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POSTER

Where does the process of nursing in an oncology out patient clinic begin?

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Introduction: Nursing consists in a sequence of moments and phases: tests, diagnosis, aims, intervention and valuation.

In order to help patients the nursing staff has deemed it necessary to have a personal contact and dialogue with the patients and/or relatives in a serene and calm setting, before starting chemotherapy treatment.

Patients and methods: The dialogue takes places in the out patients clinic, where a nurse receive the patients and/or relatives, gives them the explanatory leaflet and explain the collateral effects of the therapy and then compiles the informative nursing form. At this point the nursing process begins and increase the professional relationship between nurse and patient.

Objectives: To reassure patients by guaranteeing a continuous assistance. Introducing patients to nursing personnel and to make patient familiar with the out patients clinic and its time-table and regulations.

Results: Reduction of anxiety and stress in patients before starting the treatment, improvement of relationships between physicians and nurses and greater responsibility and satisfaction for the nurses in their daily routine.

Conclusion: Due to the human relationship which is created during the dialogue, patients understand that we are there to help them through this difficult course of their illness and the increase their compliance to the treatment and their quality of life.

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POSTER

Supporting nurses to break bad news

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Introduction: Breaking bad news in an oncology setting is only too common. It is perhaps one of the most difficult tasks faced by health care professionals, including nurses. Given the potential impact of breaking bad news, it is important that nurses are given the education, training and support to develop the skills to break bad news effectively. Literature suggests that nurses get 'burnt out' and then leave the profession as a consequence

Method: We are a large regional unit, with a 32 bedded ward offering chemotherapy, radiotherapy, and palliative care to a range of patients. The unit employs over 30 qualified nurses of varied experience. A confidential questionnaire has been developed, using a methodological approach, to gain knowledge and insight into the nurse's views of breaking bad news.

Results: The results hope to find out whether the nurses have any formal training on the subject, breaking bad news. It also hopes to ascertain whether nurses feel the need to have any training in this area, and whether they think it will benefit them at the work-place, and how. The preliminary results have shown that there is no formal training in place, with little formal support

Conclusion: Nurses will be offered support in the form of debriefing sessions, clinical supervision, and reflection using fellow colleagues such as the chaplain. Formal training will also be introduced for nurses on the ward about effective ways to break bad news, & evidence based practice for offering support.

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POSTER

Advanced course for nurses as the first step towards quality improvement of vascular access port management

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Implanted vascular access port (VAP) improves the quality of life of cancer patients treated with long-term or frequent intravenous drug applications, and facilitates the work of the nurses administering the drug by VAP. On the other hand, the implantation of VAP is certainly not sensible if health professionals are not experienced in handling it.

Due to a steadily increasing number of patients with VAP, who are treated at the institutions other than the Institute of Oncology Ljubljana, the need has arisen for special training of nurses working at these institutions (hospitals, primary health services, district nurses) as well as for nurses from our Institute. At the Division for Nursing at the Institute of Oncology Ljubljana, we responded to that felt need and decided to organize advanced training in management of standard VAP interventions intended for the registered nurses and health technicians who care for patients with VAP. So far, three advanced courses have been held. They were intended for

registered nurses and health technicians, working at other institutions, as well as for nursing trainees and novices to oncology nursing at our Institute. The course was organized in two sets of sessions. In the first, nurses and physicians from the Institute of Oncology, who routinely perform the standard interventions related to the care of patients with VAP, presented their theoretical knowledge of VAP management, and in the second set of sessions, these knowledge was enhanced in workshops. In the theoretical set of sessions, the speakers presented the following topics: indications for VAP insertion, technical characteristics of VAP, surgical technique of VAP insertion and possible complications, infection prevention, technical procedures and appliances required in standard VAP management, noncoring needle placement and therapy administration, patency maintenance with a heparin flush solution, and collection of blood samples. In workshops that followed the theory sessions the participants carried out themselves the most frequent standard procedures related to VAP management (noncoring needle placement, collection of blood samples, flushing with a heparin flush solution and needle removal).

After each course, the knowledge of participants on VAP management acquired during the course and their satisfaction with the course, were evaluated using questionnaires. On the basis of the identified deficiencies in the knowledge of the participants and in the organization, we made appropriate changes. In each subsequent course, the quality of the training was thus improved, thereby also the satisfaction of the participants. The aim of the poster presentation is to present the advanced course and its goals, the quality of the newly acquired knowledge of participants, and the evaluation of the course by 92 participants who so far attended our courses.

Poster session**Guidelines and tools for practice**

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POSTER

Interdisciplinary approach to implementation of a new treatment strategy

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In the autumn of 2004, the Dept. of Oncology, Herlev Hospital, introduced Hepatic Arterial Infusion (HAI) of a cytostatic drug, as the first Department in Denmark.

There are approximately 3500 new cases of Colorectal Cancer (CRC) in Denmark a year. Approximately 1/10 of these patients develop inoperable liver metastases. If these can be operable, liver surgery will potentially have a curative aim, making treatment with HAI relevant.

Method:

- Review of available literature
- Interdisciplinary visit to Germany for the purpose of gathering knowledge and experience in care and treatment as well as HAI catheter insertion
- Selection of HAI catheter and infusion pumps
- Preparation of checklists for preoperative, intraoperative and postoperative HAI catheter insertion as well as observation schedule and nursing
- Interdisciplinary teaching
- Preparation of written information material for patients and staff
- Preparation of interdisciplinary logistics plan for the patient – from the time of initial examination to initiation of treatment
- A radiologist from Germany supervised the first catheter insertion

Results: The material, knowledge and experience that have been gathered in the past six months has been successfully used by the interdisciplinary team to establish well-functioning treatment procedures, but adjustments are still being made as more experience being gained with HAI treatment.

Conclusion: By adopting an interdisciplinary approach when the new treatment were initiated, we experienced greater commitment, a greater degree of knowledge sharing and greater confidence in the provision of nursing care and in providing a new complex treatment.

Future perspective: The experience that we have gained in connection with the initiation of HAI has showed how important it is that all relevant members of staff are involved from the start and that they are influencing the process. We are of the opinion that this approach represents the future.

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POSTER

Development and evaluation of a clinical pathway for pain control

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Pain is an important problem in hospitalized patients and only 40–50% of patients are adequately treated for their pain.

The aim of this project was to evaluate the prevalence of pain among hospitalized patients; to increase perception of the professional caregivers for pain and to decrease the prevalence of pain by a standardized evaluation and treatment approach.

In the departments of oncology and pneumology, the nurses were trained to measure pain with a visual analogue scale (VAS); then a clinical pathway to treat pain was introduced and the physicians and nurses of the departments were given an information session on pain and pain treatment. Pain was evaluated before and after the introduction of the clinical pathway for 3 weeks.

Pain was absent (VAS = 0) in 48% and 60%; low (VAS 1-3) in 33% and 14%; mild (VAS 4-7) in 17% and 19% and severe (VAS 8-10) in 1% and 7% of 60 oncological and 43 non-oncological patients, respectively. After the intervention pain was absent in 56% and 63%; low in 18% and 16%; mild in 17% and 19%; and 9% and 2% in 48 oncological and 43 non-oncological patients, respectively.

Oncological patients experienced significant less pain than non-oncological patients, while 26% of these last patients had mild or severe pain. The intervention seemed not to result in a decrease of the pain scores. When the nurses (n = 21) were asked, they agreed that the VAS was an easy way to measure pain but 33% experienced problems to explain it to the patients. 95% of the nurses said that the physicians did not take the VAS score in consideration for adaptation of pain treatment.

Pain is an important problem oncological and non-oncological patients. VAS is an easy method to evaluate pain and should be integrated into the patient file. Physicians and nurses should be even more sensitized to the problem of pain.

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POSTER

Mammosite brachytherapy: our experience at Saint Vincent's Cancer Center

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Introduction: Currently standard radiation treatment for breast cancer is external beam RT. In 2002 the FDA approved an alternative to external beam RT called the Mammosite. This form of intracavitary brachytherapy offers patients with stage I and stage II breast cancer a different choice of therapy with same potential curative benefit of external beam radiation.

External Beam vs. Mammosite: While prescription dosage amount appears different, the two doses are biologically equivalent. Both treatment modalities are potentially equal in benefit. Mammosite has a shorter treatment duration of one week compared to 6 weeks of external beam.

Methods: From May 2002 to June 2003, 32 patients with Stage I or II disease were treated on an in house phase II study protocol using the Mammosite to deliver intracavitary brachytherapy. Mammosite partial breast irradiation is an invasive procedure which delivers a total of 34 Gy in 10 fractions. The Mammosite balloon catheter is placed by a surgeon approximately three days prior to the start of RT. The balloon is filled with contrast and a CT scan is done to ensure good dose conformance in the breast cavity. Iridium-192 is the radiation source for brachytherapy.

Results: Side effects were similar to external beam RT with the exception of infection. Side effects included mild to moderate erythema of the skin, dry or moist desquamation of skin, mild edema of the breast, infection and fatigue usually 1 to 12 wks post treatment. The majority of patients experienced mild acute skin reactions secondary treatment. Localized skin reactions occurred in the area overlying the Mammosite. The infection rate (16%) was higher than interstitial brachytherapy noted in prior studies. Cosmesis was good or excellent in over 80% of cases treated.

Nursing Care: Mammosite dressing change when drainage is noted, cleansing of surgical site with betadine and applying bacitracin to the catheter insertion site was done to reduce infection risk. Nursing care evolved as we became more familiar with the procedure. As more cases were done reemphasis on sterile technique, infection control, education of catheter and incision care with medical staff has greatly reduced the infection rate. Patient education includes teaching patients skin care and reporting reactions for effective treatment to be given for resolution.

Conclusion: Intracavitary brachytherapy with the Mammosite system has been shown to be an alternative to conventional whole breast radiation therapy for patients with Stage I or Stage II breast cancer. Nursing Care is instrumental in reducing infection risk and management of skin toxicities. Follow-up with these patients is ongoing to determine the long-term effects of this method. With the advantages of less side effects than whole breast radiation and a shorter duration of treatment, it is a viable option and is the therapy of the future.

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POSTER

Development of a nurse led e-mail cancer enquiry service

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CancerBACUP is the UK's leading cancer information charity. It provides information and advice to people affected by cancer through booklets, factsheets, walk-in cancer information centres, a freephone telephone helpline answered by specialist cancer nurses and an extensive website. To increase choice for enquirers in ways they can seek information and advice, CancerBACUP provides an e-mail response service via its website. Enquirers to the e-mail service range in age from teenagers to people in their seventies and include people with cancer, their friends and relatives as well as health professionals and those with cancer worries.

Enquiries cover requests for information about; different cancers, conventional and alternative treatments, access to specialist centres, financial and legal issues, symptom control, fertility and sexuality, prognosis, dying and bereavement, counselling and support.

In order to ensure the quality of the e-mail service, CancerBACUP nurses have developed a structure for answering e-mail enquiries. This includes setting targets for response times, having a policy for dealing with global enquiries, creating a standard information request form, triage, e-mail response skills training, and quality and audit tools.

CancerBACUP's website states that we aim to respond to most enquiries within two working days and 95% of e-mails are answered in this time. Limited resources mean we are unable to respond to e-mail enquiries outside the UK. Instead enquirers are signposted to local support organisations where these are available.

Nurses responding to e-mails have training in technical, assessment and writing skills. These skills highlight the distinction between written and oral communication as well as the differences between e-mail and letter formats. Audit is carried out regularly and measures the time taken to reply to each enquiry, the information content, language style, sensitivity and presentation of responses. Individual feedback is given to each nurse and training needs are identified as a result of audit findings.

Our e-mail enquiry service has developed to keep up with the needs and demands of our user groups and continues to expand. CancerBACUP has just launched a dedicated teenage cancer website and we are now answering e-mails from a previously under-represented group. Research is planned to assess the needs of this group.

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POSTER

Telephone follow-up for out clinic patients in IGR

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The telephone follow-up is a useful nursing tool used in IGR since 2001. This tool answers several needs: (1) legal: reinforcing information and education of patients. (2) quality: increasing quality and guaranteeing patients security. (3) economic: decreasing health costs.

Patients' objectives: Get patients' information health and give advises. Detecting patients complication risks, evaluate patients' needs and expectations of "best care given". Increasing patients' feelings of self security and well-being. Evaluating psycho-social needs and acting in accordance with these. Allowing patients to stay as long as possible with their family in the best condition possible

Material and method: Nurses follow a special training to insure quality of the information given and reliability. They built guidelines and decision trees regarding symptoms such as pain, nausea, vomiting, constipation, mucositis, diarrhoea, neurotoxicity and fatigue. In 2002, during a few months, nurses of IGR day care unit conducted a survey including 130 breast cancer patients and receiving chemotherapy. Two kinds of follow-up have been used: nursing systematic calls and patients or families calls. Nurses used guidelines and decision trees to answer questions and educate patients.

Results: Types and symptoms frequencies detected were: fatigue (70%), nausea (59%), constipation (34%), vomiting (22%) and diarrhoea (9%). Advises and recommendations were given for 60% of patients mainly regarding diet, use of antiemetics, planning of activities taking fatigue into account. When calls come from patients/families (7 to 10 per day) 50% of problems detected were fever, vomiting, fatigue, and constipation. Today, we may say that telephone follow-up is essential in our nursing practice. It increases the safety and well being of the patients, quality and continuity in nursing care and helps nurses to face patients' problems.