

- Waiting times for treatment dramatically reduced due to the role having a sole focus on chemotherapy patients on the ward
- Chemotherapy prescribed and ordered one week in advance speeding up the delivery of cytotoxic drugs to the ward.
- New documentation was implemented by comparing 5 Oncology Centres nationally
- Good working relationships with multi-disciplinary team members developed

The desire to provide a seamless service is constantly being challenged by lack of resources and capacity issues. However, by collaborative working these changes had a huge impact on patient care by improving the quality of the inpatient chemotherapy service.

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POSTER

A large scale chemotherapy quality improvement project; initiating standardized treatment, administration and information in the hospitals in the region of the Comprehensive Cancer Centre Rotterdam

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The CCCR is a network organisation that provides advice and support to professionals in the field of oncology, such as medical specialists, general practitioners and nurses in the south-western part of the Netherlands. The region covers 17 hospitals. In 1998 the nursing network in this region identified differences in the chemotherapeutic drug administration protocols between the hospitals. From 1999 - 2002 a chemotherapy quality improvement project was performed in the region in order to optimise this treatment modality. The quality improvement project consisted of five steps: implementing the Common Toxicity Criteria (CTC) checklist in order to score the treatment toxicity, initiating and coordinating the process of medical consensus to obtain regional standardized treatment guidelines for chemotherapy in solid tumours, developing standard chemotherapy administration forms based on multidisciplinary consensus, developing patient and GP information on chemotherapy in the nursing network of the National Association of Comprehensive Cancer Centres and finally providing the standard chemotherapy administration forms with an electronic application for dose calculation. All steps were performed subsequently and were evaluated on implementation success.

The use of the CTC checklist was not mandatory but proved to be helpful to obtain data in trial patients. It was used in 11 hospitals. Chemotherapy treatment guidelines for colon, breast, SCLC, NSCLC and ovarian cancer were established. The compliance to these treatment guidelines was audited in breast cancer adjuvant chemotherapy patients and was excellent with a Relative Dose Intensity less than 85% in only 7/159 patients. All hospitals complied with the standard chemotherapy administration forms, which now all have the same content. All hospitals used the developed patient information, either as an implementation project or by checking and updating their initial patient information. Finally, the standard chemotherapy administration forms were placed on the Internet together with the calculation formulas and an instruction brochure on how to insert the formulas in administration forms. A helpdesk was established. An agreement regarding the maintenance and updating of the treatment guidelines and the standard chemotherapy administration forms finalized the project. The CCCR will continue to provide the hospitals with the CTC checklists.

This quality improvement project demonstrates that a large scale project can run successfully in a network setting when innovations can be adjusted to the individual hospital standards.

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POSTER

Cancer nurse coordinator: the introduction, development and impact of a new oncology nurse specialist role in Ireland

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Introduction: In the Irish Health Strategy Shaping a Healthier Future (1996), cancer was identified as one of three major sources of premature mortality. The effect of cancer on health status in Ireland is striking; cancer accounts for one third of all deaths in those aged under 65. Certain trends were highlighted in the Health strategy which caused concern: the mortality rate from cancer was higher than the EU average.

Following on from the Health Strategy a National Cancer Strategy was published (1996). Its two main objectives are:

1. To take all measures possible to reduce rates of illness and deaths from cancer in line with the targets of the Health Strategy, and

2. To ensure that those who develop cancer receive the most effective care and treatment so that their quality of life is enhanced to the greatest extent possible.

Background: Treatment services for cancer in Ireland compared very well with standards in other countries. However, the organisation and delivery of services needed to be changed, to improve coordination and communication. Services also needed to be distributed more evenly around the country. The Cancer Nurse Coordinator Role was created to help fulfill the objectives of the National Cancer Strategy. In 1999, 24 posts were piloted in the capital city and the posts were evaluated by the government in 2002.

The role was designed to address the particular issues facing those diagnosed with cancer in Ireland eg. the need to be referred from hospital of diagnosis to another hospital for treatment, travelling long distances for treatment, or having to wait for treatment. The objectives of the role included provision of information and support for patients and families from diagnosis onwards, and being a constant contact for them along the cancer continuum.

Apart from the core concepts of the role, described above, the role has developed very differently in each hospital. Variables such as the individual nurses and the services already existing in each hospital have shaped role development.

Conclusion: This was a brand new nursing role in Ireland. It has been positively evaluated and has been recommended for roll out to other parts of the country. The introduction of the role was timely, addressing the particular problems in caring for patients in the Irish system whilst services were being developed.

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POSTER

Education in groups - the path for improved clinical practise? - a comparative study on benefits from preparatory education in radiation therapy measured before and after modified educational procedure.

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Background: Every year 250 new patients with cancer of the head and neck are admitted to our clinic. Two years ago all patients and their relatives received their preparatory education in relation to their first visit. Nurses and doctors found that there was too much information for the families to relate to in a short period of time. They decided to modify the preparatory education so that the individual case was taken care of at the first visit, and the general information was given in groups of 10 to 12 patients and the same amount of relatives. The purpose of the study is to show if there is any difference in the benefit for patients and their relatives due to the two educational procedures.

Material and methods: 103 persons completed a questionnaire with 40 standardized questions. The measurements were made in three groups; before the modification of procedure, just after and after one year using the group procedure. This last measurement was made in order to show if the experience in using group education had any impact on the benefits. Criteria of success was set in order to make this measurement possible.

Results: All answers from the questionnaires were put into tables by a key punch operator. The tables showed that group education provided an improved overall benefit. In some topics such as smoking, care of the skin, mouth and teeth the differences in benefits are statistically significant.

Conclusions: If we take these results into consideration, new perspectives opens for our daily clinical practise in our outpatient clinic. Is it likely to expect the same outcome for patients who are facing chemotherapy?

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POSTER

Nurse-led peripheral inserted central catheter (PICC) program: an audit of the St James's experience

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The Nurse-led PICC line insertion program for Haematology/Oncology patients in St James's Hospital was established in January 2002. As with all new developments, close monitoring and appraisal of its merits are a necessity. Therefore we reviewed all procedures carried out in the initial 6 months; in addition we compared this with the established X-ray department directed PICC line insertion program. 141 procedures were assessed during the study period - 46 nurse inserted and 95 X-ray inserted catheters. There was an overall complication rate of 34.7% found in the nurse inserted PICC lines, comparable to a rate of the 51.5% in the X-ray department