

of concomitant chemotherapy were used on the 43rd and 64th day of treatment: at the same time, RT has been continuously applied until the 84th day of treatment. Systematic observation and interview were used for diagnosing oropharyngeal mucositis. Pain symptoms were rated on a Visual Numerical Scale (VNS). Nutrition was given either per os (liquid diet) or parenterally. Body weight was checked at least once weekly.

Results: All patients developed grade 3 and 2 grade 4 mucositis. All patients received analgesics or topical antiinflammatory drugs, local anesthetics and corticosteroids. Adequate alleviation of pain with opiates is often a prerequisite for the continued intake of nourishment. Loss of body weight (6–10 kg) occurred in all patients.

Conclusions: Oropharyngeal mucositis can be prevented with appropriate care since notable improvements in pain control and oral intake during the course of therapy are observed with aggressive clinical management. The treatment that provide subjective relief needs to be initiated at an early stage and the patient must follow the instructions. New preventive treatments are emerging which provide measures to improve the QoL during CT-RT.

Poster Session

Nursing education and staff development

8122

POSTER

Patient focus care – implementation and evaluation of a new care model

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Background: In times of strained health care economy, there is a need to consider reforming the traditional care organisation. Also, patients demand larger involvement in decision making and care planning. The structure of having traditional nurse stations in inpatient care creates distance to the patient and a busy work environment with constant interruption and telephones ringing. The nurse feels shattered and the risk of stress increases which may decrease care quality and work satisfaction. A new care model called "patient focused care" originally came from Detroit, USA and was adjusted to the Swedish health care system by a Swedish nurse [1]. The Division of Surgery and Oncology at a University Hospital moved to a new building which gave the possibility of a large scale implementation project of the new care model. The project aim is to implement the new care model and evaluate the possible impact it may have on patients' assessment of quality of care and staffs assessment of working environment and work satisfaction.

Methods: A project group consisting of nurses from all treating units was initiated to coordinate both the implementation and the evaluation phase. Baseline assessment with a questionnaire to staff, a questionnaire to patients and assessment of patient calls both at the ward and by telephone was conducted before implementation of the new care model consisting of the following parts:

- A care coordinator is responsible for all incoming telephone calls and assists the care givers with administrative tasks.
- The traditional large nurse stations are replaced by small nurse modules placed near the patient rooms.
- Several health care teams are formed which take the whole responsibility for a fewer number of patients.

Results: The project is now in the implementation phase. Extensive baseline assessment has been conducted and will be repeated after implementation. The anticipated effects are:

- Increased patient participation
- Increased satisfaction with work environment
- Increased quality of care
- Increased cooperation between health care professionals

Conclusion: The baseline and implementation phases have been successful. In time for the conference result regarding patients and care givers assessment of variables related to quality of care and work satisfaction before and after the implementation of the new care model will be available.

References

- [1] Inde M. Framtidens vårdmodell, Patientnärmre vård – hur gör man? Landstinget i Värmland, Karlstad 2006 (In Swedish).

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POSTER

The incidence of burnout syndrome and coping strategies for staff working in oncology and palliative care department

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Background: Occupational stress is a very actual concern for medical staff, affecting their health and well being. In Romania, too little attention is paid to this syndrome. The aim of this study was to:

1. evaluate the factors that cause stress in work;
2. evaluate the incidence of burnout syndrome in the Oncology-hematology in Tg. Mures;
3. design preventive plans and coping strategies in order to decrease the incidence of burnout syndrome.

Material and Methods: The subjects of this study were 14 doctors and 54 nurses, employed at the oncology-hematology department in Tg. Mures, Romania. All variables regarding stress were assessed using A. Pines and E. Arronson self-administered questionnaires with 21 questions regarding physical and psychological status. The incidence of stress factors was reported on a scale from 0 (never) to 7 (daily).

Results: Out of 54 nurses, 44 of them (81%) experienced emotional exhaustion and less personal achievement. The most frequent stress factors were: emotional and psychological over involvement (32%), lack of material satisfaction (25%), lack of staff (20%), the time period surrounding a patient's death (13%), and bad communication with the medical team members (10%). Out of 14 doctors, 12 of them (92%) experienced emotional exhaustion and depersonalization. Stress factors identified included lack of time (30%), lack of staff (29%), over involvement in patient's problems (23%), bureaucracy (10%) and bad communication with other medical staff (8%). In both groups, the coping strategies identified were: better communication and support groups for sharing problems, psychological counseling, more staff, a more flexible work schedule, motivation and continuing medical education.

Conclusions: This study proves that burnout syndrome is a reality in oncology and palliative care departments in Romania. It is very important and necessary to implement individual and group strategies to prevent and diagnose this syndrome, measures that will, in the end, be beneficial to our patients.

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POSTER

"DIC", a digital instruction for the safe handling of cytostatic drugs in the homecare setting

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Background: During the last two decades, numerous studies have pointed out that nurses and other healthcare professionals are exposed to antineoplastic drugs during daily activities. Based on the numerous studies that identified occupational exposure to antineoplastic drugs among healthcare professionals since the beginning of the 1990's, guidelines and regulations have been introduced in the Netherlands in 1992 with revision in 1997 on how to safely handle these hazardous drugs. This has lead to specific policies and clearly defined procedures for the hospital setting. However the risk for workers in home care is equal to that of hospital nurses. But since awareness of potential exposure is low, protective equipment is hardly used. And even if an employee is aware of the fact that he or she is working with a patient who has received chemotherapy, protocols and guidelines, especially for nursing or cleaning tasks are often not available. This may lead to high dermal exposure levels through contact of contaminated surfaces or through contact with patient excreta.

Purpose: The main aim of this project was to introduce guidelines and regulations in the home care setting to prevent all employees (from housekeeper to specialized oncology nurses) to experience negative health effects from exposure to these hazardous drugs.

Method: First the original hospital guidelines, policies and procedures were translated to the homecare setting. The procedures were identified with potential exposure to antineoplastic drugs: domestic tasks and patient care. Consequently the tasks were clearly defined in regard to