8 ORAL

Integrating in- and out-patient nursing services for breast cancer patients undergoing mastectomy and breast conserving surgery

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Research has demonstrated the feasibility of discharging patients between the 6th and 7th day following mastectomy or breast conserving surgery. Although this possibility can be advantageous to patients it comprimises the time needed to achieve all the goals of nursing care.

In order to provide comprehensive nursing care and continuity in the care process, our nursing department developed an integrated in-patient and out-patient nursing care service for breast cancer patients in this phase of their disease.

This novel approach is coordinated by the nurse manager from the in-patient nursing department. Nurses from the ward rotate through the new ambulatory breast clinic giving them the opportunity to broaden the scope of their practice. This expanded role includes patient support at initial diagnoses, more extensive pre-operative patient information and post-operative symptom management and wound care.

Continuity of care and documentation of the care delivered is the major goal of this approach. Nursing care goals are now set in the out-patient department following the initial nursing assessment. The nursing interventions can be carried out either during clinic visits prior to hospital admission or during the admission period. Documentation plays a vital role and a special patient file has been developed to reflect the steps of the care process. The patient is responsible for the file and presents it to the nurse during each visit.

Nurses who assess the patient in the clinic are often those who care for the patient on the nursing ward. This provides the opportunity to build solid relationships with patients giving nurses an integral role in the patient's treatment trajectory. This role promotes a greater sense of proffesionalism and job satisfaction.

The clinic is in its grassroots phase, but as our experience increases so will the possibilities for expansion to eventually provide the breast cancer patient with continuity of care beyond the borders of surgical treatment to include rehabilitation.

9 ORAL

Nurse's counselling role in cancer

Regina Ferrario. *Plastic Surgery, Palliative care, Istituto nazionale Tumori, Milano, Italy*

Cancer is a chronic illness: the patient has to live with the diagnosis for the rest of their life. Since the nurse is the person who spends most time with the patient ideally the nurse should evolve into a "nurse-counsellor". Counselling is a method used by one person to assist or enable another person to make important life-decisions and to give effective psychosociological support. The counsellor should be involved but must mantain their autonomy. The patients empowered by "counselling" to increase their strategies for coping with the illness. The "counselling" relationship should develop the potential of the patient to overcome both psychological and medical obstacles. In the beginning the "counsellor" will have to recognize and respect their own limits, seek help when they are unsure how to proceed, and be honest with themselves. The very fact that we have chosen to become "nurses" means we already posses the basic characteristics of the "counsellor" there are no fixed rules, it is important to establish a basis for interpersonal communication and set goals to be reached together. The root and inspiration of the Nurses practice is assistance: entering into relationship with another person, understanding the experience, sharing what the "counselling role" of the nurse is irreplacable 1) Who can the patient turn to for more information after the doctor has prescribed a highly toxic therapy with life-endangering risks? 2) What weight should the patient give to the nurse's opinion before accepting to participate in Clinical-Trials? 3) Who should they ask to support their decision to stop or change treatment? 4) What is the real definition of "the good of the patient" and what are the limits of their autonomy? 5) Who can the patient talk to about suicide or euthanasia? If the main intention is to improve the quality of life, the nurse will do all they can 1) Improve the patient's self-confidence 2) Improve the rapport with family and friends. 3) Educate the patient in prevention. 4) Create a strong sense of personal responsability. 5) Reassure the patient by their presence. We can conclude by underlining the fact that "counselling" increases the efficacy of the nurse's intervention. All this goes to show that: "counselling is impossibile where the Other is completely indifferent" (Bert & Quadrino, 1992)

10 ORAL

The use of a telephone triage (TT) for an out of hours service in transmural palliative care

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Purpose: In the Rotterdam Cancer Centre a 2-person hospital based home care team (HBHC) was set up, to support transmural care for patients discharged with technical equipment for symptom management. For these patients continuity of care is of utmost importance, making accessibility during 24 hours a day necessary. Nurses from the palliative care unit (PCU) offer this accessibility out of hours. The HBHC-team developed a telephone triage (TT) to guarantee a uniform approach in handling telephone calls. We evaluated the use of this TT.

Methods: The TT questionnaires used in 1997 were collected (N = 60). They were screened with the following questions: 1. who called for assistance? 2. what were the reasons to call? 3. what was the time investment of every call? 4. was it possible to solve the problems by phone?

Results: 52 patients were discharged with technical support; 60 calls for assistance were registered out of hours. The calls came from the patient (16), the family (28), the GP (9) and the DN (7). The reasons to call were categorised into five groups: pain (23), symptoms other than pain (9), technical problem (21), just information giving (4) and logistic problems (3). The duration of the telephone calls ranged between 2 and 50 min (median 10 min). The problem could not been solved by telephone in just 2 cases.

Conclusion: The use of our TT turned out to be an efficient instrument for the management of problems in complex palliative care. By using the TT the nurses were able to help patients, family and professionals in a quick and structured way, making home care even in complex situations feasible.

11 ORAL

The crisis of sudden death: An unmet need in cancer care?

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Death and dying are a fundamental part of cancer and palliative care. Particularly within the palliaitve care setting much work has been done to enable patients to have what is known as a 'good death'. The development of ideas of what constitutes a good death can be traced to pre history. A good death is enabled by hospitals, community care and the hospice movement. It involves palliative symptom control, enabling patients to end their lives in the place most appropriate to them and their families, and spiritual and psychological support for the patient and family. An increased awareness within health care professionals has ensured the provision of appropriate education and training to meet these needs. However, within the field of cancer it is important to be aware that this level of care and support is not always available. Technological advances in cancer treatment have meant that a significant number of patients will undergo intensive treatment regimes with associated mortality. For example, high doses of chemotherapy with associated neutropenia may cause the patient to develop sepsis and septic shock. Patients may die from infection associated organ failure which is rapid in onset and unexpected. Intensive therapies may also cause profound renal, cardiac and liver toxicities as well as coagulopathies and severe electrolyte disorders. In these cases the treatment given to remedy the malignancy may precipitate sudden death. Sudden death may also occur at the point of diagnosis particularly in the cases of leukaemia with a high presenting white cell count and lymphoma patients with rapidly growing aggresive tumours.

Shakespeare described death as 'shuffling off this mortal coil', in the case of sudden death it is a much more dramatic event. Sudden death is a crisis which requires active intervention for the patients family and loved ones. It is well recognized as one of the most traumatic events that can be experienced. Sudden death can be severely damaging and disabling to the bereaved.

This paper will review the literature from the acute care settings related to sudden death and will discuss the relevance and implementation of appropraite therapeutic strategies in cancer care.

12 POSTER

Representative information on side-effects of chemotherapy

A. Does-den Heijer. *Univer. Hospital., Oncology, Leiden, Netherlands*

Patients with chemotherapy get a lot of information. For the therapy it is of great importance this information is clear.

The psychological burden as a consequence of the disease and the minimal objectivity of the oral information given could be responsible for problems.

Therfore we have developed a written information system for the side-effects of chemotherapy. This system is mend to be as a support of the oral information given. The patient can read this information again on a later moment in time for instance in the homesituation. Other persons such as the general practitioner can also read this information if there are problems with the patient.

The system contains the following items:

* a general information page to explain the purpose of the information given and explains the purpose of the questionnaire.

* 14 pages contains specific information on side-effects of the chemotherapy and also guidelines how to handle these side-effects and when you must contact your physician. You can pick the specific pages for each patient with different treatments.

* the questionnaire contains a list of questions about the contents, value and benifit of the information given to the patient and their family.

With the results of the questionnaires we want to prove the value of this information system and hopefully raise the quality of information to a higher level.

We have started this program (N = 60) in December 1998 and it will end medio 1999. the first results were very promissing and we will give the final results and recommendations on the conference in September at ECCO 10

13 POSTER

The 'Chemo-Quiz', a creative way to learn

W. de Ruijter[1], C.M. Eeltink[2]. [1] *Netherlands Cancer Institute/Antoni van Leeuwenhoek hospital, Amsterdam;* [2] *Comprehensive Cancer Centre Amsterdam, Amsterdam, Netherlands*

Knowledge about chemotherapy is essential for nurses caring for patients undergoing this treatment option. The Comprehensive Cancer Centre's nursing network has developed a chemo-quiz to supplement the existing teaching methods. The purpose of this quiz is to educate nurses in a creative manner. It has been developed particularly for new oncology nurses who are just beginning their certification program.

The quiz consists of 174 questions and answers. On one side of the card there is a question and on the other side the corresponding answer. The questions address the following categories:

- general oncology
- clinical research
- common side effects of chemotherapy
- drug specific side effects
- safely handling of chemotherapy
- nursing considerations

The questions are derived from practical experience and the existing literature. A panel of experts has verified the content of the questions and answers.

During the presentation attention will be given to the content and structure of the quiz. In addition, our first experiences with this new teaching method will be evaluated.

14 POSTER

"Plastic surgery over-then what?" The development of a network to help patients cope with altered body image and self concept following surgery

Ann Burton, Tracey Cunningham, Theresa Plaiter. *Christie Hospital NHS Trust, Manchester, United Kingdom*

Purpose: To form a patient Network to assist in the coping methods and to offer support following disfiguring plastic surgery for malignant conditions such as melanomas and squamous cell carcinomas. It has been found that some patients have difficulties in coming to terms with their altered body image. This investigation highlights issues such as sexuality, body image and salt esteem.

Methods: In the light of literature end following statements from patients, any patients having disfiguring surgery are invited to loin the patient network. The main target is to develop a useful questionnaire. The patients are offered a referal to the Group of Psychological Medicine and the advice of a camouflage make-up specialist if appropriate.

Results: The effect of and response to this Network will be presented at ECCO 10 in September 1999. If it is found necessary, a longitudinal study may be done to gain further insight into this area of support and coping methods for a disfiguring treatment.

Conclusion: The conclusion will also be presented at ECCO 10 of the degree of support this Network provides.

15 POSTER

Trained professionals as a resourse in canser care and treatment. A co-operative model for professional development and continuity in the public health system

E. Kolsvik[1]. [1] *Norwegian Canser Society, Namsos, Norway*

Norwegian Canser Society has developed a model that promotes co-operation between the institutional and community health services in the districts of Mid-Norway. The main objective is to improve the continuity in the canser care and treatment that is given to patients and their families. The model focuses upon the following:

Establishing a net of trained health care professionals, doctors and nurses, from the institutional and community health services as a resource in canser care. It is vital to establish arenas for professional development where purposeful exchangement of knowledge and experience are central matters.

Co-operation meetings and courses are therefore to be held systematically for those professionals (courses based on the metod of problem based learning).

An information folder listing all these professionals in the district of Mid-Norway is avaliable both in hospitals and in the community health servises. The health care professionals in the community health services also have a one day visit with the Regional canser clinic ‰in the patient footsteps‰ as a part of the programme. The modell has a teoretical bases in sosial network and a basis in public reports in canser care and treatment. We have experienced that structrured collaboration contributes to bridge the gap between the intitutional and the community helath servises.

In one year this new collaboration model will be evaluated. The modell demands that someone take responsibility for the progress. It is therefore important that Norwegian Canser Society is a catalyst in this work until the model is established in the public health system.

16 POSTER

Community palliative care needs assessment

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The purpose of the study is to develop a needs assessment model for use in the community. Based on services in the UK, the principles, even if not the detail, should be of interest elsewhere.

Palliative care has its roots in the voluntary sector and has therefore developed on a fairly ad hoc basis. Palliative care is also beginning to be recognised as part of mainstream healthcare and as such needs to fit into the general healthcare planning models.

The palliative care phase of cancer patients is perhaps more predictable than for patients with other diseases. Nevertheless, palliative care is about the subjective quality of life of the individual, and therefore difficult to plan for on a larger scale.

This paper explores healthcare planning in general terms and describes a model which builds on needs assessment for identification of beds. It translates these into needs in the community from two perspectives: one based on a range of service provisions, and one based on problems from the patient and carers' perspective.

17 POSTER

Backbone for research nurses within the new drug development team: Improving efficiency and communication

A.W. van Wijk. *New Drug Development Office, Amsterdam, Netherlands*

Once a new anticancer compound has completed preclinical testing successfully, the next step in the research process may be testing the compound in man. The Sponsor who requires testing of the new compound in the clinical setting generally delegates the performance and management of clinical trials to an independent organisation, taking care of all aspects in supporting and instructing all parties involved for a correct and efficient trial execution at study site(s).

The research nurse in the institute is the responsible person for direct patient care such as: drug administration, check up of vital signs, reporting toxicity, organising pharmacokinetics and follow up. The New Drug Development Office (NDDO) in Amsterdam, responsible for the execution of clinical