

Research Article

Perspectives and Experiences of Healthcare Professionals Involved in a Community Nurse-Delivered Shared Care Model Intervention Designed to Support Outpatients Receiving Chemotherapy: A Qualitative Study Using Interviews

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Background. Chemotherapy can cause a range of side effects including nausea, vomiting, diarrhea, and infection, which can have a significant impact on an individual's quality of life. Survival outcomes can be impacted when side effects are poorly managed, leading to failure to complete the defined dose of treatment. **Objective.** This study presents clinicians' experiences with a shared care model involving home-based community nurse (CN) support to improve side-effect management of individuals receiving chemotherapy as an outpatient. **Methods.** A qualitative study was conducted with CNs, cancer nurses, medical oncologists, and a general practitioner involved in the CN intervention delivered as part of a randomized controlled trial (RCT) aimed at reducing unplanned presentations to hospital of cancer patients receiving outpatient chemotherapy. Semistructured individual and focus group interviews were conducted. Key themes were identified using thematic analysis. **Findings.** Twenty-three healthcare professionals were interviewed. Three themes were identified: (1) being able to enhance patient-centered care and clinical practice during chemotherapy; (2) importance of effective communication and collaborative relationships between different care settings; and (3) ways to adapt the intervention for implementation in routine clinical practice. Participants reported that it was feasible for CNs to care for this patient group, and their home visits enabled preemptive symptom management. Suggestions to improve and modify the intervention to implement this care model within existing clinical care included a flexible approach, such as a blended delivery with face-to-face visits and telephone calls; a risk- or needs-based approach to prioritize patient groups more likely to benefit from the intervention; and sharing of electronic medical records for more effective collaboration and communication. **Conclusions.** A CN-delivered shared care model provided a feasible approach to the provision of individualized support for outpatients receiving chemotherapy. This study suggests ways to adapt this care model into existing clinical workflow and structures. This trial is registered with ACTRN12614001113640.

1. Introduction

Chemotherapy remains an essential component of treatment for many cancer types. In Australia, systemic cancer treatment, including chemotherapy, was administered to 247,939 patients in 2016, representing a 25% increase since 2012 [1]. Chemotherapy frequently causes physical side effects [2], with more than 75% of Australians undergoing chemotherapy for cancer reporting multiple moderate or severe side effects [3]. Individuals with cancer also commonly experience psychosocial and emotional challenges during treatment [4, 5]. Unmet needs are frequently reported by this group, including difficulty managing treatment side effects and coping with emotions such as anxiety and depressed mood [6]. Chemotherapy is primarily delivered in the outpatient setting. This means that patients experience and manage these side effects at home, without the direct support of hospital-based healthcare professionals (HCPs). Unplanned hospital presentations and admissions are common due to treatment side effects, accounting for a significant healthcare burden [7–11].

Several studies have been conducted investigating the effectiveness and feasibility of different models of care to support patients undergoing chemotherapy, with mixed results. A randomized controlled trial (RCT) involving community-based specialist cancer nurses demonstrated a reduction in unplanned hospital utilization and symptom burden of chemotherapy patients [12]. Another RCT testing the effectiveness of telephone-based symptom triage support during chemotherapy showed reduced symptom severity and emotional distress [13], and a study involving real-time symptom monitoring during chemotherapy with remote clinical support demonstrated a reduced symptom burden [14]. An RCT of nurse-led telephone-based support for patients undergoing chemotherapy did not, however, show significant effects on the level of supportive care needs [15]. An RCT of a nurse-led telephone-based care coordination service for colorectal cancer patients post-treatment showed no significant effects on unplanned hospital utilization and quality of life outcomes [16].

Community nurses (CN) are widely recognized for their diverse skills including advanced skills in symptom management, such as pain [17], comprehensive physical and practical assessment abilities, their information provision role, their linkage with and access to other health services, and their provision of emotional support to patients and carers [18, 19]. Based on their skills, the potential to extend the scope of practice of CNs to meet the needs of cancer patients is realistic.

This paper reports on one aspect of an RCT (Evaluating a shared-care pathway intervention to reduce chemotherapy outpatients' unplanned presentations to hospital—ESCAPI [20]) that compared a CN intervention to support patients receiving outpatient chemotherapy with usual care. The intervention included community nurses visiting patients at home on designated days across three chemotherapy cycles. Their role encompassed assessing treatment-related symptoms, both physical and psychosocial, reinforcing patient education to foster self-management, and engaging other healthcare professionals when concerning symptoms are

identified. Prior to their involvement in the study, CNs completed an education program involving online modules developed for this study, in collaboration with the Cancer Institute New South Wales. The CN's patient assessment was documented using the Chemotherapy Symptom Assessment Scale (C-SAS) [21] and faxed to the relevant cancer centers and the patient's general practitioner (GP).

This RCT investigated the effectiveness of the intervention [20] in reducing unplanned hospital presentations and improving patients' quality of life and self-efficacy in managing treatment related symptoms. The perceived feasibility and utility of the intervention were examined through qualitative interviews with relevant stakeholders, including patients/carers [22], and HCPs involved in its delivery. The trial protocol is registered at the Australian and New Zealand Clinical Trials Registry (registration number ACTRN12614001113640).

This paper presents the results of qualitative interviews conducted with HCPs. The purpose of this qualitative study was to explore HCPs' experiences with the intervention and perceived utility, their perception of the longer-term feasibility of the intervention, and their suggestions for improvement. Figure 1 illustrates an overview of the intervention delivery and overall study design.

2. Materials and Methods

This qualitative study utilized an interpretive phenomenological approach [23] to explore the narrated account of HCPs involved in the intervention. This approach values people's firsthand experiences and perspectives for informing health service design. It involved semistructured individual and focus group interviews with HCPs involved in the care of patients receiving the intervention as part of the ESCAPI trial [20]. The methodological approaches and study findings in this manuscript have been reported in accordance with the Standards for Reporting Qualitative Research (SRQR) [24].

2.1. Participants and Setting. The ESCAPI trial was conducted at two cancer centers of tertiary referral hospitals and six community nursing centers in Sydney, Australia. HCPs were eligible to participate in this aspect of the study if they were an oncologist or cancer care nurse at one of these centers, a CN working at a participating community health center and provided at least two home visits, or the GP of a patient participating in the ESCAPI trial. The sampling strategy involved an e-mail invitation to clinicians within the cancer centers and community nursing centers. The GPs of patient participants in the trial, who consented to their GPs being invited to participate, were sent a letter of invitation by mail. Interested participants contacted the research team directly. The relevant hospital research integrity committee granted ethics approval for this study (RPAH Zone protocol X13-0101). Informed consent was obtained prior to the interview and the data were stored securely within the University's data storage. Data were de-identified with the master sheet only accessible by BK and CB.

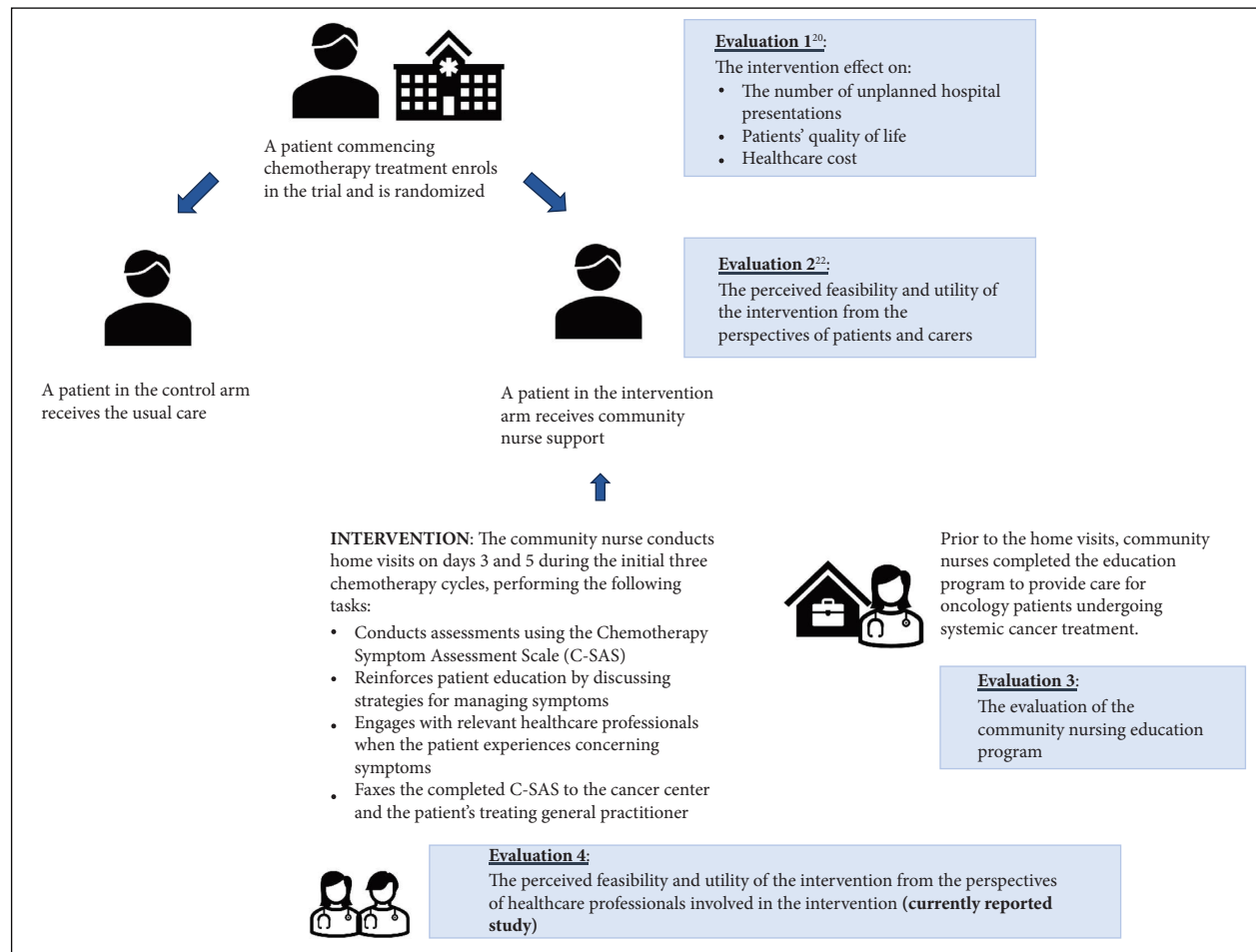


FIGURE 1: An overview of the intervention and study design.

2.2. Study Procedure. Recruitment and data collection took place throughout the trial, between February 2016 and December 2018. All clinicians involved were invited to the study and recruitment ceased when no more participants volunteered. A semistructured interview guide consisting of open-ended questions (Table 1) was used. The interviews were conducted in person by KW and a research staff member who had expertise in conducting qualitative research. The interview questions explored participants' views on the following:

- The experience of being involved with the intervention
- The perceived feasibility and utility of the intervention in helping patients manage side effects
- Whether the intervention aided communication between HCPs involved in patients' care
- The strengths and weaknesses of the intervention; and
- Ways to improve the intervention

2.3. Data Analysis. The interviews were transcribed verbatim using a transcription service that met the privacy requirements. Thematic analysis was conducted through

iterative processes involving several researchers. The interview transcripts were read by BK for generation of initial codes. LA verified the codes by reviewing the transcripts, and BK and LA proceeded to develop themes. Disagreement was discussed between the researchers and resolved. Themes were developed and then reviewed by community care clinicians (JM and NC) for confirmation. Final themes were taken to KW and further refined based on review of the transcripts and the notes provided by the other researchers. KW, BK, and LA had a contextual understanding of supportive cancer care from their research work, as well as working in clinical settings as registered nurses. Consistent with the interpretive phenomenological approach, researchers attempted to reveal new insights while acknowledging their prior conception rather than bracketing [23]. No researcher had a direct professional working relationship with the participants.

3. Results

In total, 23 HCPs participated in this qualitative study. Thirteen HCPs participated in individual interviews—four oncologists, one cancer center nurse, seven CNs, and one GP. Additionally, two focus group interviews were held with 10 CNs. To provide context, in this trial, a total of 75 CNs were

TABLE 1: Themes covered by the clinician participants.

Interview questions	Participants
Please tell me about your experience of being involved with this new clinical pathway intervention	CN, CCN, oncologist, and GP
How effective do you think the intervention has been in helping patients manage their chemotherapy side effects?	CN, CCN, oncologist, and GP
What do you consider to be the strengths and weaknesses of the intervention? (for you/for your patient)	CN, CCN, oncologist, and GP
Is there anything about the clinical pathway intervention that you would like to see done differently?	CN, CCN, oncologist, and GP
How different is the level of communication between the cancer center and yourself compared with your experience of standard care of chemotherapy patients?	GP
How satisfied were you with the level of communication between the CN, the GP, and yourself?	CCN and oncologist
What, if any, impact did the intervention have on your management of patients receiving chemotherapy?	CCN, oncologist, and GP
How helpful was it to receive the clinical information about the patient forwarded by community nurses?	CCN, oncologist, and GP
Are there any other comments you would like to make about the intervention or this RCT?	CN, CCN, oncologist, and GP

Community nurse (CN); cancer care nurse (CCN); and general practitioner (GP).

trained and provided home visits to 170 patients as part of the intervention. The study sites typically had 12–16 oncologists at any given time. The individual interview duration ranged from 9 to 26 minutes, with a mean of 17 minutes. The duration of the two focus group interviews was 42 and 52 minutes, respectively. Demographic information was not collected due to the risk of re-identification within a relatively small group of potential participants and to help participants feel comfortable expressing honest opinions about the care model. The overview of themes and summarized key findings are presented in Table 2. In the direct quotes, “Ind” stands for individual interviews and “FG” for focus group interviews. Participants’ roles are indicated as follows: Onc = oncologist, CN = community nurse, and GP = general practitioner (e.g., IndOnc1 = quote from an oncologist in an individual interview).

3.1. Being Able to Enhance Patient-Centered Care and Clinical Practice during Chemotherapy. Participants valued the supportive care provided during the intervention and described the ways in which it benefited both their patients and their own clinical practice.

3.1.1. Home-Based Community Support Allowed Pre-Emptive and Individualized Symptom Management Support. CNs discussed how they promoted preemptive side effect management, connected with relevant healthcare providers when issues arose, and provided emotional support to the patient. In their view, this all positively impacted the effective management of treatment side effects and promoted patient self-efficacy.

“... especially [on] the first visit when people have started chemo[therapy], they really don’t know what to expect, they just need that reassurance. I saw one lady for all three rounds, and by the end, she knew what to expect

... [patient said] “I know I will only be nauseous for this day, and then it will be fine,” she wasn’t anxious anymore. . . but the first time, she really didn’t know what to do, she was alone . . . she really appreciated the help and the visits.” (IndCN3)

“... I went out to one lady, and when I got there she said she was feeling unwell, flu like symptoms she described, but she didn’t feel that it would be necessary to go into hospital, and we just went through all the questions, and I took her vital signs, and it was necessary that she went in to have some antibiotics . . . she said to me, “I’m really happy that you came out, because I would have just left this.” (IndCN2)

Although patients had received education on symptom management from the cancer center before their treatment, CNs noticed that reinforcing the information was necessary. CNs reported examples of assisting patients manage treatment side effects, by educating and encouraging patients to effectively use the medication the cancer center had prescribed. Some patients were reluctant to take medication, such as anti-emetics, but with reassurance and education by the CN, they understood the importance of the medication in symptom management.

“... people have problems with nausea. Sometimes, they had the medication but because they had never taken it before, or they were just feeling so unwell they just didn’t think to take it, or pre-emptively take it, [I was] like, “Take it before you feel sick. Take it before you have your meals,” so just having some advice around those things [seemed helpful].” (IndCN5)

From the cancer care professionals, the general view was that their patients appeared positive and appreciative about the CN visits, expressing a sense of relief, especially during their first cycle of chemotherapy.

TABLE 2: An overview of themes and summary of key findings.

Themes	Subthemes	Key findings
Being able to enhance patient-centered care and clinical practice during chemotherapy	Home-based community support allowed preemptive and individualized symptom management support	(i) CN home visits promoted preemptive symptom management through patient education (ii) CNs connected with relevant healthcare providers when issues arose (iii) CNs provided emotional support to the patient (i) Oncologists were reassured knowing that clinically vulnerable patients receive CN support at home
	The benefit to clinicians' practice by improving patient symptom monitoring during treatment and broadening clinical skill sets	(ii) CNs could expand their skill set in cancer care (iii) C-SAS enabled oncologists to gain better insights into how their patients manage symptoms at home (iv) The intervention offered an opportunity for GPs to be engaged in care during chemotherapy treatment
	The need for building collaborative relationships between cancer and community services	(i) Fostering collaborative relationships between cancer and community services was important and this could have been enhanced through clinical observership at the cancer center, face-to-face training, and mentoring during CN training
The importance of effective communication and collaborative relationships between different care settings	Effective communication between healthcare providers was challenged by preexisting system barriers	(i) A communication gap existed between cancer services and general practices, requiring exploration for a more effective way of engaging with GPs (ii) The importance of shared electronic medical record (eMR) systems across different settings
	Identifying patients who are in the greatest need of the intervention to optimize healthcare resource utilization	(i) Given limited resources, a risk- or need-based referral to CN support will be needed (ii) Potential groups could include those more prone to treatment toxicity, experiencing social isolation, dealing with disease-related symptoms, undergoing curative intent treatment, or receiving chemotherapy for the first time (i) The need for a more flexible approach, such as substituting some face-to-face visits with telephone calls or adjusting the timing of visits (ii) Needing the option for clinicians to exercise discretion in arranging CN support while allowing patients to opt in or out
Ways to adapt the intervention for implementation in routine clinical practice	Needing flexibility in delivering the model	

“Just reading the nurse’s comment in the evaluation form (symptom assessment form), you know, patients are happy, they’re relieved and they feel supported. They feel a bit more supported in the community after chemotherapy.” (IndOnc3)

“The patients really liked to have support, and they really loved being contacted after chemotherapy . . . I think they really resent being left alone for three weeks . . . the idea of someone contacting them at home was very appealing for them . . . there was certainly a lot of interest.” (IndOnc2)

3.1.2. The Benefit to Clinicians’ Practice by Improving Patient Symptom Monitoring during Treatment and Broadening Clinical Skill Sets. An oncologist shared a view that many of their patients receiving chemotherapy increasingly have advanced disease and are older and frail; they therefore felt reassured to know their patient was receiving community nursing support. CNs also felt that the education they received throughout this study had broadened their skill set and enhanced their ability to provide care for this patient group. An oncologist noted that the symptom assessment records generated by CNs during home visits assisted them with pre-chemotherapy consultations as it allowed a better understanding of how patients manage symptoms at home.

“it (symptom assessment form) sort of gives me a heads-up as to what the issues are and . . . facilitates a faster clinic for me because I already know the problem, so I already have a plan in my head. . . that was helpful for me.” (IndOnc1)

A GP participant shared their usual experience of receiving little communication from cancer services, “GPs generally get cut out once the diagnosis is made.” They expressed preferences for being included in their patients’ treatment progress. The CN symptom assessment records gave them an opportunity to be involved in their patient care during chemotherapy.

“I actually picked up the phone and called the patient and said “I haven’t seen you for a long time, how are you going? You are going through chemotherapy” . . . I think it is a good idea that the GPs are kept in touch and when the patient comes in, knows that the GP is one step away and goes, “yes, I know my GP knows what is going on in my life.” (IndGP)

3.2. The Importance of Effective Communication and Collaborative Relationships between Different Care Settings. Participants suggested ways the shared care pathway could be improved, particularly in relation to communication and collaboration between different settings involved in the intervention.

3.2.1. The Need for Building Collaborative Relationships between Cancer and Community Services. Participants emphasized the importance of building collaborative

relationships between cancer and community services. For example, a cancer nurse noticed that CNs were not utilizing the support available from cancer center nurses. The cancer nurse observed that CNs appeared hesitant to seek support, stressing that fostering relationships among clinicians in both settings could improve communication and collaboration. To enhance collaboration, two cancer care staff suggested clinical observership and mentoring opportunities. Specifically, they recommended that CNs spend time at the cancer center, including chemotherapy suites and oncologist consultations, to gain a better understanding of how patients’ symptoms are managed in the context of chemotherapy treatment.

“ . . . if there’s a program where they (CNs) can just come in maybe once a week just to observe how our nursing staff work and how they counsel our patients [who] drop in, feeling unwell [would help CNs upskill] . . . How do we deal with sleeplessness. How do we deal with gastritis . . . it’s often the art of practising medicine” (IndOnc1)

Several CNs also echoed this view by saying that they felt in-person training at the cancer center could provide valuable hands-on learning and an opportunity to ask questions.

3.2.2. Effective Communication between Healthcare Providers Was Challenged by Pre-Existing System Barriers. According to one oncologist interviewed, a communication gap exists between cancer services and general practices, with cancer services often only communicating notable changes to the GP. Therefore, in general, little communication is exchanged between the cancer service and the GP during treatment. The GP interviewed also noted that patients infrequently contact GPs during treatment and GPs are not included in the line of communication from cancer services. As a GP, they expressed a desire to be involved in the care of their patients during treatment. While acknowledging the complexities in this issue, an oncologist expressed the view that exploring a more effective way of engaging with GPs is needed.

“it’s hard to keep the GP completely in the loop . . . we update them on any big changes in treatment or treatment doses, but if things are exactly the same, it wouldn’t necessarily feed that back to them, So, I think it really is an unmet need. . . with how we communicate with GPs and I don’t think the answer is writing lots of letters, It probably comes down to a bit of health literacy from the patient’s point of view, but then again, they have a new cancer, how can you put that burden on them; it’s quite complicated.” (IndOnc4)

CNs would have liked more information included on the community nursing referral form from cancer services, including patients’ medical history, health status, and intent of treatment. CNs did not always have access to hospital electronic clinical notes, depending on which hospital the

patients were treated at. Several CNs considered this a significant barrier to care, and they highlighted the importance of shared electronic medical record (eMR) systems across different settings involved in the intervention.

3.3. Ways to Adapt the Intervention for Implementation in Routine Clinical Practice. Participants shared their concerns about potential resource issues if this program were to be offered to all patients commencing chemotherapy treatment. An oncologist noted that the CN service would need to review its funding model before this program could be rolled out as part of routine care. A CN echoed this view, stating that if this were to be a routine practice, there would need to be a way to screen patients and manage priorities to ensure the program could operate fairly. Participants suggested ways this intervention could be modified.

3.3.1. Identifying Patients Who Are in the Greatest Need of the Intervention to Optimize Healthcare Resource Utilization. CNs felt that providing tailored support based on risk assessment would be a realistic approach. Several CNs indicated that when patients were well, community visits seemed unnecessary and inconvenienced them. An oncologist shared the view that screening patients could reduce the pressure on the CN service by targeting resources on those most likely to benefit. Another oncologist suggested that if referrals were risk- or need-based, there would need to be agreed criteria for referral.

“... if the district took over the funding of it there’d have to be an agreement that there was a quota, in terms of the number of patients ... and in your referral form you’d have to say, eligible in view of either toxic regiment [sic], disease-related risk factors, previous problems with chemo, or perhaps social isolation ... and then there could be a triage point.” (IndOnc3)

Participants expressed views on potential groups of patients who would particularly benefit from this intervention if it were to be implemented more broadly. Three cancer care staff shared a view that it would be beneficial to focus on patients such as those more likely to experience toxicity of treatment, social isolation, disease-related symptoms, and those with advanced disease or receiving chemotherapy for the first time.

Two oncologists reported that patients with curative intent could benefit particularly from the intervention suggesting they should be offered CN visits if this program were to continue, and it would be highly beneficial to this group for their long-term survival outcomes.

“... people who are having curative intent treatment that support is paramount, because if they have terrible symptoms, they’re not going to want to continue, and therefore it may compromise the curative rate. But, they will represent the best feeling patients, I would argue that in those people, it may provide the best outcome, the curative intent people are neglected ... you can’t refer

them to the community pal[liative] care people if they’re having curative chemotherapy... to me it would be an important group of people to provide extra support for.” (IndOnc2)

3.3.2. Needing Flexibility in Delivering the Model. HCPs suggested adopting a more flexible approach to maximize clinical benefits.

“You can really pick the ones who get a lot out of [the CN visits]... it would be a different study if the next round was just for people who needed it and when they needed it... because that’s when we really see the benefit of our presence there, when the patient really need us there.” (FGCN1)

Participants proposed several ways to implement a flexible approach to providing the intervention. For instance, CNs suggested replacing some face-to-face visits with a telephone call or adjusting the timing of visits to meet each patient’s specific needs. This would ensure continuity of care by enabling the same nurse to attend to each patient as needed.

An oncologist proposed an approach where patients receiving noncurative treatment are automatically referred, while those with curative intent are referred at the clinician’s discretion. In their view, patients themselves should also have the choice to opt in or out of CN involvement based on their perceived benefit.

Another oncologist suggested that the involvement of CNs could be on an as-needed basis, where the visits do not necessarily occur at the first cycle but are offered when patients have issues or require additional support. A different oncologist suggested offering patients a face-to-face visit at the start of treatment, followed by telephone follow-ups. In their view as an oncologist, if a patient manages well in the first cycle, they are unlikely to need the same level of support during subsequent cycles as, in most cases, treatment side effects will be similar except for difficult to avoid clinical events such as infection.

“Some people do surprisingly well with chemotherapy on the first round and then, they actually don’t need help the next round, because we expect it to be very similar and if they did develop the problem in subsequent cycles, it’s probably because they’ve got an infection ... and they need to come into hospital. Not so much the nursing support [is needed in this case].” (IndOnc04)

4. Discussion

Chemotherapy commonly causes side effects that typically require a two to four weeks recovery period at home before patients can receive the next dose in their treatment regime. Patients may feel challenged by having to cope with the treatment side effects without the presence of HCPs [25]. Unmet needs during cancer treatment are well documented [26, 27] and unplanned hospital utilization is prevalent

[7, 8], leading to high healthcare costs [28]. Given CNs have transferable skills in managing many of these side effects, such as pain and nausea, and providing emotional support in the context of other patient groups, such as palliative care [29], we conducted an RCT to examine clinical and economic effects of CN-delivered follow-up care between cycles of chemotherapy within a shared-care model. This study makes a valuable contribution to the existing literature by providing qualitative accounts from HCPs involved in the intervention regarding their experiences and the perceived feasibility of implementing the intervention. Their suggestions will assist with planning for optimum home-based chemotherapy support models for the future.

The CN participants reported that they reinforced patient education and supported patients in building their confidence to manage side effects. This finding is consistent with a qualitative exploration of participating patients' experiences [22]. Patients in this trial described feeling relieved at being supported by CNs and becoming more confident in self-care [22]. This suggests the potential transferability of CNs' clinical skills, commonly practiced within other noncancer patient groups [29–31], to the care of patients undergoing chemotherapy.

Participants suggested ways the intervention could be adapted to dynamic and diverse clinical contexts. One suggestion was having a more flexible model in terms of the timing, frequency and mode of CN follow-up care based on patients' needs and preferences, and clinicians' judgement of patients' health status. This was echoed by some patient participants in the current trial who stated that one CN visit would have been sufficient for them as they experienced minimal side effects and had adequate social support [22].

Given limited resources, participants noted the need to identify patients at higher risk for poorer health outcomes and increased healthcare utilization during cancer treatment. In this study, HCPs suggested prioritizing patients more likely to experience treatment toxicity, social isolation, disease-related symptoms, and those with advanced disease or receiving chemotherapy for the first time. Identified risk factors for unplanned hospital utilization during chemotherapy include hematological toxicity [7], pleural effusion [7], certain demographics (non-white ethnic background, lower education) [28], treatment modality (concurrent radiotherapy) [28], lower performance status [8], advanced cancer stage [8], and certain cancer types (upper gastrointestinal, colorectal, gynecological, breast cancers [32], leukemia, and lymphoma [9]). The presence of any of these factors can guide the development of a patient's risk profile, facilitating targeted triage.

Access to virtual healthcare evolved rapidly during the COVID-19 pandemic and is now discussed as a potentially equivalent or in some circumstances, even more clinically effective mode of care delivery compared to in-person care [33]. Some participants suggested using blended delivery for implementing the current intervention. Blended delivery could involve remote assessment, provision of clinical advice, and monitoring of low-risk patients, as well as triage for possible in-person care based on clinical urgency of each patient [34]. To implement such a model, evidence-based

risk assessment protocols should be developed to accurately estimate the severity of each patient's condition and ensure provision of equitable care [35].

Some participants suggested including in-person training of CNs, in addition to the existing self-paced online modules. This would not only provide hands-on learning opportunities [36], but build relationships with cancer care staff. Fostering relationships between HCPs has been noted to be an important enabler for the successful delivery of a shared-care model [37–39]. Collaboration can be fostered through rapport building, mechanisms for efficient communication, training support, clinical knowledge sharing, and understanding each member's roles and responsibilities [37, 39]. The study participants also noted the importance of integrating shared eMRs to facilitate efficient communication. A qualitative study of primary care physicians and oncologists highlighted the importance of an integrated eMR in reducing unnecessary workload from e-mail clarifications and sending letters, and in improving real-time communication between primary care and oncologists [40]. Clinical and economic benefits of IT-supported shared care interventions in chronic disease have also been demonstrated [41].

4.1. Implications for Practice. Refining the risk assessment process based on patient acuity and supportive care needs is an important next step for implementing follow-up care during chemotherapy. Utilization of telehealth and face-to-face delivery needs to be considered and integrated into the risk assessment tool. Strategies for ongoing collaboration between cancer services and community services should be considered. These might include nursing case conference, clinical observership, and mentoring opportunities. Finally, the shared-care model needs to be supported by an integrated IT system. In Australia, the use of My Health Record, a web platform that allows sharing of health information with patients and clinicians, might be one way to facilitate information sharing across sectors and empower patients to be actively involved in their care.

4.2. Strengths of the Study. In view of the growing cancer population globally, the need for providing quality care beyond specialist cancer care settings is an important research agenda. Several studies have explored nurse-led models to support cancer patients within the community settings; however, the delivery was mostly restricted to cancer care nurses [42]. Our study contributes to the current literature by demonstrating the feasibility of expanding the scope of practice of generalist CNs to care for cancer patients.

4.3. Limitations of the Study. This study was conducted in two health districts in a metropolitan area, and as such, the application of the findings may have limited relevance for resource-limiting settings such as regional and remote settings.

5. Conclusion

From the perspectives of the HCPs, the delivery of support by CNs was considered a feasible approach for patients receiving chemotherapy as outpatients. It offered several benefits such as allowing for proactive management of side effects, emotional support, and education on symptom management. For this intervention to be implemented widely, it is important to identify which patient groups would benefit the most and explore flexible and practical delivery methods.

Data Availability

The qualitative data used to support the findings of this study have not been made available due to ethical approval requirements and the potential risk of re-identification of study participants.

Conflicts of Interest

The authors declare that there are no conflicts of interest regarding the publication of this paper.

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