consider GP referral for a Chronic Disease Management plan to access allied health services
- Consider referral to a prehabilitation program if appropriate
- Provide evidence-based information and education about palliative care and end of life care and facilitate referrals when appropriate

Selfcare & lifestyle

- Provide education and information on the importance of exercise and where appropriate, facilitate referral to an Exercise Physiologist or Physiotherapist or other cancer related exercise program
- Provide information and resources on wellness programs and guidance to support a healthy lifestyle and lifestyle modifications e.g., smoking cessation, physical activity, nutrition and limiting alcohol intake
- Refer to the Living well section for more information

Assessment Tools

Screen, assess, address and share any outcomes from the person's assessment using the following tools:

- Australian-modified Karnofsky Performance Status
- Brief Fatigue Inventory
- ECOG Performance Status Scale
- Edmonton Symptom Assessment Scale
- Malnutrition Screening Tool
- MASCC Oral Agent Teaching Tool
- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List
- Chemotherapy Toxicity Calculator

Resources for Individuals

- Treatment Decisions | WeCan
- Living with Advanced Cancer | Cancer Council
- Caring for someone with Advanced Cancer | Cancer Council

RESOURCES & LINKS

Resources for Nurses

- Prehabilitation | PeterMac

RESOURCES & LINKS

"Clear communication, repeated over time due to information overload."

LIVED EXPERIENCE PARTICIPANT

Waiting for treatment

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Activities

First steps

- Provide timely access to MCCN either at or soon after diagnosis
- Check individual's understanding of their diagnosis and treatment plan and provide tailored information as required e.g., verbal and written
- Encourage the person to ask questions and allow adequate time for discussion
- Use therapeutic conversations to provide emotional support
- Assess supportive care needs using a validated assessment tool
- Assess performance score with a validated assessment tool
- Assess the person's needs related to gender at birth, gender identity and sexual preferences
- Assess the person's needs related to their culture and beliefs
- Assess the person's needs related to their age, mental health, presence of a disability, geographical location and socioeconomic status

Clinical roles & multidisciplinary care

- MCCN collaborates and communicates within the MDT, inclusive of the person's GP
- MCCN role and scope of practice is clear among cancer care team
- Provide information on who and when to contact for non-urgent, urgent and emergent events e.g., ED or SURC
- Assess indications for genetic testing (e.g. family history) or genomic profiling (e.g. targeted treatment options) and facilitate referral where appropriate
- Consider clinical trial requirements if applicable

During the waiting time

- Assess, manage and escalate symptoms of disease
- Provide information on the treatment and treatment schedule including the timing of supportive pathology or investigations and communicate the next steps
- Foster empowerment and self-advocacy and support informed decision making and consent by providing evidence-based education and information in varied formats (e.g., written translated into first language and verbal using an interpreter)
- Provide support and resources to manage anxiety and fear of disease progression
- Provide culturally safe and inclusive care to people of priority populations. Refer to information specific to priority populations
- Ensure there is a clear plan for escalation of care if disease progresses
- Ensure the person is aware they can contact the MCCN if they have concerns
- Discuss oral and dental health and facilitate referral to a dental service if appropriate
- Ask the person if they are using any complementary or alternative therapies and explore for contraindications

Practical assistance

- Provide information and facilitate appropriate referrals to meet practical needs e.g., travel, accommodation and parking
- Assess for the risk of financial distress e.g., current employment type and access to sick leave, income protection or trauma insurance
- Provide referrals for financial support, guidance and counselling where appropriate e.g., Social Work, Centrelink, Cancer Council Pro Bono Financial Counselling

Supportive Care Needs

Significant supportive care needs during this stage are:

- Emotional
- Informational
- Psychological

Delivery Considerations

- During this stage people may prefer phone calls, telehealth or online forms of communication
- The amount of contact will depend on length of time waiting for treatment
- People may want their support people to be involved in this stage

LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Waiting for treatment

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL

Key Activities

Practical assistance (continued)

- Provide evidence-based information and resources for the individual and their employer about employment during cancer treatment if relevant
- Provide evidence-based information and resources for the individual about studying during cancer treatment if relevant

Common referrals & information provision

- **Refer to specialist cancer support through ACNNP and other partner organisations. Consider if referral assistance is required during any stage of treatment.**
- Provide information on MDT referral pathways and expected timing of contact
- Provide education and information on the importance of diet, which may include referral to a Nutritionist or Dietitian
- Provide guidance on where to find reliable sources of information
- Facilitate navigation of the broader health system and access to services closer to place of residence e.g., pathology collection, medical imaging and medication dispensing
- Provide information and appropriate referrals to support services and peer support groups for the individual and their support people
- Consider referral to a prehabilitation program if appropriate
- Provide information and appropriate referrals for Psychological support e.g., health service Psychologist or GP for referral to psychology services as part of a Mental Health Care Plan
- Provide information and referrals to locally available allied health support or consider GP referral for a Chronic Disease Management plan to access allied health services

Selfcare & lifestyle

- Provide the person and support people with guidance on self-care activities
- Provide information and resources on wellness programs and guidance to support a healthy lifestyle, and lifestyle modifications e.g., smoking cessation, physical activity, nutrition and limiting alcohol intake
- Provide education and information on the importance of exercise and where appropriate, facilitate referral to an Exercise Physiologist or Physiotherapist or other cancer related exercise program
- Refer to Living well section for more information

Assessment Tools

Screen, assess, address and share any outcomes from assessment using the following tools:

- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List
- Brief Fatigue Inventory
- Malnutrition Screening Tool
- Edmonton Symptom Assessment Scale
- ECOG Performance Status Scale
- Australian-modified Karnofsky Performance Status
- MASCC Oral Agent Teaching Tool

Resources for Individuals

RESOURCES & LINKS

Resources for Nurses

- Prehabilitation | PeterMac

RESOURCES & LINKS

> *"Long waiting times for initial investigations, leading to increased anxiety and potential progression of the disease*

LIVED EXPERIENCE PARTICIPANT

Treatment

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Activities

First steps

- Provide timely access to MCCN either at or soon after diagnosis
- Check individual's understanding of their diagnosis and treatment plan and provide tailored information as required e.g., verbal and written
- Encourage the person to ask questions and allow adequate timefor discussion
- Use therapeutic conversations to provide emotional support
- Respect and include the individual's support people
- Assess supportive care needs using a validated assessment tool
- Assess performance score with validated assessment tool
- Assess the person's needs related to gender at birth, gender identity and sexual preferences
- Assess the person's needs related to their culture and beliefs
- Assess the person's needs related to their age, mental health, presence of a disability, geographical location and socioeconomic status

Clinical roles & multidisciplinary care

- MCCN collaborates and communicates within the MDT, inclusive of the person's GP
- MCCN role and scope of practice is clear among cancer care team
- Discuss treatment intent (curative versus palliative)
- Provide information on who and when to contact for non-urgent, urgent and emergency events e.g. ED or SURC
- Assess indications for genetic testing (e.g. family history) or genomic profiling (e.g. targeted treatment options) and facilitate referral where appropriate
- Consider clinical trial requirements if applicable

Clinical roles & multidisciplinary care (continued)

- Assess sexual function and oncofertility needs, facilitate referrals appropriately

Treatment

- Consider current treatment plan (concurrent treatments including non-cancer treatments)
- Foster empowerment and self-advocacy and support informed decision making and consent by providing evidence-based education and information in varied formats (e.g., written translated into first language and verbal using an interpreter)
- Assess, manage and escalate symptoms of disease and side-effects of treatment
- Provide information on the treatment and treatment schedule including the timing of supportive pathology or investigations and communicate the next steps
- Discuss oral and dental health and facilitate referral to a dental service if appropriate
- Provide comprehensive information on potential side effects, follow up and reinforce
- Provide information and guidance on what to look for in disease progression
- Provide evidence-based information on safe sex, sexual function and family planning
- Provide information and advice on bone health
- Provide culturally safe and inclusive care to people of priority populations. Refer to information specific to priority populations
- Ensure the person is aware they can contact the MCCN if they have any concerns

Supportive Care Needs

Significant supportive care needs during this stage are:

- Informational
- Physical
- Practical

Delivery Considerations

People would like support provided in conjunction with treatment visits, which occur in hospital or treatment clinics. With support people and potentially their treating specialist.

The specialist treating team may be the first point of contact during this stage of care. The level of MCCN contact should complement the service provision by the specialist treating team.

Treatment

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Key Activities

Practical assistance

- Consider referral to local community resources for regional, rural and remote people
- Discuss financial implications of treatment and possible out of pocket expenses
- Provide information and facilitate appropriate referrals to meet practical needs e.g., travel, accommodation and parking
- Assess for the risk of financial distress e.g, current employment type and access to sick leave, income protection or trauma insurance
- Provide referrals for financial support, guidance and counselling where appropriate e.g., Social Work, Centrelink, Cancer Council Pro Bono Financial Counselling
- Provide evidence-based information and resources for the individual and their employer about employment during cancer treatment if relevant
- Provide evidence-based information and resources for the individual about studying during cancer treatment if relevant

Common referrals & information provision

- Provide information on MDT referral pathways and expected timing of contact
- Facilitate navigation of the broader health system and access to services closer to place of residence e.g., pathology collection, medical imaging and medication dispensing
- Provide information and appropriate referrals to support services and peer support groups for the individual and their support people

Common referrals & information provision (continued)

- **Refer to specialist cancer support through ACNNP and other partner organisations. Consider if referral assistance is required during any stage of treatment.**
- Provide information and appropriate referrals for psychological support e.g., health service Psychologist or GP for referral to psychology services as part of a Mental Health Care Plan
- Provide information and referrals to locally available allied health support or consider GP referral for a Chronic Disease Management plan to access allied health services
- Provide information, education and/or referral about palliative care and end of life, when appropriate

Selfcare & lifestyle

- Provide the person and support people with guidance on self-care activities
- Ask the person if they are using any complementary or alternative therapies and explore for contraindications
- Provide education and information on the importance of diet, which may include referral to a Nutritionist or Dietitian
- Provide education and information on the importance of exercise and where appropriate, facilitate referral to an Exercise Physiologist or Physiotherapist or other cancer related exercise program
- Refer to Living Well section for more information

Treatment

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Resources for Individuals

- Treatment Decisions | WeCan
- Skin and nails during treatment | Cancer Council
- What to expect when receiving medication for cancer care | Safety and Quality
- Understanding taste and smell changes | Cancer Council
- Mouth health | Cancer Council
- Managing neuropathy | eviQ
- Managing nausea and vomiting | eviQ
- Managing anticancer medicines | eviQ
- Bone Health Action Plan | NPS Medicinewise
- Osteoporosis and treatment | Healthy Bones Australia
- List of cancer treatments | HealthDirect
- Local information about parking and any subsidies available

RESOURCES & LINKS

Resources for Nurses

- Skin and nails during treatment | Cancer Council
- Understanding taste and smell changes | Cancer Council
- Mouth health | Cancer Council
- What to expect when receiving medication for cancer care | Safety and Quality
- Malnutrition and Sarcopenia | COSA

RESOURCES & LINKS

"Treatment specific FAQs on side effects to take away... including where to go for help.

LIVED EXPERIENCE PARTICIPANT

Neo-adjuvant

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Key Points

- Neo-adjuvant treatment may include: chemotherapy, radiotherapy, immunotherapy or targeted therapy. Refer to other treatment specific tabs and cancer site specific Optimal Care Pathways
- Current treatment plan (consider concurrent treatments including non-cancer treatments)
- Assess venous access and facilitate referral for central venous access device insertion if required
- Consider clinical trial requirements if applicable
- Facilitate access to cooling therapies, if desired
- Provide evidence-based information on safe sex, sexual function and family planning
- Assess, manage and escalate neo-adjuvant therapy related adverse events
- Refer to Living well section for more information

What is next for the person? Who needs to know?

- Provide information on who and when to contact for non-urgent, urgent and emergency events e.g., ED or SURC
- Ensure person has an appointment with their treating specialist after completion of neo-adjuvant treatment
- Is the person aware of the next planned MCCN or other cancer care provider contact?
- Facilitate information sharing within the MDT
- Facilitate the ongoing treatment plan as determined by histopathology and MDT discussion

Common Referrals

- Provide referral to the following, as required:
  - Wig and headwear service
  - Dietitian/ Nutritionist
  - Exercise Physiologist
  - Occupational Therapist
  - Physiotherapist
  - Speech Therapist
- Facilitate referral to other specialties for management of targeted treatment side effects e.g., Endocrinologist, Cardiologist, bone health, and menopause specialists

Delivery Considerations

- Face to face, telehealth or telephone
- People on oral treatments may not have regular contact with the hospital or clinic and may require greater MCCN or other cancer care provider support

The specialist treating team may be the first point of contact during this stage of care. The level of MCCN contact should complement the service provision by the specialist treating team.

Neo-adjuvant

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL

Resources for Nurses

- Pharmaceutical access schemes
- PBS Co payment measure | PBS
- Neo-adjuvant Systemic Therapy (NAST) local protocols (if available)
- Compassionate access to medicines trial | Medicines Australia

RESOURCES & LINKS

Resources for Individuals

- PBS Co payment measure | PBS
- Neoadjuvant immunotherapy for melanoma | Melanoma Institute Australia
- Neoadjuvant therapy | Cancer Australia
- Neoadjuvant therapy | BCNA
- Neoadjuvant Patient Decision Aid | Breast Cancer Trials

RESOURCES & LINKS

Assessment Tools

Screen, assess, address and share any outcomes from assessment using the following tools:

- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List
- Brief Fatigue Inventory
- Malnutrition Screening Tool
- Edmonton Symptom Assessment Scale
- Triage Tool
- Chemotherapy Toxicity Calculator
- ECOG Performance Status Scale
- Australian-modified Karnofsky Performance Status
- MASCC Oral Agent Teaching Tool
- eviQ Anti-cancer drug patient education checklist

> *"Cancer is a very lonely disease, you're not alone or lonely but you are in this disease, but having these supports, information and connections to others in the same situation helps you feel not so alone.*

LIVED EXPERIENCE PARTICIPANT

Surgery

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Key Points

- Discuss financial implications of treatment and possible out of pocket expenses
- Current treatment plan (consider concurrent treatments including non-cancer treatments)
- Assess and provide evidence-based education and information on pre and post-surgical expectations
- Provide evidence-based information on safe sex, sexual function and family planning
- Special needs post-surgery e.g., stoma, reconstruction or complex wounds
- Lymphoedema assessment, education and early referral
- Assess, manage and escalate surgery related adverse events
- Refer to Living well section for more information

What is next for the person? Who needs to know?

- Ensure person is aware of date, time and location of surgery
- Advise of possible length of stay and assess and facilitate discharge planning needs
- Advise the person of likely timeframe to receive histopathology results
- Is the person aware of their surgical follow up with their treating specialist or other cancer care provider prior to discharge from surgery?
- Is the person aware of the next planned MCCN or other cancer care provider contact?

Common Referrals

- Provide referral to the following, for rehabilitation, as required:
  - Exercise Physiologist
  - Occupational Therapist (regain range of movement)
  - Physiotherapist (regain range of movement)
  - Dietitian/ Nutritionist
  - Speech Therapist
- Facilitate referral to other specialties for management of surgical side effects e.g., Pain Specialist, Plastic Surgeon or menopause specialist

Delivery Considerations

- Pre-surgery and post-surgery contacts
- Face to face contacts in alignment with treatment or specialist visits. These may be held in conjunction with other members of treatment team or specialists
- Telehealth or telephone in the interim

The specialist treating team may be the first point of contact during this stage of care. The level of MCCN contact should complement the service provision by the specialist treating team.

Surgery

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Resources for Nurses

- Local surgical pathways or guidelines
- Local access to Specialist Nurse support e.g., Stoma, Wound Care or Community Nurse

RESOURCES & LINKS

Resources for Individuals

- Understanding surgery | Cancer Council
- Surgery | Cancer Australia

RESOURCES & LINKS

Assessment Tools

Screen, assess, address and share any outcomes from assessment using the following tools:

- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List
- Brief Fatigue Inventory
- Edmonton Symptom Assessment Scale
- Malnutrition Screening Tool
- ECOG Performance Status Scale
- Australian-modified Karnofsky Performance Status

> *"I would have liked to have access to information about what the future would be like following my surgery.*

LIVED EXPERIENCE PARTICIPANT

Chemotherapy (oral and intravenous agents)

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Key Points

- Current treatment plan (consider concurrent treatments including non-cancer treatments)
- Assess venous access and facilitate referral for central venous access device insertion if required
- Consider clinical trial requirements if applicable
- Facilitate access to cooling therapies if desired
- Provide evidence-based information on safe sex, sexual function and family planning
- Assess, manage and escalate chemotherapy related adverse events
- Refer to Living well section for more information

What is next for the person? Who needs to know?

- Provide information on who and when to contact for non-urgent, urgent and emergency events e.g., ED or SURC
- Prior to completion of treatment, ensure the person has an appointment for the next stage of treatment or follow up
- Facilitate information sharing within the MDT
- Facilitate the ongoing treatment plan as determined by histopathology and MDT discussion

Common Referrals

- Provide referral to the following, as required:
  - Wig and headwear service
  - Dietitian/ Nutritionist
  - Exercise Physiologist
  - Occupational Therapist
  - Physiotherapist
  - Speech Therapist
- Facilitate referral to other specialties for management of chemotherapy side effects e.g., Cardiologist, bone health, menopause specialist

Delivery Considerations

- Face to face, telehealth or telephone
- People on oral chemotherapy may not have regular contact with the hospital or clinic and may require greater MCCN or other cancer care provider support

The specialist treating team may be the first point of contact during this stage of care. The level of MCCN contact should complement the service provision by the specialist treating team.

Chemotherapy (oral and intravenous agents)

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL

Resources for Nurses

- Pharmaceutical access schemes
- PBS Co payment measure | PBS
- Compassionate access to medicines trial | Medicines Australia
- Common questions about chemotherapy | eviQ
- Chemotherapy local protocols (if available)

RESOURCES & LINKS

Resources for Individuals

RESOURCES & LINKS

Assessment Tools

Screen, assess, address and share any outcomes from assessment using the following tools:

- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List (at cycle 1 and as required)
- Brief Fatigue Inventory
- Edmonton Symptom Assessment Scale
- Malnutrition Screening Tool
- Chemotherapy Toxicity Calculator
- Triage Tool
- MASCC Oral Agent Teaching Tool
- eviQ Anti-cancer drug patient education checklist
- ECOG Performance Status Scale
- Australian-modified Karnofsky Performance Status

> *It feels like there is not a lot of support once chemotherapy finishes, even though your still on active treatment for life, and while you might be doing ok, there's a lot of side effects and stress that comes with it all.*

LIVED EXPERIENCE PARTICIPANT

Immunotherapy

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Key Points

- Current treatment plan (consider concurrent treatments including non-cancer treatments)
- Assess venous access and facilitate referral for central venous access device insertion if required
- Consider clinical trial requirements if applicable
- Provide evidence-based information on safe sex, sexual function and family planning
- Provide evidence-based information and education on the different side-effects of immunotherapy compared with chemotherapy and how these are identified and managed
- Provide evidence-based information and education on delivery of immunotherapy e.g., Bacillus Calmette-Guerine (BCG)
- Assess, manage and escalate for immune related adverse events (IRAEs) and educate on the potential for delayed effects
- Refer to Living well section for more information

What is next for the person? Who needs to know?

- Prior to completion of treatment, ensure the person has an appointment for the next stage of treatment or follow up
- Is the person aware of the next planned MCCN or other cancer care provider contact?

Common Referrals

- Provide referral to the following, as required:
  - Dietitian/ Nutritionist
  - Exercise Physiologist
  - Occupational Therapist
  - Physiotherapist
  - Speech Therapist
- Facilitate referral to other specialties for IRAEs management e.g., Endocrinologist, Dermatologists

Delivery Considerations

- Screen routinely for changes as IRAE's can occur after ceasing treatment
- People on oral immunotherapies may not have regular contact with the hospital or clinic and may require greater MCCN or other cancer care provider support

The specialist treating team may be the first point of contact during this stage of care. The level of MCCN contact should complement the service provision by the specialist treating team.

Immunotherapy

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL

Resources for Nurses

- Pharmaceutical access schemes
- Immunotherapy local protocols (if available)
- Intravesical Immunotherapy (BCG) for Bladder Cancer | Cancer Council (NSW)
- Management of immune-related adverse events (irAFs) | eviQ
- Immunotherapy | Cancer Australia
- Immunotherapies | eviQ
- Malnutrition and Sarcopenia | COSA

RESOURCES & LINKS

Resources for Individuals

- Understanding immunotherapy | eviQ

RESOURCES & LINKS

Assessment Tools

Screen, assess, address and share any outcomes from assessment using the following tools:

- Immunotherapy patient assessment tool
- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List (at cycle 1 and as required)
- Brief Fatigue Inventory
- Edmonton Symptom Assessment Scale
- Malnutrition Screening Tool
- Triage Tool
- eviQ Anti-cancer drug patient education checklist
- ECOG Performance Status Scale
- Australian-modified Karnofsky Performance Status
- MASCC Oral Agent Teaching Tool

> *"Going through immunotherapy and no one knew the outcome, puts a lot of weight on the support person.*

LIVED EXPERIENCE PARTICIPANT

Radiation therapy

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL

Key Points

- Current treatment plan (consider concurrent treatments e.g., chemotherapy/ immunotherapy and non-cancer treatments)
- Educate about radiation treatment modality and duration
- Educate on rationale and practice of deep inspiration breath hold during radiotherapy if indicated
- Discuss financial implications of treatment pathway including out of pocket expenses
- Educate about the rationale and practice of using immobilisation techniques and appliances during radiation if indicated
- Assess for reduced range of movement and ability to remain in a consistent position, escalate concerns and facilitate referral to a Physiotherapist if indicated
- Provide evidence-based information on safe sex, sexual function and family planning
- Assess, manage and escalate side-effects and educate on the potential for delayed effects
- Refer to Living well section for more information

What is next for the person? Who needs to know?

- Discuss the delayed effects of radiation reactions, including changes in skin and mucosa
- Ensure person has an appointment for the next stage of care or follow up
- Is the person aware of the next MCCN or other cancer care provider contact?

Common Referrals

- Provide referral to the following, as required:
  - Dietitian/ Nutritionist
  - Exercise Physiologist
  - Occupational Therapist
  - Physiotherapist
  - Speech Therapist
- Facilitate referral to other specialties for management of radiation therapy side effects e.g., Dermatologist

Delivery Considerations

- Contact within first week and 10-14 days post treatment to assess delayed reaction
- Face to face, telehealth or telephone

The specialist treating team may be the first point of contact during this stage of care. The level of MCCN contact should complement the service provision by the specialist treating team.

Radiation therapy

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL

Resources for Nurses

- Local radiation protocols
- Radiation therapy for cancer | GenesisCare
- TROG
- Targeting Cancer

RESOURCES & LINKS

Resources for Individuals

- Radiation therapy treatments | eviQ
- Skin care and dressings relevant to local treatment protocol
- Deep Inspiration Breath Hold (DIBH) | PeterMac
- Radiation therapy for cancer | GenesisCare

RESOURCES & LINKS

Assessment Tools

Screen, assess, address and share any outcomes from assessment using the following tools:

- Radiation induced dermatitis assessment tool
- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List (at cycle 1 and as required)
- Brief Fatigue Inventory
- Edmonton Symptom Assessment Scale
- Malnutrition Screening Tool
- Triage Tool
- ECOG Performance Status Scale
- Australian-modified Karnofsky Performance Status

> *"During radiation treatment I was feeling so isolated, everyone who cared in my life was back at work."*

LIVED EXPERIENCE PARTICIPANT

Targeted therapy

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Key Points

- Current treatment protocol (consider concurrent treatments e.g., chemotherapy/ immunotherapy and non-cancer treatments)
- Discuss financial implications of treatment and possible out of pocket expenses
- Facilitate cardiac/ blood/ bone health investigations according to treatment protocol and shared care treatment management team
- Provide evidence-based information on safe sex, sexual function and family planning
- Refer to Living well section for more information

What is next for the person? Who needs to know?

- Prior to completion of targeted therapy, ensure the person has an appointment for the next stage of treatment or follow up
- Is the person aware of the next planned MCCN or other cancer care provider contact?

Common Referrals

- Provide referral to the following, as required:
  - Dietitian/ Nutritionist
  - Exercise Physiologist
  - Occupational Therapist
  - Physiotherapist
  - Speech Therapist
- Facilitate referral to other specialties for management of targeted treatment side effects e.g., Endocrinologist, Cardiologist, menopause specialist

Delivery Considerations

- Contact at commencement, two weeks post commencement and then as required in collaboration with prescribing team
- Face to face, telehealth, or telephone
- People on oral targeted therapies may not have regular contact with the hospital or clinic and may require greater MCCN or other cancer care provider support

The specialist treating team may be the first point of contact during this stage of care. The level of MCCN contact should complement the service provision by the specialist treating team.

Targeted therapy

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL
AGE
CULTURALLY & LINGUISTICALLY DIVERSE
FIRST NATIONS
HEALTH STATUS
LGBTIQA+
RURAL & REMOTE
SOCIAL CHALLENGES

Resources for Nurses

- Local protocols for targeted therapy

RESOURCES & LINKS

Resources for Individuals

- Understanding targeted therapy | eviQ
- Side effects of targeted therapy | Cancer Council (NSW)

RESOURCES & LINKS

Assessment Tools

Screen, assess, address and share any outcomes from assessment using the following tools:

- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List
- Brief Fatigue Inventory
- Edmonton Symptom Assessment Scale
- Malnutrition Screening Tool
- Triage Tool
- eviQ Anti-cancer drug patient education checklist
- ECOG Performance Status Scale
- Australian-modified Karnofsky Performance Status
- MASCC Oral Agent Teaching Tool

> *"Check in with patient how they are feeling, help to recover from treatment e.g., exercise and what to expect.*

LIVED EXPERIENCE PARTICIPANT

Post treatment recovery

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Activities

First steps

- Check individual's understanding of their diagnosis and treatment plan and provide tailored information as required e.g., verbal and written
- Use therapeutic conversations to provide emotional support
- Assess supportive care needs using a validated assessment tool
- Assess performance score with a validated assessment tool
- Set expectations around ongoing contacts with the person and support people to alleviate sudden decrease in contact with cancer care team
- Assess the person's needs related to gender at birth, gender identity and sexual preferences
- Assess the person's needs related to their culture and beliefs
- Assess the person's needs related to their age, mental health, presence of a disability, geographical location and socioeconomic status

Clinical roles & multidisciplinary care

- MCCN collaborates and communicates within the MDT, inclusive of the person's GP
- MCCN role and scope of practice is clear among cancer care team
- Provide the person with the contact details of the MCCN/ service
- Provide information on who and when to contact for non-urgent, urgent and emergency events e.g., ED or SURC

Post treatment

- Assess, manage and escalate symptoms of disease recurrence or progression
- Provide information on signs/symptoms of disease progression/ recurrence and who and when to contact with concerns
- Provide information on the treatment follow-up including the timing of supportive pathology or investigations and communicate the next steps
- Provide comprehensive information on potential delayed or late side-effects of treatment and who to contact with concerns
- Provide support and resources to manage anxiety and fear of recurrence, disease progression and anxiety around investigations
- Foster empowerment and self-advocacy and support informed decision making and consent by providing evidence-based education and information in varied formats (e.g., written translated into first language and verbal using an interpreter)

Practical assistance

- Provide evidence-based information and resources for the individual and their employer about employment after cancer treatment if relevant
- Provide evidence-based information and resources for the individual about studying after cancer treatment if relevant
- Assess for the risk of financial distress e.g., current employment type and access to sick leave, income protection or trauma insurance
- Provide referrals for financial support, guidance and counselling where appropriate e.g., Social Work, Centrelink, Cancer Council Pro Bono Financial Counselling

Supportive Care Needs

Significant supportive care needs during this stage are:

- Informational
- Emotional
- Practical

Delivery Considerations

- People may prefer for contact to be made via phone, telehealth or online
- People may like to have support people involved during this stage of care

Post treatment recovery

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Activities

Common referrals & information provision

- **Refer to specialist cancer support through ACNNP and other partner organisations. Consider if referral assistance is required during any stage of treatment.**
- Provide guidance on where to find reliable sources of information
- Consider referral to local community resources for regional, rural and remote people
- Facilitate navigation of the broader health system and access to services closer to place of residence e.g., pathology collection, medical imaging and medication dispensing
- Provide information and appropriate referrals for psychological support e.g., health service Psychologist or GP for referral to psychology services as part of a Mental Health Care Plan
- Provide information and appropriate referrals to support services and peer support groups for the individual and their support people
- Provide evidence-based information on safe sex, sexual function and contraception
- Provide information on available allied health support generally e.g., Physiotherapist, Exercise Physiologist, Occupational Therapist. Consider GP referral for Chronic Disease Management Plan

Selfcare & lifestyle

- Provide information and resources on wellness programs and guidance to support a healthy lifestyle, and lifestyle modifications e.g., smoking cessation, physical activity, nutrition and limiting alcohol intake
- Provide education and information on the importance of exercise and where appropriate, facilitate referral to an Exercise Physiologist or Physiotherapist or other cancer related exercise program

Selfcare & lifestyle (continued)

- Provide the person and support people with guidance on self-care activities
- Ask the person if they are using any complementary or alternative therapies and explore for contraindications
- Develop a transition plan, to enable individual supported self-management. e.g., a survivorship plan where relevant and feasible
- Facilitate referral for rehabilitation and recovery services for the assessment and management of long-term side effects of disease and treatments. These may be local or state-based programs

Assessment tools

Screen, assess, address and share any outcomes from assessment using the following tools:

- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List
- Brief Fatigue Inventory
- Malnutrition Screening Tool
- Edmonton Symptom Assessment Scale
- Triage Tool
- ECOG Performance Status Scale
- Australian-modified Karnofsky Performance Status

Resources for Individuals

- Living well after cancer | Cancer Council (Vic)

RESOURCES & LINKS

Resources for Nurses

RESOURCES & LINKS

Surveillance, Managing recurrence or Disease progression

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Activities

First steps

- Provide timely access to MCCN either at or soon after diagnosis
- Check individual's understanding of their diagnosis and treatment plan and provide tailored information as required e.g., verbal and written
- Use therapeutic conversations to provide emotional support
- Assess supportive care needs using a validated assessment tool
- Assess performance score with a validated assessment tool

Clinical roles & multidisciplinary care

- MCCN collaborates and communicates within the MDT, inclusive of the person's GP
- MCCN role and scope of practice is clear among cancer care team
- Assess indications for genetic testing (e.g., family history) or genomic profiling (e.g., targeted treatment options) and facilitate referral where appropriate
- Consider clinical trial requirements if applicable

Surveillance, Managing recurrence or Disease progression

- Assess, manage and escalate symptoms of disease and side-effects of treatment
- Provide information on the treatment schedule including the timing of supportive pathology or investigations and communicate the next steps
- Ensure there is a clear contact for concerns of recurrence and or disease progression
- Provide information on signs/symptoms of disease progression/ recurrence and to report immediately to treatment team
- Assess sexual function and oncofertility needs, facilitate referrals appropriately

Surveillance, Managing recurrence or Disease progression (continued)

- Provide culturally safe and inclusive care to people of priority populations. Refer to information specific to priority populations.
- Foster empowerment and self-advocacy and support informed decision making and consent by providing evidence-based education and information in varied formats (e.g., written translated into first language and verbal using an interpreter)
- Provide comprehensive information on potential side effects of treatment and who to contact
- Ask the person if they are using any complementary or alternative therapies and explore for contraindications
- Provide support and resources to manage anxiety and fear of recurrence, or disease progression
- Ensure the person is aware they can contact the MCCN if they have concerns

Practical assistance

- Consider referral to local community resources for regional, rural and remote people
- Make sure the individual and/ or support person knows what to do or who to contact in different scenarios
- Assess for the risk of financial distress e.g., current employment type and access to sick leave, income protection or trauma insurance
- Provide referrals for financial support, guidance and counselling where appropriate e.g. Social Work, Centrelink, Cancer Council Pro Bono Financial Counselling
- Provide contact details of the local urgent and emergency care clinic e.g., ED or SURC

Supportive Care Needs

Significant supportive care needs during this stage are:

- Emotional
- Informational
- Psychological

Delivery Considerations

- People may prefer for contact to be made via phone, telehealth or online
- Regular check-ins during this stage assists in managing the uncertainty and anxiety associated with fear of recurrence
- People with disease recurrence or disease progression may be having ongoing treatments. Refer to the relevant treatment pages for treatment specific information

Surveillance, Managing recurrence or Disease progression

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL

Key Activities

Common referrals & information provision

- **Refer to specialist cancer support through ACNNP and other partner organisations. Consider if referral assistance is required during any stage of treatment.**
- Provide information and appropriate referrals for psychological support e.g. health service Psychologist or GP for referral to psychology services as part of a Mental Health Care Plan
- Provide evidence-based information and education about palliative care and end of life care and facilitate referrals where appropriate
- Provide information and or referral to survivorship programs
- Provide evidence-based information on safe sex, sexual function and contraception
- Provide information and referrals to locally available allied health support or consider GP referral for a Chronic Disease Management plan to access allied health services

Selfcare & lifestyle

- Provide the person and support people with guidance on self-care activities
- Provide education and information on the importance of exercise and where appropriate, facilitate referral to an Exercise Physiologist or Physiotherapist or other cancer related exercise program
- Develop a transition plan to enable the person to self-manage. e.g., a survivorship plan where relevant and feasible
- Refer to Living well section for more information

Assessment Tools

Screen, assess, address and share any outcomes from assessment using the following tools:

- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List
- Brief Fatigue Inventory
- Malnutrition Screening Tool
- Edmonton Symptom Assessment Scale
- ECOG Performance Status Scale
- Australian-modified Karnofsky Performance Status

Resources for Individuals

- Dreams2Live4
- Healthy End of Life Program
- Fear of the cancer returning | Cancer Council
- Living with Advanced Cancer | Cancer Council
- Caring for someone with Advanced Cancer | Cancer Council

RESOURCES & LINKS

Resources for Nurses

- Healthy End of Life Program
- Fear of the cancer returning | Cancer Council

RESOURCES & LINKS

Palliative care | End of life care

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Activities

First steps

- Use therapeutic conversations to provide emotional support
- Respect and include the individual's support people
- Assess supportive care needs using a validated assessment tool
- Assess performance score using a validated assessment tool
- Foster empowerment and self-advocacy and support informed decision making and consent by providing evidence-based education and information in varied formats (e.g., written translated into first language and verbal using an interpreter)

Clinical roles & multidisciplinary care

- MCCN role and scope of practice is clear among cancer care team
- Assess indications for genetic testing (e.g., family history) or genomic profiling (e.g., targeted treatment options) and facilitate referral where appropriate
- Communicate to treatment team when death has occurred

Palliative care and End of life care

- Provide support to manage symptoms, side effects and physical changes
- Ask the person if they are using any complementary or alternative therapies and explore for contraindications
- Provide culturally safe and inclusive care to people of priority populations. Refer to information specific to priority populations

Practical assistance

- Consider referral to local community resources for regional, ruraland remote people
- Provide information and facilitate appropriate referrals to meet practical needs e.g., travel, accommodation and parking
- Assess for the risk of financial distress e.g., current employment type and access to sick leave, income protection or trauma insurance
- Provide referrals for financial support, guidance and counselling where appropriate e.g., Social Work, Centrelink, Cancer Council Pro Bono Financial Counselling
- Provide information on who and when to contact for non-urgent, urgent and emergency events e.g., palliative care service, ED or SURC

Living well considerations

- Consider treatment breaks
- Person may request transition plan to move from active treatment to best supportive care
- Consider spiritual needs

Supportive Care Needs

Significant supportive care needs during this stage are:

- Emotional
- Psychological
- Informational

Delivery Considerations

- Having support people present during this stage is key
- During this time, the individual and their support team may face complex supportive care needs that span several domains
- Reassess needs of the person and their support people as these can change throughout the end of life and post death stages

The specialist treating team may be the first point of contact during this stage of care. The level of MCCN contact should complement the service provision by the specialist treating team.

Palliative care | End of life care

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Activities

Common referrals & information provision

- **Refer to specialist cancer support through ACNNP and other partner organisations. Consider if referral assistance is required during any stage of treatment.**
- Provide information on MDT referral pathways and expected timing of contact
- If the person requests information about Voluntary Assisted Dying (VAD), refer to relevant state or territory legislation
- Provide information and appropriate referrals to support services and peer support groups for the individual and their support people
- Facilitate navigation of the broader health system and access to services closer to place of residence e.g., pathology collection, medical imaging and medication dispensing
- Provide information and appropriate referrals for psychological support e.g., health service Psychologist or GP for referral to psychology services as part of a Mental Health Care Plan
- Provide information, education and or referral about palliative care and end of life care
- Provide information on available allied health support generally e.g. Physiotherapist, Exercise Physiologist, Occupational Therapist. Consider GP referral for Chronic Disease Management Plan

Selfcare & lifestyle

- Develop a transition plan, to enable the person to self-manage moving from active treatment to best supportive care

Assessment Tools

Screen, assess, address and share any outcomes from assessment using the following tools:

- National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List
- Brief Fatigue Inventory
- Malnutrition Screening Tool
- Edmonton Symptom Assessment Scale
- ECOG Performance Status Scale
- Australian-modified Karnofsky Performance Status

Resources for Individuals

- Palliative care resources | Care Search
- Dreams2Live4
- Healthy End of Life Program
- Palliative Care Australia
- National Centre for Childhood
- I am a Patient | Palliative Care Australia

RESOURCES & LINKS

Resources for Nurses

- Healthy End of Life Program
- Palliative Care Australia
- PalliBytes | Palliative Care Education and Training Collaborative
- Program of Experience in Palliative Approach
- Prompts for End-of-Life Planning (PELP) Framework | caring@home project
- National Palliative Care Standards | Palliative Care Australia
- Caring at Home Apps | caring@home project
- Palliative care resources | Care Search
- Healthy End of Life Program

RESOURCES & LINKS

Living Well

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Considerations

The following are key points to consider to help people live well throughout all the stages of care. These should be considered in conversation with the person and what is relevant to them:

- Determine the person's understanding of treatment intent
- Work and financial considerations
- Lifestyle modification factors and goal setting including smoking cessation, nutrition, physical activity and limiting alcohol intake
- Emphasise on the role of the GP to manage existing conditions and liaise with the cancer care team if needed
- Discuss screening for other cancers and comorbidities
- Link in with relevant support groups
- Assess sexual function and sexual health needs
- Discuss advance care planning, and guide to resources
- Discuss who to contact within the treatment team for urgent needs
- Discuss dental and oral health
- Identify local services that can support the person and their support people
- Discuss bone health

Resources for Individuals

- Referral to local wellness programs
- Referral to local support or peer support groups
- GP Managed Care Plan
- Advance Care Planning
- Exercise in cancer care | COSA
- Living well after cancer | Cancer Council
- Lifestyle risk reduction | Cancer Australia

RESOURCES & LINKS

Resources for Nurses

- Living well after cancer | Cancer Council

RESOURCES & LINKS

> *"I want to feel as well as I can and get the most out of life, regardless of cancer."*
>
> LIVED EXPERIENCE PARTICIPANT

Age

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Considerations

The following are key points to consider that may be relevant to younger people or older people. These should be considered in conversation with the person:

Younger person

- Assess family planning/ oncofertility needs
- Explore carer roles of the person and who they are caring for
- Assess long term employment and financial implications of diagnosis
- Explore working or studying whilst on treatment options and information for the workplace or educational institution
- Explore returning to work support options and information for the workplace
- Refer to Adolescent/Young Adult services if person is under the age of 25

Older person

- Consider the intersection with aged care services and coordination of care
- Explore supports and services already in place and leverage any supports for the person
- Explore if the person has an advance care plan
- Explore issues around mobility and transport needs
- Carer and support people may play a critical role in care decisions – with consent
- Explore issues of fear of age discrimination related to treatment
- Provide clear information about clinical trials to the person and their support people, and address concerns that age or co-existing illnesses may limit eligibility or options
- Explore the need for financial support or use of concession cards

Older person (continued)

- Consider management of co- existing illnesses and possible polypharmacy management
- Monitor for and report suspected elder abuse

Resources for Individuals

Younger people

- Mymuse
- Cancer Hub
- The Shitshow Companion | NINOX Cancer Support Crew
- Cancer and study | Cancer Council (NSW)
- How to be a student with cancer | Canteen

Older people

- My Aged Care
- Carer Gateway
- OlderCan | WeCan
- This is me | WeCan
- Comprehensive Geriatric Assessment | Geriatric Care Australia

RESOURCES & LINKS

Resources for Nurses

Older people

- Chemotherapy – Toxicity Calculator
- Practical Geriatric Assessment
- Clinical Frailty Scale
- SARC-F A Simple Questionnaire to Rapidly Diagnose sarcopenia
- The Lee and Schonberg Index
- Comprehensive Geriatric Assessment | Oncology Republic Podcast

RESOURCES & LINKS

Culturally & linguistically diverse

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Considerations

The following are key points to consider that may be relevant to a person who is culturally and/or linguistically diverse. These should be considered in conversation with the person:

- Provide culturally appropriate care, discuss and assess cultural needs with the person and support people
- Consider cultural gender roles of support people and provide culturally relevant care and information
- Explore cultural beliefs around cancer, death and dying with the person and support people and tailor information appropriately
- Explore any underlying distrust /and or issues with information privacy
- Support people may attempt to influence decision making processes, consent should be sought from the person regarding involvement
- Consider the person's faith and beliefs, including access to relevant services and practices at key points in their care
- Explore use of traditional medicines and create open dialogue around their use
- Advice around lifestyle modification tailored to the individual, their needs and circumstances to be delivered with culturally relevant sensitivity
- Consider need for greater advocacy within treatment team when English comprehension and communication is a challenge for the person
- Consider cultural beliefs around gender when referring to other practitioners
- Explore any previous experience or possible distrust of the health system due to previous discrimination

Resources for Individuals

- Consider any resources that may be available in their language
- Australian Multicultural Health Collaborative
- Multilingual resources | Cancer Council
- Translating and Interpreting Services | Department of Home Affairs (DHA)
- National Ethnic Disability Alliance
- Sisters Cancer Support Group
- Multilingual Resources| Head and Neck Cancer
- Information and Support in Other Languages | Ovarian Cancer Australia
- CALD resources | Cancer Australia
- CanRevive

RESOURCES & LINKS

Resources for Nurses

- Australian Multicultural Health Collaborative
- Multilingual resources | Cancer Council
- Translating and Interpreting Services | Department of Home Affairs (DHA)
- National Ethnic Disability Alliance
- Translations of the Distress Thermometer and Problem List
- CALD cancer information needs for consumers and carers project | WA Health Consumers

RESOURCES & LINKS

First Nations

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS
LIVING WELL

Key Considerations

The following are key points to consider that may be relevant to a person who is First Nations. These should be considered in conversation with the person:

- Enquire about any cultural beliefs or past experiences that may influence the patient's views on illness, treatment, or healthcare systems and provide culturally sensitive care
- Acknowledge the importance of cultural history, spirituality, and connection to Country in shaping health beliefs and wellbeing
- Be mindful of potential distress related to historical trauma or mistrust of medical institutions
- Get to know the person and explore connections to Mob and community within local or regional context
- Build trust with the person and confidence in privacy of information shared
- Offer access to the hospitals Indigenous Health Liaison Officer (IHLO) or Aboriginal Health Liaison Officer (AHLO)
- Refer the person to a local Aboriginal Community Controlled Health Organisation (ACCHO) for community connection and culturally safe care
- Explore First Nations health care /treatment team options. For example, Aboriginal Nurse Navigators for cultural support and advocacy, Closing the Gap PBS Co-Payment Program or State based co-payment programs for financial support with medicines
- Consider Women's and Men's business - identify any gender-specific protocols and adapt care (e.g., match clinician/person gender where possible, ensure privacy and consent, involve Aboriginal and/or Torres Strait Islander Health Workers/Elders)
- Consider relationships between family and Mob and the impact this may have on care delivery, for example some family members do not communicate with each other as part of cultural Lore
- Understand that family may include extended kinship networks beyond biological relatives
- Ask the patient who they would like involved in care planning and decision-making
- Consider the use of cultural or bush medicines that may be accessed by the person
- Consider support people and Mob needs when facilitating travel and accommodating needs
- Include support people in decision making with consent of the person
- Ensure there is privacy and space for consultations that is appropriate
- Explore distrust of health care service due to previous discrimination
- Consider timing of care around cultural/Mob events
- Approach sensitive topics such as cancer, Sorry Business (mourning practices), and gender-specific cultural matters with care and cultural awareness
- Routinely reassess needs and direct resources accordingly to ensure ongoing culturally safe care
- When discussing clinical trials with First Nations people, Nurses should use culturally safe, respectful communication that supports informed decision-making and honours First Nations data sovereignty and interconnected wellbeing

Resources for Individuals

- Connect with local ACCHO
- First Nations Peoples | Cancer Mind Care
- Cancer resources | National Aboriginal Community Controlled Health Organisation (NACCHO)
- Our Mob and Cancer | DOHAC
- First Peoples Disability Network
- Seedpods for Yarns | GI Cancer
- Chemotherapy | menzies
- Resources | menzies
- Cancer resources for First Nations | Cancer Australia
- Healing | WellMob

RESOURCES & LINKS

Resources for Nurses

- Complete cultural training in your local health service or with local ACCHO
- First Nations Toolkit | PEPA
- NACCHO Cancer resources
- Health Professionals Our Mob and Cancer | DOHAC
- WellMob
- Culturally safe communication skills | Cancer Australia
- First Peoples Disability Network
- Seedpod of Yarns

RESOURCES & LINKS

Health status

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Considerations

The following are key points to consider that may be relevant to a person who has other health conditions. These should be considered in conversation with the person:

People with disability

- Explore supports and services already in place and leverage any supports for the individual and their support people
- Consider the intersect of NDIS and supports available. Complications exist around claiming NDIS support for disability as a result of cancer diagnosis and treatment
- May require greater support from support people but person must consent to inclusion within treatment and care planning
- Explore any previous experience or possible distrust of health system due to previous discrimination
- Explore the person's need for greater advocacy or desire to be included in decision making
- Explore if any carer supports are in place
- Monitor and report suspected disability or carer abuse

Mental illness

- Explore supports and services already in place and leverage any supports for the individual and their support people
- Explore any previous experience or possible distrust of health system due to previous discrimination
- Explore gaps in health care that may have been overlooked in caring for mental health concerns
- Explore what the person needs to be able to attend planned and unplanned care and meet their health needs
- Explore the person's understanding of treatments and how and when they are required

Mental illness (continued)

- Discuss lifestyle modification needs with consideration of the person feeling judged or overwhelmed
- Engage with support people in treatment and care planning, with the person's consent
- Assess and record medications for possible drug interactions and polypharmacy needs
- Consider referral to GP for Mental Health Care Plan and Chronic Disease Management Plan

Comorbidities

- May have polypharmacy and need medication support or a review to take place
- Facilitate coordination with GP and ensure that co-morbidities or co-existing illnesses continue to be monitored and managed during cancer care
- Explore supports and services already in place and leverage any supports for the individual and their support people

Resources for Individuals

- THIS WAY UP
- My Health Matters | Council of Intellectual Disability
- National Ethnic Disability Alliance
- First Peoples Disability Network
- People with Disability Australia
- PBS Co payment measure | PBS

RESOURCES & LINKS

Resources for Nurses

- Clinicians Professional Development | Cancer Mind Care
- National Ethnic Disability Alliance
- Social model of disability | People With Disability Australia
- Australian Disability Clearinghouse on Education and Training
- 30 Best Australia Disability Podcasts | FeedSpot
- First Peoples Disability Network
- PBS Co payment measure | PBS

RESOURCES & LINKS

LGBTIQA+

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Considerations

The following are key points to consider that may be relevant to a person who is LGBTIQA+. These should be considered in conversation with the person:

- A good way to start a conversation is by introducing yourself and offering your own pronouns when meeting with the person and support people
- Understanding and using inclusive language is crucial in respecting and supporting LGBTIQA+ people
- Discuss with the person their preferred pronouns, gender identity and sexual orientation without making assumptions. With their consent, ensure this is recorded and shared with the care team
- LGBTIQA+ support systems may look very different from those of non-LGBTIQ+ communities. Next of kin may be partners, friends, or other chosen family
- Use inclusive communications that show respect for people's terminology, self-identification and relationships, ensuring the person feels safe within the health service
- For some people, gendered terms like 'breast' can be distressing. Discuss the cancer type in neutral terms and use the patient's preferred language
- Facilitate identification of local LGBTIQA+ services and link people in with LGBTIQA+ peer support groups if available
- Provide tailored evidence-based information on safe sex, sexual function, intimacy and family planning without assumptions of gendered roles
- Use gender-neutral, non-judgemental language and terms considering the diversity of sexuality, gender, age, culture, relationships and overall health to support discussions about sexual wellbeing
- Be aware of intersectionality as people can have multiple identities and cultural considerations that shape their experience of health and cancer care
- Use LGBTIQA+ language and ensure the person feels safe within treatment setting

Resources for Individuals

- Qlife
- LGBTQI+ Peer support | Cancer Council
- Trans and Gender Diverse Support Groups
  email: admin@tgdcancersupport.com
- LGBTQI+ People and Cancer | Cancer Council
- Acon - Cancer

RESOURCES & LINKS

Resources for Nurses

- Complete the LGBTIQA+ education course
- LGBTIQ+ Palliative Care Project | LGBTIQ Health
- LGBTQI+ People and Cancer | Cancer Council
- Qlife

RESOURCES & LINKS

Rural and remote

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Considerations

The following are key points to consider that may be relevant to a person who lives in a rural or remote area. These should be considered in conversation with the person:

- Facilitate scheduling to coordinate appointments and minimise travel
- Facilitate co-ordination of accommodation and travel assistance
- Explore all treatment centres involved in the person's care and facilitate timely information sharing across sites
- Consider and facilitate use of telehealth where possible to minimise burden of travel
- Provide information and support around treatment options with consideration of optimal treatments, convenience, out of pocket expenses, and referral pathways
- Explore financial needs around travel and employment
- Explore burden of travel on the person and their support people. Explore resources to assist with travel and/or accommodation
- Understand that the person and support people may feel greater burden of privacy within smaller communities
- Explore clinical trial options with a rural/remote access focus and advocate for inclusion during MDT discussions
- Identify access to allied health services close to the place of residence and facilitate services to align with treatment appointments
- Assistance with lifestyle modification services may be limited. Explore online/telephone supports
- Explore access to primary health care/GP services close to individual's place of residence, consider online support
- Provide education on who to contact and where to present within the local area in an emergency during treatment stages
- Consider access to primary and or community health care/GP if access to specialist palliative /end of life services are limited
- Explore access to technology/telephone reception when considering virtual care needs

Resources for Individuals

- Rural Health Connect
- RFDS
- Angel Flight
- Government Assistance Travel Schemes | pancare

RESOURCES & LINKS

Resources for Nurses

- RFDS
- Rural Health Pro
- Angel Flight
- Government Assistance Travel Schemes | pancare
- CRANA plus

RESOURCES & LINKS

Social challenges

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Key Considerations

The following are key points to consider that may be relevant to a person who is experiencing complex social situations. These should be considered in assessment with the person:

- Facilitate referral to financial/support services
- Explore options for primary care and allied health with limited out of pocket expenses
- Explore literacy and health literacy challenges and tailor information accordingly
- Consider access to safe and affordable accommodation and/or transport to attend the care/treatment centre
- Explore personal safety, assess for and report suspected domestic abuse
- Assess for co-existing illnesses that may not be being managed
- Refer to social and community services to assist with basic living needs
- Explore if the person's decision making around treatment options is being impacted by financial distress
- Explore any previous experience or possible distrust of health system due to previous discrimination
- Explore social and local community connections if limited access to support people
- Explore access to technology and/or data restrictions for contacts or virtual care

Resources for Individuals

- AskIzzy
- Treatment Decisions | WeCan
- Practical and financial assistance | Cancer Council
- Government-assisted travel schemes
- myGov

RESOURCES & LINKS

Resources for Nurses

- Explore local social support services and resources

RESOURCES & LINKS

Resources & links

Resources for people relevant to all stages

1800 RESPECT
Domestic family and sexual violence counselling, support and resources.

About Herbs, Botanicals and Other Products | Memorial Sloane Kettering
An online tool for health professionals and the person to help figure out the value of using common herbs and other dietary supplements.

Advance Care Planning
Information about planning future health care by making some decisions now about the care a person would like to receive in the event they become seriously ill and are unable to make treatment decisions.

AskIzzy
A website that connects people in need with housing, a meal, money help, family violence support, counselling and much more.

Australian Cancer Trials
Provides the latest clinical trials in cancer care, including trials that are currently recruiting participants.

Beyond Blue
Provides access to mental health information and qualified support.

Bone health | Macmillan
Information about bone health for people who have had cancer.

Cancer Council
National independent charity organisation that works across every area of cancer, including support, research prevention, and advocacy.

Cancer Council Complementary Therapies
Information about complementary therapies that can be used together with conventional therapies to support the person's quality of life and wellbeing.

Cancer Hub
Cancer Hub helps families impacted by cancer (with children aged 0-25) to access the practical and emotional support they need.

Cancer Mind Care
A self-help online platform, providing a one-stop-shop for tailored mental health support for people with cancer, their support person's, clinicians and First Nations peoples.

Cancer support organisations | Cancer Australia
List of all consumer support and advocacy groups, and cancer charities across Australia.

Cancer treatments
A list and information of all available cancer treatments.

Cancer, work and you | Cancer Council (Vic)
Guidance on going back to work after cancer treatment.

Carers Australia
The national peak body that represents and supports Australia's unpaid carers through advocacy, information, programs and services to improve their wellbeing, recognition, and financial security.

Carerhelp
Trustworthy information, guidance, resources and links to services and support for carers.

Resources & links

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Resources for people relevant to all stages

Carer Gateway
An Australian Government program providing free services and support for carers. Online courses, telephone helplines and peer support are just some of the resources available.

Complementary medicines | NHMRC
Information and guidance on talking to people about complementary medicines. It aims to prompt collaborative discussion between clinicians and their patients about the use of complementary medicine and better equip patients to make informed decisions about their care.

Cancer | Department of Health, Disability and Ageing
Provides information on what cancer is, types of cancer, prevention, screening, diagnosis, treatment, ongoing programs and government efforts to reduce cancer's impact in Australia.

Exercise in cancer care | COSA
Information and guidance on the role of exercise in cancer therapy, the use of exercise guidelines and referral of the person to health professionals that specialise in the prescription and deliver of exercise.

eviQ Patients and carers
Information sheet for every cancer protocol available on the eviQ website.

Find a Nurse | McGrath Foundation
Online, free tool providing contact details for referral to an MCCN.

Gather my Crew
Supports people to ask for and coordinate help from their family and friends during life's most challenging times, through the use of a free app and expert advice.

Inherited Cancers Australia
An organisation providing information on inherited cancer to help people manage their cancer risk.

Lifestyle cancer risk | Cancer Australia
An online tool to help users evaluate how lifestyle factors such as diet, physical activity, alcohol and sun exposure affect their cancer risk and offers practical tips for reducing it.

List of trusted cancer resources | Cancer Council
Resources list compiled by Cancer Council.

Looking after yourself | Cancer Council (NSW)
Information about how to take care of yourself after cancer treatment. Explore lifestyle changes, exercise routines, and healthy eating for better overall health.

look good feel better
Website offering free in person and online workshops and Confidence Kits to help people with any type of cancer manage the common physical and psychological impacts.

Managing the effects of treatment, guide for managers and human resource professionals | Cancer Council
Information on the possible effects of treatment and strategies for managing side effects in the workplace.

Resources & links

Resources for people relevant to all stages

Menopause management | Jean Hailes for Women's Health
Fact sheet on how to manage your final period.

MindSpot
Online platform providing free, confidential psychological assessments and treatments, and access to qualified therapists.

mummy's wish
A website providing tailored and practical support for mums diagnosed with cancer who have young children.

myagedcare
Information and resources on aged care homes or getting help around the house.

my CarePlan
Support to create a plan for people who have finished curative cancer treatment.

myGov
A platform providing secure access to government services online.

Mymuse
Support, education and practical strategies for people affected by cancer in the workplace, whether as patients, caregivers or colleagues.

National Public Toilet App | DOHAC
An app providing information on over 19,000 available toilets across Australia.

Omico
Information on how to access precision oncology.

Oncana
Online platform providing resources and support for people living with cancer.

Oral Mucositis fact sheet | Peter Mac
Provides information on oral mucositis, a side effect of cancer treatment.

Overseas Travel | Services Australia
Information on reciprocal health care agreements.

Practical and financial assistance | Cancer Council
Resources and information on the financial and transport assistance the Cancer Council can provide.

Resources for Carers | Cancer Council (Qld)
Resources to support carers and to take care of themselves.

Shared decision making resources for consumers
Resources and tips to understand the consumer's role in the shared decision-making processes.

Sisters Cancer Support Group

Smoking cessation | Cancer Council
Guide to quitting smoking including strategies, resources and support.

Rural Health Connect
Online platform linking people to Psychologists.

Resources & links

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Resources for people relevant to all stages

The Foundation for Peripheral Neuropathy
Guidance on exercises to assist with peripheral neuropathy.

THIS WAY UP
Provider of evidence-based internet delivered Cognitive Behavioural Therapy (iCBT) programs.

The Australian Cancer Survivorship Centre | Peter Mac
Information and support for survivors and carers following cancer treatment.

WeCan
A supportive care website which helps people affected by cancer find the information, resources and support services they may need following a diagnosis of cancer.

> *"There are many great services already available, but it is hard to know about all of them.*
>
> LIVED EXPERIENCE PARTICIPANT

Resources & links

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Resources for nurses relevant to all stages

1800 RESPECT
Domestic family and sexual violence counselling, support and resources.

About Herbs, Botanicals and Other Products | Memorial Sloane Kettering
An online tool for health professionals and people to help figure out the value of using common herbs and other dietary supplements.

Advance Care Planning
Information about planning future health care by making some decisions now about the care a person would like to receive in the event they become seriously ill and are unable to make treatment decisions.

All about multidisciplinary care (MDC)
A selection of web-based practical tools to assist health professionals and health service administrators implement MDC at the local level.

Australian Cancer Trials
Provides the latest clinical trials in cancer care, including trials that are currently recruiting participants.

Australian Menopause Society
Provides access to a range of educational materials to assist in the management of women's health around midlife and menopause.

Beyond Blue
Provides access to mental health information and qualified support.

Bone health | Macmillan
Information about bone health for people who have had cancer.

Cancer Council
National independent charity organisation that works across every area of cancer, including support, research prevention, and advocacy.

Cancer Hub
Cancer Hub helps families impacted by cancer (with children aged 0-25) to access the practical and emotional support they need.

Cancer support organisations
List of all consumer support and advocacy groups, and cancer charities across Australia.

Cancer treatments
A list and information of all available cancer treatments.

Cancer, work and you | Cancer Council
Guidance on going back to work after cancer treatment.

Clinical Practice Guidelines in Bone Health | ESMO
Information and recommendations in diagnosis and multidisciplinary management of bone metastases, metastatic prevention, management of cancer treatment-induced bone loss, and safety aspects.

Complementary Therapies | Cancer Council
Information about complementary therapies that can be used together with conventional therapies to support people's quality of life and wellbeing.

COSA guidelines for fertility preservation for people with cancer | Cancer Council
Structured, evidence-based recommendations to guide health professionals in discussing fertility risks, preservation options, referrals and reproductive support for cancer people of reproductive age.

Resources & links

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Resources for nurses relevant to all stages

eviQ Clinical resources
Updated, evidenced-based tools and guidelines for cancer care.

Exercise in cancer care | COSA
Information and guidance on the role of exercise in cancer therapy, the use of exercise guidelines and referral of people to health professionals that specialise in the prescription and delivery of exercise.

Find a Nurse | McGrath Foundation
Online, free tool providing contact details for referral to an MCCN.

GenesisCare
Information about various cancer diagnosis and treatments offered.

General resources | Cancer Council
Downloadable resources from Cancer Council.

Informed financial consent | Cancer Council
The Standard for Informed Financial Consent guides health professionals and practices to discuss the risks and benefits of treatment to include expenses.

Health professionals | Cancer Council
A range of resources to help GPs and other health professionals advise the person about cancer prevention, screening and diagnosis.

Healthcare professionals | Inherited Cancers Australia
Information for Specialists, GPs, Nurses and Genetic Counsellors managing patients with a high risk of hereditary cancer.

Health Professionals | Ovarian Cancer Australia
Resources to support health professionals treating people with ovarian cancer. Including patient referrals to the Teal Support Program, Homologous Recombination Deficiency (HRD) testing guidelines, educational webinars, support resources and the National Action Plan.

Health Professionals | Peter MacCallum Cancer Centre
Information about referrals, the cancer streams that they manage, our services and clinical trials and Allied Health resources.

Healthcare professional resources | MacMillian
Resources for health professionals form MacMillan.

Menopause management | Jean Hailes for Women's Health
Fact sheet on how to manage your final period.

look good feel better
Website offering free in person and online workshops and Confidence Kits to help people with any type of cancer manage the common physical and psychological impacts.

Macmillan Cancer Support
A comprehensive suite of free, role specific tools, resources, training, and news to support all stages of cancer care.

Managing the effects of treatment, guide for managers and human resource professionals | Cancer Council
Information on the possible effects of treatment and strategies for managing side effects in the workplace.

Multidisciplinary care guidelines | Cancer Australia
Cancer Australia has developed web-based practical tools to assist health professionals and health service administrators implement MDC at the local level.

Resources & links

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Resources for nurses relevant to all stages

MindSpot
Online platform providing free, confidential psychological assessments and treatments, and access to qualified therapists.

My CarePlan
Support to create a plan for people who have finished curative cancer treatment.

Mymuse
Support, education and practical strategies for people affected by cancer in the workplace, whether as patients, caregivers or colleagues.

National Public Toilet App | DOHAC
An app providing information on over 19,000 available toilets across Australia.

Omico
Information on how to access precision oncology.

Oral Mucositis fact sheet | Peter Mac
Provides information on oral mucositis, a side effect of cancer treatment.

Overseas Travel | Services Australia
Information on reciprocal health care agreements.

TRIO Guidelines | PoCoG
Guidelines to help health professionals effectively engage with family carers of the person.

Primary Health Network (PHN) Locator | DOHAC
Tool to determine the boundaries and locations of PHNs across Australia.

rare cancers Australia
Information, support and resources for people with a rare cancer.

Sex and intimacy | Cancer Council (Vic)
Guidance and information on how cancer treatment impacts your sex life.

Shared decision making resources for consumers | Safety and Quality Commission
Resources and tips to understand the consumer's role in the shared decision-making processes.

Smoking cessation | COSA
Resource to support best practice smoking cessation care, produced by COSA.

Smoking and vaping cessation | eviQ
This rapid learning module provides a summary of the Clinical Oncology Society of Australia (COSA) guidelines on embedding smoking cessation care in Australian oncology health services.

Structured pathology reporting | RCPA
Standardised, evidence-based guidance documents developed to ensure consistency, completeness and clarity in cancer pathology reports across Australia.

The Foundation for Peripheral Neuropathy
Guidance on exercises to assist with peripheral neuropathy.

the limbic
Oncology specific, editorially independent updates, expert insights and CPD resources.

Resources & links

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Resources for nurses relevant to all stages

THIS WAY UP
Provider of evidence-based internet delivered Cognitive Behavioural Therapy (iCBT) programs.

WeCan
A supportive care website which helps people affected by cancer find the information, resources and support services they may need following a diagnosis of cancer.

> "You want things explained in detail not just for you but also family.
>
> LIVED EXPERIENCE PARTICIPANT

Resources & links

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Disease specific resources

Table 1: Disease specific resources for people and nurses

Cancer type	Resources for individuals	Resources for Nurses	Phone number
All Cancers	• Support and Services | Cancer Council	• Health professionals | Cancer Council	131 120
Bowel Cancer Australia	• Bowel Cancer Australia	• Resources for Health Professionals | Bowel Cancer Australia	1800 727 336
Bladder	• Bladder cancer information & support | BEAT	• Urology / Oncology Nurse Education | BEAT	
Brain Tumour Alliance Australia	• Brain Tumour Alliance Australia • Brain Tumours Online • Services and resources | Peace of Mind Foundation	• Brain Tumour Alliance Australia • Brain Tumours Online • Services and resources | Peace of Mind Foundation	1800 857 221
Breast Cancer Network Australia	• Breast Cancer Network Australia (BCNA) Helpline – 1800 500 258 9am-5pm (AEST) • Information and resources hub | BCNA • Online Network | BCNA	• BCNA • Order a My Care Kit | BCNA • Information and resources hub | BCNA	1800 500 258
Cancer Hub	• https://cancerhub.org.au/	• https://cancerhub.org.au/	1800 431 312
Canteen	• Canteen Australia | Charity Support For Young People Facing Cancer	• Health & Education | Young People Living With Cancer | Canteen Australia	1800 431 312
Camp Quality	• Register Your Family | Camp Quality	• Refer Someone to Camp Quality | Camp Quality	1300 662 267
Cervical	• Faces of Cervical Cancer Support Booklet | ACCF • Ovarian Cancer Australia | www.ovariancancer.net.au	• Faces of Cervical Cancer Support Booklet | ACCF • Ovarian Cancer Australia | www.ovariancancer.net.au	1300 660 334
Gastrointestinal Pancare	• GI Cancer • Pancare Foundation	• GI Cancer • Pancare Foundation	1300 881 698
Head and neck	• Head and Neck Cancer Support Group | Head and Neck Cancer Australia • Resources | Head and Neck Cancer Australia • Multilingual Resources| Head and Neck Cancer • Head and Neck Cancer Australia	• Head and Neck Cancer Support Group | Head and Neck Cancer Australia • Resources | Head and Neck Cancer Australia • Multilingual Resources| Head and Neck Cancer • Head and Neck Cancer Australia	1300 424 848

Resources & links

Disease specific resources

Table 1: Disease specific resources for people and nurses

Cancer type	Resources for individuals	Resources for Nurses	Phone number
Leukaemia	• Leukaemia Foundation	• For healthcare professionals - The Leukaemia Foundation	1800 620 420
Liver Australia	• Liver Foundation - Home	• Nurse Education | Liver Foundation • Transarterial chemoembolisation (TACE) | Cancer Council (NSW) • Health Professionals - Liver Foundation	1800 841 118
Lung Foundation Australia	• Training | Lung Foundation Australia	• Health Professionals | Lung Foundation Australia	1800 654 301
Lymphoma Australia	• Support for You - Lymphoma Australia	• Healthcare Professionals - Lymphoma Australia	1800 953 081
Melanoma Patients	• Melanoma Resources | Melanoma Institute Australia • Melanoma Patients Australia - Reducing the impact of melanoma. • Learning Hub | Melanoma & Skin Cancer Advocacy Network (MSCAN)	• Melanoma Resources | Melanoma Institute Australia • Melanoma patients australia • Melanoma & Skin Cancer Advocacy Network – Learning Hub • National Melanoma Nurses Program | Melanoma Institute Australia	1300 884 450
Mesothelioma	• What is Mesothelioma | Mesothelioma and Dust Diseases Australia (MADDA) • Mesothelioma and Dust Diseases Australia (MADDA)	• What is Mesothelioma | Mesothelioma and Dust Diseases Australia (MADDA) • Mesothelioma and Dust Diseases Australia (MADDA)	
Myeloma Australia	• Myeloma Australia - Home - Myeloma Australia	• Health Professional resources - Myeloma Australia	1800 693 566
NeuroEndocrine Cancer Australia	• For Patients | Neuroendocrine Cancer Australia	• Health Professionals | Neuroendocrine Cancer Australia • Neuroendocrine Tumour Education Course | Neuroendocrine Cancer Australia	1300 287 363
Ovarian Cancer Australia	• Information and Support in Other Languages | Ovarian Cancer Australia • Information and Support Resources | Ovarian Cancer Australia	• Health Professionals | Ovarian Cancer Australia	1300 660 334
Prostate Cancer	• Prostate Cancer Support | PCFA	• Prostate Cancer Treatment and Awareness | PCFA telenurse@pcfa.org.au	1800 220 099
Rare Cancers Australia	• KnowledgeBase | rare cancers Australia • Rare Cancer Support Guide | rare cancers Australia	• KnowledgeBase | rare cancers Australia • Supporting your patient | rare cancers Australia	1800 257 600
Redkite	• Childhood cancer charity in Australia | Redkite	• Childhood cancer charity in Australia | Redkite	1800 733 548

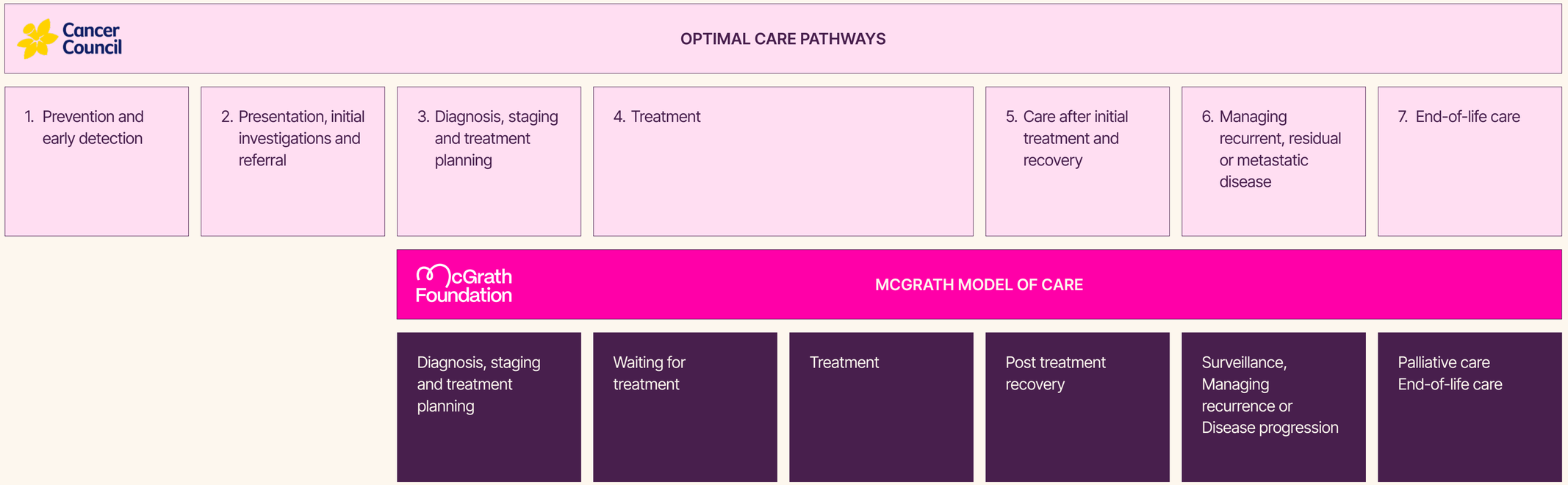
Optimal Care Pathways

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

To support consistency and standardisation of care, the Cancer Council's Optimal Care Pathways (OCP) have been considered in the design of the McGrath Model of Care. The OCPs are a framework for the delivery of consistent, safe, high-quality and evidence-based care for people with cancer. They aim to ensure all people diagnosed with cancer receive the best care, irrespective of where they live or receive cancer treatment. The relationship between the stages of care in the McGrath Model of Care and the seven steps of the OCPs are illustrated in Figure 9.

Figure 9:

Relationship between the OCPs and the McGrath Model of Care



Optimal Care Pathways

ABOUT THE MODEL

HOW TO USE THIS DOCUMENT

FIRST CONTACT

DIAGNOSIS, STAGING & TREATMENT PLANNING

WAITING FOR TREATMENT

TREATMENT

POST TREATMENT RECOVERY

SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION

PALLIATIVE CARE END OF LIFE CARE

RESOURCES & LINKS

OPTIMAL CARE PATHWAYS

GLOSSARY

SKILLS & KNOWLEDGE

ASSESSMENT TOOLS

- ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE
- ADOLESCENTS AND YOUNG ADULTS
- BREAST
- CANCER UNKNOWN PRIMARY
- CERVICAL
- COLORECTAL
- ENDOMETRIAL
- HEAD AND NECK
- HEPATOCELLULAR CARCINOMA
- HIGH GRADE GLIOMA
- LUNG CANCER
- MELANOMA
- NEUROENDOCRINE TUMOURS
- KERATINOCYTE CANCER (SQUAMOUS CELL CARCINOMA/ BASAL CELL CARCINOMA)
- OESOPHAGOGASTRIC CANCER
- OLDER PEOPLE
- OVARIAN
- PANCREATIC CANCER
- PROSTATE CANCER
- SARCOMA

> *Information is powerful but there is additional stress having to continually request details i.e. size of tumour and blood test results.*
>
> LIVED EXPERIENCE PARTICIPANT

Glossary

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Table 2: Glossary

Term	Description
Advance care planning	The legal documents in which people give written instructions about their health care if, in the future, due to the state of their health, they cannot speak for themselves.
Advanced disease	Cancer where the goal of treatment and care may not be cure, or where cure is not an option (Cancer Australia). Or Advanced cancer means the cancer has spread from the original (primary) site or has come back (reoccurred) (Cancer Council).
Anxiety	A feeling of worry, nervousness, or unease about something with an uncertain outcome. Anxiety as a mental health condition is slightly different, defined as anxious feelings that do not go away, that happen without any reason or that make daily life difficult.
Assessment tools	Used to gather information concerning the patient's individual physiological, psychological, sociological, and spiritual needs. It is the first step in the successful evaluation of a person. The tools used should be validated and offer empirical evidence of reliability.
Bone scan	A procedure to check for abnormalities or damage in the bones. A bone scan can be a valuable tool for detecting cancer that has spread (metastasised) to the bone from the tumour's original location, such as the breast, and cancers that originate in the bones. Performed in Nuclear Medicine facilities using small amounts of radio-tracing substance.
Cancer agency/service/organisation	Cancer agency/service/organisation refers to any other service or agency that is involved in delivering services to support someone's cancer experience. For example, an acute treatment centre or another non-government organisation within the cancer sector.
Cancer Council	Cancer Council is the only charity in Australia to work across every area of every cancer, from research to prevention and support. Cancer Council helps people from the point of diagnosis through to treatment and survivorship.
Clinical practice guidelines	Evidence-based recommendations developed to optimise person centred care and assist clinical decision-making or service planning. These guidelines have been developed by clinical experts and key stakeholders within the relevant field of practice. Ideally, they are designed to assist healthcare professionals and people with cancer to make shared decisions about screening, prevention, treatments and follow-up.
Clinical supervision	A formal and disciplined working alliance that is, but not necessarily, between a more experienced and a less experienced worker, in which the supervisee's clinical work is reviewed and reflected upon. It aims to improve the supervisee's work with patients; ensuring client welfare; support the supervisee in relation to their work and support the supervisee's professional development.
Clinical trials	A clinical trial is a study that tests and compares different ways of improving people's health. Trials may look at whether a treatment is safe, its side effects or how well a treatment or procedure works. Some trials look at how well treatments control symptoms or whether they improve quality of life.

Glossary

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Table 2: Glossary

Term	Description
Cooling therapy	Application of cooling system garments that help reduce toxicities that affects hair, skin, nails and peripheral nerve endings.
Comorbidities	The co-occurrence of one or more diseases or conditions in the same person at the same time. Comorbidities are often long-term or chronic conditions.
Complementary and alternative medicines	Therapy used in addition to (complementary) or instead of (alternative) standard medical treatment. These approaches to care aim to enhance quality of life and improve wellbeing. Examples may include dietary supplements, massage therapy, meditation, acupuncture, aromatherapy, art and music therapy. It is important that the health care team are aware of all supplements being taken as these can interact with cancer therapies.
Cultural needs	Practices and rituals specific to a person's individual cultural beliefs and spirituality.
CVAD (Central venous access device)	Small, flexible tubes placed in large veins for people who require frequent access to the bloodstream. CVADs are often referred to as venous access ports or catheters, because they allow frequent access to the veins without direct vein cannulation.
Deep Inspiration Breath Hold (DIBH)	Radiation therapy technique where people take a deep breath during treatment and hold this breath while the radiation is delivered. By taking a deep breath in, the lungs fill and move the heart from the direct radiation beams.
eviQ	A free, online resource comprising evidence-based, consensus driven cancer treatment protocols. Developed by the Cancer Institute of New South Wales, it aims to make sure people with cancer receive appropriate treatment in a timely manner.
Family history	Involves collecting the previous cancer diagnoses and reasons for death of grandparents, mother/father and siblings. Cancers due to inherited faulty genes are much less common than cancers due to random gene changes during cell reproduction as we age, or exposure to other physical or chemical factors.
Fatigue	Extreme tiredness and inability to function as a result of a lack of energy. Fatigue relating to cancer is different to normal feelings of tiredness and can be caused by the cancer itself, medicines, side effects of treatment, stress and mood changes, changes in diet, sleeping difficulties, lack of physical activity and other related health problems.
Genomic sequencing	Uses a sample of blood to look for specific inherited changes (variants) or mutations in a person's genes. Genetic variants can have harmful, beneficial, neutral (no effect), or unknown or uncertain effects on the risk of developing diseases. Harmful variants in some genes are known to be associated with an increased risk of developing certain diseases or cancers.
Health literacy	The degree to which an individual can obtain, read, understand, and use healthcare information in order to make appropriate health decisions.
Immune related adverse events	Immediate or latent local or systemic toxicities that occur during or after immunotherapy cancer treatments. These adverse events need to be assessed, managed and escalated as soon as observed by the patient or clinician.

Glossary

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Table 2: Glossary

Term	Description
Immunotherapy	A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases. Some types of immunotherapies only target certain cells of the immune system.
Infertility	The inability to produce children. Cancer and its treatments can affect a person's fertility (ability to conceive a child or maintain a pregnancy).
Lifestyle modification	Actions and behaviours directed at making healthy lifestyle choices and reducing cancer risk and recurrence. Include smoking cessation, maintaining healthy weight, limiting UV exposure, limiting alcohol intake, being physically and socially active.
Living well	The holistic care of a person that focuses on life beyond cancer, during and after treatment. This focus begins at diagnosis and considers life after treatment during the stage often referred to as survivorship.
Local service	This refers to the local cancer or health service that is closest to the person's home residence.
Malnutrition	A condition caused by not getting enough calories or the right amount of nutrients. This may occur when a person's diet is lacking nutrients or when their body cannot absorb nutrients from food. Eating issues caused by cancer treatment side effects can contribute to, or be symptoms of, malnutrition.
McGrath Cancer Care Nurse (MCCN)	A cancer nurse funded by the McGrath Foundation.
Medium to long term effects	A health problem that occurs months or years after a disease is diagnosed or after treatment has ended. Medium to long term effects may be caused by cancer or cancer treatment. They may include physical, mental, and social problems and secondary cancers.
Model of Care	Broadly defines the way health services are delivered, outlining best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event.
Molecular profiling	Uses a sample of tumour to identify its unique biomarkers. Used in clinical practice in two broad categories: (1) characterisation of cancers beyond the standard histopathologic features such as tumour grade, histologic subtype, and biomarker profile for prognostic information; and (2) prediction of response to therapy and clinical outcome.
Multidisciplinary team (MDT)	A health care team consisting of a group of healthcare professionals who are experts in specific areas, working together to deliver comprehensive care. An MDT can include a general practitioner, a surgeon, a medical oncologist, a radiation oncologist, a palliative care specialist, a nurse consultant, nurses, a dietitian, a physiotherapist, an occupational therapist, a social worker, a psychologist, a counsellor and a pastoral care worker.

Glossary

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Table 2: Glossary

Term	Description
Oncofertility	A field of medicine that bridges oncology and reproductive practice. Involves research to minimise the negative effects of cancer treatment on fertility and to explore and expand options for the reproductive future for people undergoing cancer treatments.
Oncologic emergency	Any acute, potentially morbid or life-threatening event directly or indirectly related to a patient's cancer or its treatment.
Optimal Care Pathways (OCPs)	National guidelines to promote best practice cancer care. The pathways describe key stages in a person's cancer journey and the expected optimal care at each stage.
Palliative care	Care that aims to improve the quality of life of people who have a life-threatening illness. It also provides support to families and carers. Prevention and relief of suffering is provided through early identification, assessment and treatment of pain and assisting with any physical, emotional, cultural, social and spiritual needs.
Pathology	A medical specialty that examines the cause of diseases by assessing changes in body tissues, blood and other body fluids. Histopathology and cytopathology are the main tools utilised in the diagnosis of cancer.
Pathological complete response (pCR)	No residual or viable tumour cells remain in the tumor or resected lymph nodes following systemic treatment.
Peripheral neuropathy	A relatively common neurological condition that may be caused by cancer or cancer treatment as well as injury, infection, toxic substances and chronic diseases. Symptoms of peripheral neuropathy include pain, numbness, tingling, swelling or muscle weakness in different areas of the body.
Psychosocial needs	Mental, emotional, social, family and spiritual needs that may relate to the overarching considerations and arise as a result of a disease, such as cancer.
Quality of life (QoL)	According to the World Health Organization, QoL is "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment.
Radiation immobilisation	Techniques and tools used to help the patient stay in the same position for all radiation treatments. The tools are custom made and are dependent on what body part is being treated.
Range of movement	The capability of a joint to go through its complete spectrum of movements.
Sexual function	A complex interaction involving both the mind and the body. The nervous, circulatory, and endocrine (hormonal) systems all interact with the mind to produce a sexual response. A delicate and balanced interplay among these systems controls the body's sexual response.

Glossary

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Table 2: Glossary

Term	Description
Shared care	Shared care is where there is joint responsibility for planned care that is agreed between healthcare providers, the person and any carers they would like to engage. In cancer care, refers to shared care with GPs and the cancer treatment team.
Side effects	Local or systemic reactions to treatments that may occur immediately or months to years following cancer treatments. All side effects should be assessed, managed and escalated as soon as reported or observed. Medium to long term side effects are those that occur months or years after the treatment has ended.
Spiritual needs	An essential domain of psychosocial care, which focuses on the needs of the whole person and their family. Spirituality is a fundamental element of human experience. It encompasses the individual's search for meaning and purpose in life and the experience of the transcendent. For some people spirituality can be largely faith based, for others it may be their relationship with nature or the profound connections they have with other people.
Surgical wound complications	Unplanned delays in surgical wound healing, including seroma development, infection and wound breakdown.
Supportive care	Supportive care in cancer is the prevention and management of the adverse effects of cancer and its treatment. This includes management of physical and psychological symptoms and side effects across the continuum of the cancer journey from diagnosis through treatment to post-treatment care. Supportive care aims to improve the quality of rehabilitation, secondary cancer prevention, survivorship, and end-of-life care.
Surveillance	Planned examinations that may include clinical exams, blood work, function tests, imaging and scans to monitor for cancer recurrence or progression.
Targeted therapy	Often used in conjunction with standard chemotherapy or endocrine therapies, targeted therapies act on specific molecular targets and cancer cells without harming healthy cells.
Telehealth	The use of telecommunications and virtual technology to deliver healthcare, often allowing people in regional or remote areas to connect with healthcare providers in major centres.
Therapeutic communication	A purposeful, interpersonal process in nursing that uses verbal and nonverbal techniques to build a trusting relationship with a patient, support their emotional and physical well-being, and encourage their participation in their own care.
TNM classification	Tumour (T), nodes (N), metastasis (M). TNM is the most widely used cancer staging system used to describe the amount and spread of cancer in a person's body. Most hospitals and medical centres use the TNM system as their main method for cancer reporting.
Waiting for treatment	During this stage, the patient's cancer has been diagnosed but the cancer is being observed without immediate active treatment. This stage often involves regular monitoring through tests and check-ups to assess the cancer's status. This can be a relatively short period, but for some people it can be longer as they are monitored for indications regarding the nature of treatment.

Skills & knowledge

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

The skills and knowledge required by an MCCN to deliver high quality care specific to cancer treatment at each stage of care are outlined in the Table 3 below.

Table 3: Overview of skills and knowledge required by stage

Skills & Knowledge	Diagnosis, Staging & Treatment planning	Waiting for treatment
• Active listening • Body image and sexuality (sexual disfunction) • Safe sex • Complementary and alternative medicines • Fertility and oncofertility • Genetics • Pathology and tumour characteristics • Symptom assessment, management and escalation • Patient advocacy • Find, navigate and communicate information and resources • Barriers to care (financial, cognitive, language, transportation) • Mental health support • Maintaining a healthy weight range • Oncologic emergencies • Self-efficacy skills development e.g., goal setting, planning, problem solving, self-regulation and reflective practice • Therapeutic communication	• Body image and sexuality • Complementary and alternative medicines • Genetics • Genomic profiling • Molecular testing • Oncofertility • Pathology and tumour characteristics • Patient advocacy • Risk assessment (epidemiology) and modifiable risk factors (lifestyle behaviours) • Screening and early detection • Staging criteria (TMN classification) • Understanding of diagnostic procedures	• Understanding pathology procedures and tests

Skills & knowledge

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Table 3: Overview of skills and knowledge required by stage

Treatment (Neo-adjuvant)	Treatment (Surgery)	Treatment (Chemotherapy & immunotherapy)
• Bone health • Cooling therapies • Immune and related adverse events • Nutrition assessment and management • Oral and dental health • Skin and nail care	• Nodal dissection expectations • Pre-surgical investigations • Reconstructive/ plastic surgery • Treatment considerations (performance status, comorbidities) • Additional studies (CT, PET Scan, bone scan) • Neurosensory changes • Pain • Post surgical wound complications and management • Range of movement expectations • Re-excision of margins/ nodes surgery • Scar management • Staging criteria (TNM classification) • Tumour features (LVI, margins)	• Bone health • Cardiovascular investigations and complications • Clinical trials • Cognitive dysfunction • Cooling therapies • eviQ Immune Adverse Event Management • Fatigue assessment and management • Gastrointestinal and genitourinary health • Maintaining healthy weight range • Oral care • Peripheral neuropathy

Skills & knowledge

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Table 3: Overview of skills and knowledge required by stage

Treatment (Radiation therapy)	Treatment (Targeted therapy)	Post treatment recovery
• Local treatment modalities (external bean, brachytherapy, stereotactic) • Treatment duration and modality • Skin reactions and management	• Bone health • Cardiovascular complications • Cognitive dysfunction • Genitourinary health • Blood pathology • Peripheral neuropathy • Maintaining healthy weight range	• Rehabilitation (e.g., pain, range of motion, cognitive impairment)

Surveillance, Managing recurrence or Disease progression	Palliative care / End of life	Living well
• Surveillance protocols and rapid access	• Palliative care for those with confirmed advanced disease	• Advance Care Planning • Assessment, management and escalation of medium to long term side-effects of treatment • Delayed reconstructive/ plastic surgery • Genitourinary health • Lifestyle modification • Maintaining healthy weight range • Rehabilitation (e.g., pain, range of motion, cognitive impairment) • Routine screening for other cancers • Survivorship care planning

Skills & knowledge

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Education and development opportunities for nurses

- American College of Surgeons (ACS) Cancer Staging Systems | American College of Surgeons
- Training on Disability | Australian Disability
- Clearinghouse on Education and Training (ADCET)
- Online Learning Modules | Bowel Cancer UK
- Clinicians | Cancer Mind
- Building nurses' capacity to provide health care for people with intellectual disability and/or autism | APNA
- eviQ
- Cancer Genomics | NHS
- Nursing Certificate Program | International Gynaecologic Cancer Society (IGCS)
- Nurse Education | Liver Foundation
- Training | Lung Foundation Australia
- Melanoma Resources | Melanoma Institute Australia
- National Palliative Care Standards | Palliative Care Australia
- Navigating difficult interactions with family and friend carers | COSA
- Neuroendocrine Tumour Education Course | Neuroendocrine Cancer Australia
- Health Centre for Genetics Education | NSW Gov
- Lung Cancer | Oncology Nursing in Practice
- PalliBytes
- Program of Experience in The Palliative Approach (PEPA)
- Radiation Oncology Nursing Knowledge and Skills (RONKAS) | eviQ
- CPD | thelimbic
- Urology / Oncology Nurse Education | BEAT
- Explore clinical supervision opportunities within workplace or cancer agency
- Cultural safety and education modules provided through workplace or cancer agency
- Ensure up to date cultural competency training has been completed

Assessment tools

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

In alignment with the principles of the McGrath Model of Care, the following assessment tools are recommended.

At the time of publication of the McGrath Model of Care, the inclusion of the assessment tools in the McGrath Model of Care does not constitute extending a licence for use, or approval from the copyright holder to alter the documents.

AUSTRALIA-MODIFIED KARNOFSKY PERFORMANCE STATUS SCALE	The Australia-modified Karnofsky Performance Status (AKPS) scale is a clinician-rated measure of an individual's ability to perform daily activities, self care, and work, where lower scores indicate greater impairment. Abernethy AP, Shelby-James T, Fazekas BS, Woods D, Currow DC. The Australia-modified Karnofsky Performance Status (AKPS) scale: a revised scale for contemporary palliative care clinical practice [ISRCTN81117481]. BMC Palliative Care. 2005;4:1-12.
BRIEF FATIGUE INVENTORY	The Brief Fatigue Inventory (BFI) is a short self-report tool that allows for the rapid assessment of fatigue levels in people with cancer. Mendoza TR, Wang XS, Cleeland CS, Morrissey M, Johnson BA, Wendt JK, Huber SL. The rapid assessment of fatigue severity in cancer patients. Cancer. 1999, 85(5):1186-1196.
CHEMO-TOXICITY CALCULATOR	The Chemo-Toxicity Calculator is a tool for estimating an older person's risk of severe chemotherapy-related toxicity by integrating clinical, functional, and laboratory factors.
CLINICAL FRAILTY SCALE	The Clinical Frailty Scale (CFS) is a 9-point tool used to summarise the overall level of fitness or frailty of an older adult. Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, Mitnitski, A. A global clinical measure of fitness and frailty in elderly people. CMAJ. 2005;173(5):489-495.
ECOG PERFORMANCE STATUS SCALE	The Eastern Cooperative Oncology Group (ECOG) Performance Status Scale is a measurement to describe a person's level of functioning in terms of their ability to care for themselves, daily activity and physical ability. Oken MM, Creech RH, Tormey DC, Horton J, Davis TE, McFadden ET, Carbone PP. Toxicity and response criteria of the Eastern Cooperative Oncology Group. Am J Clin Oncol. 1982;5(6):649-655. The ECOG Performance Status Scale was developed by the Eastern Cooperative Oncology Group (ECOG), now the ECOG-ACRIN Cancer Research Group, and published in 1982. To learn more, visit ecog-acrin.org/scale
EDMONTON SYMPTOM ASSESSMENT SYSTEM REVISED - CANCER	The revised Edmonton Symptom Assessment System for Cancer (ESAS-r Cancer) is a valid and reliable patient reported outcome measure for capturing the severity of common symptoms experienced by people with cancer. Watson L, Link C, Qi S, Delure A, Chmielewski L, Hildebrand A, Barbera L. Designing and validating a comprehensive patient-reported outcomes measure for ambulatory cancer settings: the revised Edmonton Symptom Assessment System for Cancer. JCO Oncology. 2024;20(12):1764-1775.
EVIQ ANTI-CANCER DRUG PATIENT EDUCATION CHECKLIST	The Anti-cancer drug patient education checklist is a checklist to ensure that people receiving anti-cancer drugs (and their support people) are provided with the necessary information about their cancer treatment. Clinical resource: Anti-cancer drug patient education checklist 2023 V.5, eviQ Cancer Treatments Online, Cancer Institute NSW, viewed 25 November 2025, https://www.eviq.org.au/clinical-resources/assessment-tools/550-anti-cancer-drug-patient-education-checklist
EVIQ IMMUNOTHERAPY PATIENT ASSESSMENT TOOL	The Immunotherapy patient assessment tool is utilised by health professionals in collaboration with individuals prescribed immunotherapy, prior to the commencement of each immunotherapy cycle. The tool enables screening of risk factors, assessment of vital signs, laboratory trends, and grading of symptoms across organ systems to detect and manage treatment-related toxicities early. Clinical resource: Immunotherapy patient assessment tool 2023 V.3, eviQ Cancer Treatments Online, Cancer Institute NSW, viewed 25 November 2025, https://www.eviq.org.au/getmedia/4946238e-a60d-453a-9640-ca89cb93c657/ID-3533-Immunotherapy-patient-assessment-tool-v-3.pdf.aspx?ext=.pdf

Assessment tools

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

MALNUTRITION SCREENING TOOL	The Malnutrition Screening Tool (MST) is a brief questionnaire that can be completed by a health professional, individual with cancer, or support person, to screen for unintentional recent weight loss, to identify risks of malnutrition. The Victorian Cancer Malnutrition Collaborative (2019). The culturally adapted Malnutrition Screening Tool. Peter MacCallum Cancer Centre: https://www.petermac.org/MST
MASCC ORAL AGENT TEACHING TOOL	The MASCC Oral Agent Teaching Tool (MOATT) assists healthcare providers in the assessment and education of people receiving oral agents as treatment for their cancer, to ensure that people know and understand their treatment and the importance of taking tablets as prescribed. Kav S, Fleury M, Fernandez-Ortega P, Manzullo EF, Kerr KA, DeGennaro R, Ginex PK. 15 years supporting adherence to oral anti-cancer treatment: use of the MASCC Oral Agent Teaching Tool (MOATT) worldwide, a review for the future. Supp Care in Cancer. 2025;33(229) https://doi.org/10.1007/s00520-025-09274-3
NCCN DISTRESS THERMOMETER AND PROBLEM LIST	The National Comprehensive Cancer Network® (NCCN®) Distress Thermometer and Problem List is an assessment tool designed to screen for distress in people with cancer. It informs healthcare professionals of emotional, practical, social, physical or spiritual challenges that an individual may be experiencing. https://www.nccn.org/docs/default-source/patient-resources/nccn_distress_thermometer.pdf
PRACTICAL GERIATRIC ASSESSMENT	The Practical Geriatric Assessment (PGA) is a multidimensional screening tool designed to evaluate age-related vulnerabilities associated with older adults undergoing cancer treatment. It can be completed by healthcare providers or individuals with cancer.
EVIQ RADIATION-INDUCED DERMATITIS ASSESSMENT TOOL	The Radiation-induced dermatitis assessment tool screens for skin changes in a radiation treatment area and monitors the severity of skin reactions during radiotherapy. The tool comprises two parts: Part A is completed by the individual with cancer and Part B is completed by the health professional. Clinical resource: Radiation-induced dermatitis assessment tool 2025 V.6, eviQ Cancer Treatments Online, Cancer Institute NSW, viewed 25 November 2025, https://www.eviq.org.au/getmedia/ec7ccf80-deb2-49c1-b049-dd076c80552d/231-Radiation-induced-dermatitis-assessment-tool-V6.pdf.aspx?ext=.pdf
SARC-F SCREEN FOR SARCOPENIA	The SARC-F Screen for Sarcopenia questionnaire screens for self-reported signs suggestive of sarcopenia, which include deficiencies in strength, walking, rising from a chair, climbing stairs and experiencing falls. Malmstrom TK, Morley J. SARC-F: A simple questionnaire to rapidly diagnose sarcopenia. JAMDA. 2013;14:531-532.
LEE SCHONBERG INDEX	The LeeSchonberg Index of prognosis is a risk calculator designed for use in adults over 50 that prognosticates mortality across a 4-14 year range, incorporating age, sex, health status, chronic diseases, functional ability and other risk factors. Lee SJ, Lindquist K, Segal M, Covinsky K. Development and validation of a prognostic index for 4-year mortality in older adults. JAMA. 2006;295(7):801-808.
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Distress Thermometer and Problem List

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Cancer Care Alberta

Edmonton Symptom Assessment System Revised – Cancer (ESAS-r Cancer)

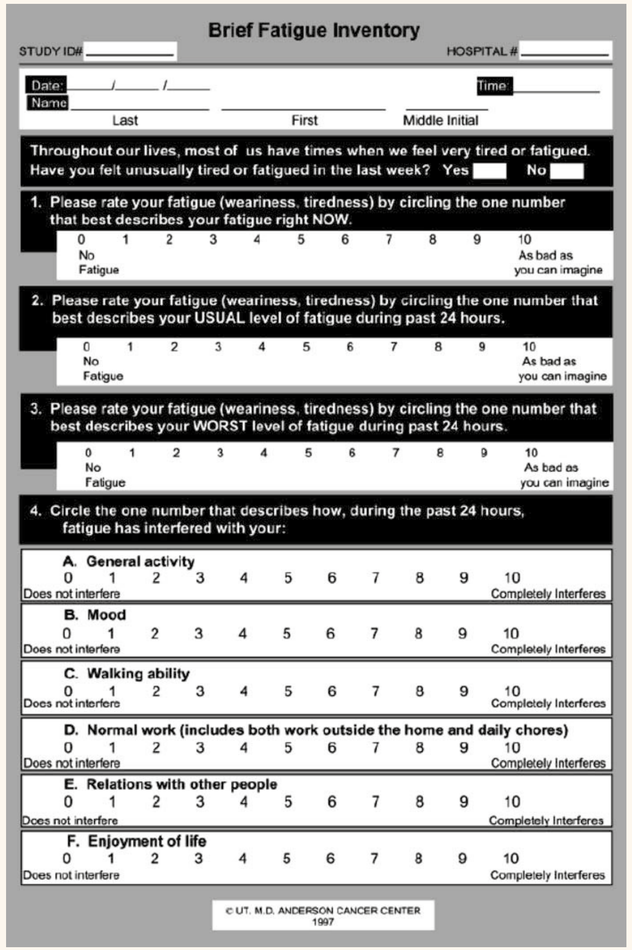
Help your care team understand how you are feeling by completing this self-assessment

Date (yyyy-Mon-dd):											
Select the number (0 to 10) that best describes how you feel NOW											
Pain Physical discomfort or suffering	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Tiredness Lack of energy that does not go away with rest	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Drowsiness Feeling sleepy or having trouble staying awake	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Nausea Feeling sick to my stomach or like I need to vomit	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Lack of Appetite Loss of interest in food or eating	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Shortness of Breath Difficulty breathing or taking a full breath	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Depression Sadness that does not go away, loss of interest or feeling hopeless	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Anxiety Feeling nervous, agitated or worried	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Well-Being How I feel overall	Best 0	1	2	3	4	5	6	7	8	9	Worst 10
Diarrhea Loose or watery bowel movements more often than normal	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Constipation Hard stool or difficulty having a bowel movement	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Numbness or Tingling Loss of feeling; burning or prickly sensations	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Sleep Problems Trouble with quality, timing or amount of sleep	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Thinking Problems Trouble with remembering, concentrating or brain fog	None 0	1	2	3	4	5	6	7	8	9	Worst 10
Mobility Problems Trouble with walking, balance or movement	None 0	1	2	3	4	5	6	7	8	9	Worst 10

Watson L, Link C, Qi S, Delure A, Chmielewski L, Hildebrand A, Barbera L. Designing and validating a comprehensive patient-reported outcomes measure for ambulatory cancer settings: the revised Edmonton Symptom Assessment System for Cancer. JCO Oncology. 2024;20(12):1764-1775. Permission granted to copy for research and educational purposes only. 6 February 2026.

Brief Fatigue Inventory

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS



Brief Fatigue Inventory

STUDY ID# _____ HOSPITAL # _____

Date: ____/____/____ Time: _____

Name _____ _____ _____

Last First Middle Initial

Throughout our lives, most of us have times when we feel very tired or fatigued. Have you felt unusually tired or fatigued in the last week? Yes ☐ No ☐

1. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your fatigue right NOW.

0 1 2 3 4 5 6 7 8 9 10
No Fatigue — As bad as you can imagine

2. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your USUAL level of fatigue during past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Fatigue — As bad as you can imagine

3. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your WORST level of fatigue during past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Fatigue — As bad as you can imagine

4. Circle the one number that describes how, during the past 24 hours, fatigue has interfered with your:

A. General activity
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

B. Mood
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

C. Walking ability
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

D. Normal work (includes both work outside the home and daily chores)
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

E. Relations with other people
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

F. Enjoyment of life
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

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Cancer Experience Advisory Group

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ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

Research Advisory Group

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Appendix 1: Evidence informing the McGrath Model of Care

ABOUT THE MODEL
HOW TO USE THIS DOCUMENT
FIRST CONTACT
DIAGNOSIS, STAGING & TREATMENT PLANNING
WAITING FOR TREATMENT
TREATMENT
POST TREATMENT RECOVERY
SURVEILLANCE MANAGING RECURRENCE OR DISEASE PROGRESSION
PALLIATIVE CARE END OF LIFE CARE
RESOURCES & LINKS
OPTIMAL CARE PATHWAYS
GLOSSARY
SKILLS & KNOWLEDGE
ASSESSMENT TOOLS

In addition to the co-design process, it was important for the McGrath Model of Care to leverage the latest available academic evidence on nurse led supportive care interventions. To inform this, the Flinders University were commissioned to undertake a systematic review to provide a comprehensive and contemporary evidence base to inform and refine the McGrath Model of Care and to guide the establishment of optimal evaluation methods for the model.

This review consisted of three objectives:

1. To understand peoples' preferences and the value placed on Specialist Cancer Nurses
2. To assess the effectiveness and cost-effectiveness of nurse-led interventions and models of care
3. To identify optimal evaluation methods and quality indicators for these interventions

The review employed three complementary methodologies: a systematic review to assess peoples' preferences for Specialist Cancer Nurses, an umbrella review to evaluate the effectiveness and cost-effectiveness of nurse-led interventions, and a scoping review to identify optimal evaluation methods and quality indicators.

Key insights from this review included:

Patient preferences and value of Specialist Cancer Nurses

Findings consistently demonstrated that people with cancer place high value on the role of Specialist Cancer Nurses, particularly for supportive care needs. People with cancer prefer Specialist Cancer Nurses for supportive care due to their expertise and ability to address post-treatment informational needs. These nurses play a key role in building peoples' confidence by collaborating with GPs in shared follow-up care. Additionally, people value flexibility in the timing and mode of care delivery, which should be central to the design of specialist cancer nursing models.

Effectiveness and cost-effectiveness of nurse-led interventions and models of care

Evidence shows that Specialist Cancer Nurses improve symptom management, self-care behaviours, and peoples' satisfaction across all stages of the cancer experience. Importantly, the evidence shows that Specialist Cancer Nurses improve the outcomes for people living with cancer across all stages of care. While their impact on quality of life, healthcare expenses, and survival is comparable to standard care, further research is needed to fully assess their value in delivering high-quality, cost-effective cancer care.

Optimal evaluation methods and quality indicators

The review also identified a lack of consistent metrics and evaluation frameworks. Current evaluation of nurse-led interventions is hindered by non-standardised roles and poorly defined indicators. The findings support the development of a national suite of key performance indicators, co-designed with clinicians and consumers, to effectively measure and communicate the value of Specialist Cancer Nurses.