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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 compromises 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 professionalism 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.

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ORAL

Nurse's counselling role in cancer

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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 maintain 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 possess 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 irreplaceable 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 responsibility. 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 impossible where the Other is completely indifferent" (Bert & Quadriño, 1992)

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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 be 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.

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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 palliative 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 aggressive 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 appropriate therapeutic strategies in cancer care.

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POSTER

Representative information on side-effects of chemotherapy

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