1684 POSTER

Using standardized nursing records in patients receiving hematopoyetic stem cell transplantation

A. Domènech, R. Benet, A. Ciurana, N. Borràs, M. Valverde. *Hospital Clinic, Institute of Hematology and Oncology, Hematology De, Barcelona, Spain*

Introduction: Patients undergoing hematopoyetic stem-cell transplantation (HSCT) require close monitoring throughout all the phases of the procedure: administration of the conditioning regimen, stem-cells infusion, and bone marrow depression period, which is marked by a great risk for developing complications. The accurate recording of all transplantation events is essential to ensure their appropriate management.
Aim: To describe the development of an easy to be used inpatient documentation record system that registers nursing processes and care delivered.
Material and method: A literature review was conducted. PubMed, DOCUMED and COCHRANE databases were consulted. Search words: HSCT, nursing documents and clinical guidelines. Based on this review, new registry and flow charts were prepared. This was followed by a pilot phase study in order to allow nursing staff to make suggestions aimed at enriching these documents.
Results: Transplantation events and nursing interventions were recorded and analyzed for consistency, the results being highly satisfactory. In addition, the degree of complicance was extremely high.
Conclusion: Using standardized recording forms facilitates the nursing care of patients submitted to HSCT.

1685 POSTER

Liverpool care pathway for the dying phase: implementation in the Netherlands by the Comprehensive Cancer Centre Rotterdam

E.M. Van den Aardweg[1], P.M. Geurts[2], S. Swart[3], C.M.P. van Zuylen[3]. *[1]Comprehensive Cancer Centre Rotterdam, Palliative Care, Rotterdam, The Netherlands; [2]Nursing Home Antonius IJsselmonde, Rotterdam, The Netherlands; [3]Erasmus MC Daniel den Hoed Cancer Centre, Rotterdam, The Netherlands*

Background: At the beginning of 2003 the research-project 'Care and quality of life in the dying phase' started in the region of the Comprehensive Cancer Centre Rotterdam. Part of this project is the implementation of the Dutch version of the Liverpool Care Pathway for the Dying Phase (LCP). We evaluated the role of the regional and local co-ordinators in the implementation process.
Method: Following the general implementation method of the Comprehensive Cancer Centre the implementation process is supervised by a regional steering committee (RSC) in which a regional co-ordinator (RC) participates. In the participating organisations a local co-ordinator (LC) is part of a local steering committee (LSC) that guides the local process. Local implementation plans were formulated and professionals involved were informed and instructed. The LSC discusses local problems on a regular base with the RC. If necessary the RSC is called in by the RC. The RC organises 3-monthly meetings during which LCs are educated and experiences are exchanged. A periodic newsletter informs all professionals involved.
Discussion: The RC co-ordinated the implementation of the Dutch LCP in eight organisations. The LCs felt supported and facilitated by the input from the RC. During the implementation process it became clear that LCs not only have a crucial function but also have a vulnerable position. Crucial because of the essential link with RC, nursing and medical staff. Vulnerable because of different or conflicting tasks, high workload and the one-man-position.
Conclusion: In this research project we demonstrated that the (general) implementation method developed and used by the Comprehensive Cancer Centre Rotterdam is a solid base for implementation of the Dutch LCP in local settings.

1686 POSTER

Training nurses to treat patients in the UK with oral chemotherapy: the capecitabine nurse toolkit

K. Harrold[1], O. Craven[2], K. Bennett[3], V. Aston[4], P. Gent[5], A. MacLeod[6], C. Vidall[7]. *[1]Mount Vernon Cancer Centre, Oncology, London, United Kingdom; [2]Christie Hospital, Oncology, Manchester, United Kingdom; [3]Addenbrookes NHS Trust, Oncology, Cambridge, United Kingdom; [4]Velindre Cancer Centre, Patient Information Centre, Cardiff, United Kingdom; [5]Grampian University Hospitals Trust, Aberdeen, United Kingdom; [6]Beatson Oncology Centre, Oncology, Glasgow, United Kingdom; [7]Royal Devon & Exeter NHS Foundation Trust, Oncology, Devon, United Kingdom*

Background: The oral fluoropyrimidine Capecitabine has proven efficacy and tolerability in the treatment of metastatic colorectal cancer (CRC) and breast cancer (BC). In addition, in early-stage colon cancer adjuvant Capecitabine is at least equivalent to 5-FU/LV in terms of disease-free survival (DFS), with trends toward superior DFS, relapse-free survival and overall survival. Home-based therapy with oral Capecitabine has a number of advantages over i.v. hospital-based regimens, including improvement in quality of life and medical resource/cost savings vs. 5-FU/LV. However, the demands of patient (pt) management for oral therapy differ significantly from those of i.v. chemotherapy.
Materials and Methods: An oncology nurse-training programme was initiated in the UK. In collaboration with the Capecitabine National Nursing Advisory Board, Roche Products Ltd produced a Capecitabine nurse toolkit, which was distributed at a UK nursing meeting held in London in April 2005. The toolkit is also being distributed to local oncology centres across the UK.
Results: The toolkit contains the following: key contacts details for the teaching faculty and representatives from Roche Products Ltd; case studies on CRC and BC designed to provide example background information, treatment decisions and outcomes; a clinical management plan for pts receiving Capecitabine (covering dosing, side-effect management, pt education and advice on working in a healthcare team); examples of protocols developed for a Capecitabine clinic; a guide to the pathway for pts receiving Capecitabine as a single agent, in combination with i.v. chemotherapy and synchronous radiotherapy; a guide to the establishment of a clinic to treat pts receiving Capecitabine for CRC in the palliative or adjuvant setting; a protocol providing guidance and the agreed management of pts receiving Capecitabine as adjuvant therapy for Dukes' B or C CRC (for whom the treatment pathway is potentially curative); a pt management competency framework (providing a single, consistent, comprehensive and explicit framework on which to base review and development for staff working in a chemotherapy unit and giving care to pts receiving oral chemotherapy); a workmat forming part of the Capecitabine clinic workshop; a nurse training questionnaire designed to test nurses' knowledge of Capecitabine.
Conclusions: With the increasing use of oral Capecitabine there is a need to enhance pt education skills, communication and management. The Capecitabine nursing toolkit is a vital tool for training oncology nurses to play a more significant and pivotal role in the clinical oncology team to ensure the effective management of pts receiving oral chemotherapy.

1687 POSTER

Providing advice for structured care of radiation induced diarrhoea in rectal cancer patients

K. Titmarsh. *Royal Surrey County Hospital, Clinical Trials Unit, St. Luke's Cancer Centre, Guildford, United Kingdom*

Background: The aim of this review was to consider the evidence base for supportive therapy in patients treated with external beam radiation for rectal cancer. Radiation induced diarrhoea is a common acute toxicity in this group of patients and can have a detrimental effect on their quality of life.
Method: A literature survey was undertaken to explore the evidence that is currently available to health care practitioners involved in the care of patients with rectal cancer. Pubmed, CINAHL and the Cochrane databases were searched using the following terms: "diarrhoea", "radiotherapy", "rectal cancer". The search was limited to publications between 1994 -2004 to find out how patients with rectal cancer had been managed in recent years.
Results: A total of eighteen articles were found from the Pubmed and CINAHL search. Most studies of radiation induced diarrhoea have focussed on patients treated for gyneacological or prostate malignancies. Supportive care has mainly included dietary advice and pharmacological interventions. Agents that have been used to reduce treatment related diarrhoea include sucralfate and octreotide. However few studies have focussed on the efficacy of these agents in patients with rectal cancer and even fewer have considered radiation induced diarrhoea.

Conclusion: Loperamide hydrochloride remains the first line therapy for management of radiation induced diarrhoea although further research is required to investigate the efficacy of the other agents. Whilst dietary advice is an important part of the management process, it is evident that further research is necessary in this area to provide the evidence base for the advice that is generally given to patients receiving radiotherapy. Structured care is considered to be more effective in the management of symptoms and accurate assessment forms a key part of symptom management.

1688 POSTER

Treatment of oral mucositis for head and neck cancer patients

A. Lartey. *Bristol Oncology & Haematology Centre, Bristol, United Kingdom*

Introduction: Head and neck cancer patients are being treated more successfully with combined methods including radiotherapy in combination with chemotherapy, surgery, or both (Shaha et al 2001). Radiotherapy does remain the primary method of treatment. The irradiated field often includes the salivary glands and all or a large portion of the oral mucosa, thereby increasing the risk of oral mucositis. Oral mucositis is an inflammatory reaction resulting in ulcerative lesions of the mouth and or pharynx. Morbidities include oral pain, local and systemic infections, insufficient nutritional weight loss, taste changes and xerostomia (Shih 2003).
Methods: The high prevalence of oral mucositis in patients with head and neck cancer makes it important for cancer nurses to understand the mechanisms and manifestations of the problem so they can perform more comprehensive assessments. Bristol oncology centre is the regional unit for head and neck cancers, offering a combination treatment approach. A high percentage of patients are admitted to the inpatient ward with severe oral mucositis. There are no multidisciplinary clinical guidelines, in place as to how assess to or treat mucositis for this group of patients. A retrospective audit is being conducted of both medical and nursing notes. The aim is to identify:
– Assessment on admission
– Daily assessment
– Pain Control
– Prevention of infection
– Patient education
– Documentation
Results: The interim results have shown that there is no formal assessment tool in place, and assessment is subjective rather than objective. Pharmalogical management is used, but once again there are no formal guidelines in place. Nursing documentation was very poor, with little reference to mucositis in daily reviews and evaluation of patients.
Conclusions: In today's climate practice should be evidenced based, and multidisciplinary guidelines will be developed in response to the audit. A formal assessment tool will be developed, with guidelines in place about pharmacological, pain and infection management. Teaching sessions and packs will be developed on patient education and documentation.

References

[1] Haha AR et al. Head and Neck cancer. In Lenhard RE JR, Osteen RT, Gansler T eds. *The American Cancer Society's Clinical Oncology*. Atlanta, GA: American Cancer Society: 2001: 297–329.
[2] Shih. A et al (2003) Mechanisms for Radiation-induced Oral Mucositis and the Consequences. Cancer Nurse, 26(3) pp. 222–229.

1689 POSTER

A consultant nurse's experiences of the nurse's role in the administration of oral capecitabine treatment and control of adverse effects

H. Natunen. *Helsinki University Central Hospital, Department of Oncology, Helsinki, Finland*

As the number of oral treatments at the Helsinki University Central Hospital, Department of Oncology is increasing, these patients' need for guidance, support and contact during treatment has been recognised. In connection with oral treatment, the patients' regular contact with a chemo nurse decreases, but the need for information and support increases as the patients administer the therapy themselves. Symptomatic treatment of adverse effects (AE's) is not enough, and the management of chemotherapy (treatment pauses and dose adjustments) also plays an important role.
The Department started an outpatient clinic for patients receiving oral chemotherapy, where a full-time nurse with dedicated training focuses on patient guidance and follow-up. The nurse works in cooperation with the oncologist, and the contacts with the patient have been scheduled in a treatment plan made by the doctor. For example, during eight cycles there can be three doctor and eight nurse scheduled check-up's (reception, call and/or laboratory results check). The aim is to maximise the patients' quality of life and control over their lives, to ensure the success of treatment according to the plan with minimal AE's, and to reduce the incidence of adverse reactions. The methods used are pretreatment counselling, monitoring of treatment success and the patient's condition during treatment, and the nurse's availability in all queries or problems.
In my experience, patients who received thorough, appropriate pre-treatment counselling are motivated/compliant and administer treatments according to the treatment plan. If necessary, they are able to prevent and treat AE's and pause their chemotherapy independently. The existence and availability of a consultant nurse has made the patients feel secure and improved the likelihood of the treatment being administered appropriately. The fact that the patient has sufficient information about the course of treatment and a low threshold for contacting the nurse has allowed efficient intervention in toxicities, and also prevention of AE's through early timing of treatment pauses and dose adjustments.
The centralised treatment management has enabled me to gain a wide range of knowledge. Having extensive experience and training on capecitabine treatment, I am able to ensure the patients' appropriate, consistent counselling, advice during treatment and an early intervention in problematic or rare situations, as well as, the training of health care staff.

1690 POSTER

The nurse discussing self-care in breast cancer treatment

T.C. Camargo[1], M.I.R. Moita[2], M.C.R.G. Caldas[3]. [1]*National Cancer Institute, Continuing Education, Rio de Janeiro, Brazil;* [2]*National Cancer Institute, Outpatient Wards, Rio de Janeiro, Brazil;* [3]*National Cancer Institute, Nursing Division, Rio de Janeiro, Brazil*

Self-care consists in the performance on the part of the individual of activities aiming at preserving life, health, and well-being. When there is any hindrance or restriction to the attainment of self-care, there is said to exist a deficit, which points to the need for action on the part of the nurse. When dealing with women who have undergone radical breast surgery with axillary drainage at the Cancer Hospital [Hospital do Câncer III (HC III/INCA)] specializing in the treatment of breast cancer, those women, upon discharge from hospital, have been shown to need help for carrying out self-care of the surgical site and for facing the biopsychosocial effects of the surgery and of the disease. Thus, the performance of recently recommended self-care measures, which are complex and demand knowledge and development of special skills through training and experience, may overburden a person who is facing a disease both serious and disfiguring in its treatment. Resorting to some of the methods pinpointed by Orem which promote the performance of self-care: orientation and guidance; extension of physical and psychological support, and teaching; the nurses at the HC III have held operative group meetings for discharge from hospital with the women and their relatives, aiding in the development of skills for self-care, for rehabilitation, and for the improvement of life quality. In that sense, the purpose of this paper is to describe the nursing care rendered to the woman who is discharged from hospital after radical breast surgery with axillary drainage; to point out the possibilities for self-care as an effective therapeutic measure. With this report of the practical experience of caring for the woman subjected to radical breast surgery, with axillary drainage, we hope to contribute to amassing knowledge in breast cancer nursing; and to point out that the nurse does make a difference when preparing the woman for self-care, taking over the role of instructor and agent for therapeutic care.

1691 POSTER

Good practice in the manipulation of chemotherapy drugs

J. Moreira, L. Veloso. *Regional Oncology Center of Coimbra, Oncology Medicine, Coimbra, Portugal*

Background: The chemotherapy drugs have a high toxic potential. For that reason, the health professionals that manipulate these kinds of drugs, should take all the measures to avoid personal contamination in the preparation and administration stages.
The aim of this work is the following:
– to sensibilize the health professionals for the risks connected with the manipulation of chemotherapy drugs;
– to compare the different methods of preparation and administration of these kinds of drugs.
Resources and Methods: In the chemotherapy manipulation we should care about the protection, as a safety way for the health professionals, namely in what concerns the following aspects:
– individual protection equipment
– collective protection
When we manipulate the chemotherapy drugs we must use close punch systems with Luer-Lock connections and prolongers (connection system