and proposals. However the tool alone isn't enough, it become an important tool only if included in a integrated project of improvement of care quality and of development of professional culture oriented to the nurse research and of the using evidence in the own professional practice.

**4223** POSTER

**Urinary Neopterin Concentrations at Screening Predict Serious Adverse Events in Cancer Patients Enrolled in Clinical Trials**

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**Background:** Clinical trials are essential for the progress of cancer therapy, but risk and benefit of experimental therapy should be carefully assessed in each individual patient. Biomarkers that would identify patients with high risk of adverse event are urgently needed for optimal patient management from the medical as well as nursing perspective. Neopterin, a product of activated macrophages, is a well-defined prognostic biomarker in cancer patients. In previous studies, increased neopterin was also associated with the toxicity of anticancer therapy. From a practical nursing perspective, determination of neopterin could be of advantage because measurement could be performed in urine, without the need for venepuncture.
**Material and Methods:** One-hundred and twenty-eight cancer patients screened for inclusion in clinical trials at a single site were studied. Neopterin/creatinine ratio was determined in morning urine samples obtained at the screening visit by high performance liquid chromatography. Differences were examined by Mann-Whitney test, and correlations were studied with Spearman's rank correlation coefficient. The decision on statistical significance was based on $p = 0.05$.
**Results:** A non-significant trend of higher neopterin concentrations was observed in patients who were excluded ($n = 16$) from enrollment (mean $\pm$ standard deviation $305 \pm 196$ vs. $232 \pm 152$ μmol/mol creatinine; $p = 0.12$). Urinary neopterin was significantly increased in 18 patients who subsequently had serious adverse event ($350 \pm 223$ vs. $210 \pm 124$ μmol/mol creatinine; $p = 0.003$). A significant correlation between neopterin and Karnofsky performance status was also noted ($r_s = -0.24$; $p = 0.008$).
**Conclusions:** Urinary neopterin correlates with perfomance status in cancer patients. Neopterin could represent a biomarker of risk of serious complications in clinical trials.

**4224** POSTER

**Development and Psychometric Validation of an Evaluation Instrument for a Breast Cancer Nursing Consult**

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**Background:** Nursing consultations are a new development in breast cancer care in Belgium. A breast cancer consult refers to the meetings in which support is given by the breast care nurse to the specific care demands of breast cancer patients. It is essential to assess patients' experiences and perspectives about this new care development. The aim of this study is to offer breast care nurses (BCN) a validated instrument to evaluate their breast cancer nursing consult.
**Method:** A literature review was performed to identify patients' expectations about nursing consultations and the desired support in relation to their needs. In addition, the data of four qualitative studies about breast cancer patients' experiences (45 semi-structured interviews with breast cancer patients and four focus group interviews with BCN) were reviewed in order to develop the evaluation instrument.
Face validity of the instrument was assessed by breast cancer patients, BCN and nurse specialists.
Psychometric validity (internal consistency, stability and construct validity) of the instrument will be evaluated amond a convenience sample of 80 breast cancer patients.
**Results:** A 71-item instrument was developed. Comprehensibility and phrasing of each question was assessed by eight breast cancer patients. Major revisions were performed and seven questions were added to the questionnaire. Questions were classified in nine themes, reflecting important aspects of nursing consultations and breast cancer care.
The relevance of each question was assessed by 15 BCN. Discussion raised about 32 items which had both high and low relevance-scores. Consensus was sought in two panel discussions with eight BCN. Seven questions were deleted and eight questions were reformulated. Another four questions were removed as BCN found them to overlap with other items in the questionnaire. Finally four new relevant items, as suggested by the BCN, were included. The final questionnaire consisted 71 items.
The subdivision of questions among nine themes was assessed by eight nurse specialists. The appropriateness of the classification was evaluated. Thirteen items, which were classified under two possible themes, were ranked under the theme with the highest mean score. Only one item with a low mean score was replaced after a second assessment of the nurse specialists.
**Conclusion:** This study is the first step in the validation of an evidence-informed instrument to evaluate breast cancer care of a nursing consultation. Validity of the instrument will be evaluated by 80 breast cancer patients between April 2011 and June 2011. The preliminary data, available in August 2011, will reveal an insight in the psychometric properties of this new evaluation instrument. At the same time, questionnaires are being disseminated to a larger sample of approximately 300 patients to increase the validity of this new developed instrument.

**4225** POSTER

**Establishing Safety Culture Between the Members of Healthcare Team**

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**Background:** Safety culture is a combination of values, approaches, perceptions, qualifications and behaviour patterns of individuals or groups that determine support, manner and ability for management of healthcare practice and safety issues. European Commission estimates that safety complications happen in 8 to 14% of hospitalizations in Europe. In 2010 Slovenian Ministry of Health issued a National quality and safety strategy in healthcare (2010–2015). The goal of the strategy is to achieve a total quality management and high safety of healthcare services through introduction of culture of continuous improvement and systematic connecting.
**Material and Methods:** Members of the multiprofessional healthcare team at the medical oncology unit at the Institute of Oncology Ljubljana decided to improve quality and safety in routine work processes with different approach. In previous practices our approaches to management of safety issues were unsystematic, mostly oriented in major complications, and were dealt within particular professional groups, and rarely in connection with other professional team members. The described approaches proved to be ineffective in safety management. With increased complexity of systemic cancer treatments, the need for connecting all professional groups involved in patient care, for cantered patient care, for evidence based care, and for continuous evaluation of routine work processes and introduction of change when necessary, aroused. We decided to place safety and quality of patient care as a priority of each team member, irrespective of position and profession. Vital importance to our new approach was systematic awareness and reporting of safety complications and its management.
**Results:** In 2011 we have started systematically performing safety meetings of all healthcare professionals and other personnel involved in patient care safety events. At the safety meeting we analyze the event, we discuss and agree on necessary measures and write a report. On this basis we introduce agreed safety measures and changes in patient care to prevent repetition of safety complications. We are very aware that we must collaborate and share information if we want to reduce safety complications and that every team member can contribute to safety of patient care. At this point we are still learning about open communication, analyzing and reporting of safety events without assigning the blame to individual team members, but rather to focus on system improvement. The poster will present a evalvation data of new management of safety events.
**Conclusions:** With until now performed safety meetings we managed to capture many deficiencies in our system of patient care, which would otherwise remain unsolved and concealed. Safety meetings definitely help improve patient safety but we still have a lot to learn on our journey toward improved safety culture.

**4226** POSTER

**Development and Area Adaptation of Flow Charts Related to Gynecologic Oncology Nursing Practices**

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**Aim:** This study is planned to be a one grouped semi-experimental research to develop and adapt the flow charts of the nursing practices applied to gynecologic oncology patients to the field.
**Methods:** The research was conducted between October 2008 and March 2009 in 6 hospitals in Istanbul (3 health ministry hospitals, 2 private