115 POSTER

The Blood Transfusion Committee necessary evil – or a major contribution to the patient's care

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From March 1999 the Department of Health (DoH) in the UK following a symposium held by Chief Medical Officers advised that all NHS trusts must ensure the provision of a Blood Transfusion Committee (BTC). Further to this the DoH decreed that all trusts where blood or blood products are transfused should by March 2000:

- have agreed and disseminated local protocols for blood transfusion-based on guidelines and best national practice, and supported by in-house training;
- have explored the feasibility of autologous blood transfusion and ensured where possible that patients are aware of this option;
- should consider the possibility of perioperative cell salvage.

At the Royal Marsden NHS Trust the BTC has been active for over 2 years – during this presentation the author will discuss the work of the BTC and its effects on the care of the patient with cancer.

In conclusion the author will demonstrate the positive benefits of the BTC in terms of therapy, training, risk management, communication with patients and a closer relationship with the local Blood transfusion service.

116 POSTER

Promoting clinical effectiveness in intravenous therapy

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Traditionally venous access in intravenous therapy has been a reactive process whereby the repeated use of peripheral cannulae can be a painful ordeal for the patient. Complications associated with peripheral venous access may cause delays and interruptions in treatment. In addition use of this means of venous access may limit the type, duration and frequency of intravenous therapies as well as the patients environment during infusion.

Current options in vascular access design encompasses a wealth of choice and has lead to confusion as to the most appropriate device for each individual patient. The use of individualized patient assessment and in-depth knowledge of therapy and device related factors can result in proactive device selection. This in turn enhances patient outcomes and can result in evidence based, clinically effective intravenous therapy.

117 POSTER

Autologous peripheral blood stem cell transplantation (PBSCT): "Patient booklet"

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Purpose: In 1994 we started a program of "multiple sequential high-dose chemotherapy" treatment, followed by PBSCT for lymphoma patients (pts) with unfavourable prognostic factors. Four different high-dose chemotherapy regimens are sequentially given over a 10 week-period. Treatments are given as inpatient or outpatient alternatively with pts being hospitalized for therapy administration, leukapheresis and final PBSCT-phase. In between, pts have to manage their aplasia-periods at home and take care of hematological controls at the outpatient clinic every other day. It was our hypothesis that a "patient booklet" could be of great help to pts undergoing such a demanding medical process.

Methods: Information gathered from clinical experience and literature review on PBSCT and nursing techniques are implemented with respect to pts medical history, local behaviours and available medical facilities.

A set of colours each one corresponding to one phase of this medical process was built on a diary basis (orange: hospitalisation, red: outpatient clinic, green: domiciliary preventive measures, blue: diet.)

Results and Conclusions: The "patient booklet" was very much appreciated by the medical community, pts and relatives as an educational tool. Pts seemed to be less anxious about treatment procedures and were able to recognize and prevent early complications. Pts medical planning was also facilitated with improvement of social and family life.

118 POSTER

The use of administrative tools in clinical trials to improve the quality and systemisation of data: The responsibility of the Research Nurse

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At present The Department of Oncology performs approx. 40 phase I, II and III clinical trials. These protocols are handled according to GCP, for which reason we have developed a system to secure the validity of data including various administrative tools. The phases in implementing an accepted protocol in the clinic include the following: 1) The research nurse (RN) meets the sponsor, investigator and coinvestigator to discuss details about the trial. 2) RN makes the forms for conducting the trial: a] Treatment and examination form describing the flow of the protocol; what to do and when, with the possibility to check when done in each cycle. b] Prescription forms used for registration of adverse events both generally and specific according to the protocol, blood samples necessary for prescription and other laboratory values as described in protocol, all leading to signed prescription on the form. c] Drug specific forms for handling nausea. d] Patient registration forms for easy access to patient numbers and eventually result of the randomisation. e] Administration and hydration forms to secure that the drugs are administered correctly and combined with proper hydration as specified in protocol. a], b], d] are required in all trials to obtain the necessary data. c], e] depends on special requirements of the protocols. 3) RN arranges a protocol committee consisting of the investigator, 1–2 nurses from each involved ward and the RN. The committee will go through the protocol and forms for final adjustments. 4] RN trains the staff from the involved wards in handling the trial and in the special features of the forms. 5] RN is responsible for maintaining the tools.

The above described administrative tools have been a major help in collecting trial required data. The system developed has been of special value in the systemisation and easy access to data, and has also helped preventing erroneously randomisation.

119 POSTER

An audit of 100 deaths at a regional cancer centre

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Purpose: At this centre there are approximately 400 deaths per annum. The Palliative Care Team (PCT) identified a need for baseline information on how deaths are managed at ward level. The aim of this audit was to assess problems encountered by patients, families and staff in order to determine ways to improve standards of care for patients and support for families and staff.

Methodology: A retrospective study of expected and unexpected deaths. Questionnaires were completed by the ward staff within 24 hours of the patient's death. 100 questionnaires were returned (May 1996–February 1997) = audit population of 38% of the total number of deaths in that time period. The questionnaire included: multi-professional team involvement; insight of patients and families; pharmacological symptom management; sources of distress for patients, carers and staff; why patients die at this cancer treatment centre.

Results: 54% of deaths had been anticipated for more than 48 hours. 61% had no provision for sedative or anti-secretory drugs. Staff distress was highlighted particularly in cases of rapid deterioration. The PCT were involved in 27% of cases, chaplaincy 30%. 72% of patients had family present, the likelihood of death had been discussed in 58% of cases.

Conclusions: A need for clinical practice guidelines and education to provide appropriate symptom management, to address communication issues with families and patients, to increase multi-professional team work and to encourage staff support. The poster will outline outcomes to date including cardio pulmonary resuscitation policy, care of the dying resource pack, educational and training events. A re-audit is scheduled for late 1999.