

2013 Oncology Nursing Society Annual Congress: Clinical/Evidence-Based Practice Abstracts

Each abstract has been indexed according to first author below.

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78965 (Poster)

PAIN, ODOR, DIGNITY, WOUNDS: MANAGEMENT OF A COMPLEX ONCOLOGY PATIENT WITH MULTIPLE WOUNDS. Marcy Turkos, BSN, RN, WCC, LLE, Princeton Medical Center, Plainsboro, New Jersey

Significance and Background: A 71 year old male presents to acute care facility with malodor and pain from open lesions associated with squamous cell carcinoma chanting he just wants to die. History reveals tumor invading tear duct and extensive history of multiple treatments of squamous cell carcinoma to upper torso, head, neck, and upper extremities with multiple open lesions including mouth sores. Patient reports pain of 10 on a scale of 1-10 and wound dressing changes upon admission took more than two hours.

Purpose: A clinical decision to initiate ALH wound care products to all areas was made. The mechanisms of action of ALH are in line with the goals to help to clear wound beds of debris, reduce pain, control odor, and reduce risk for further infection in the patient with extensive squamous cell carcinoma.

Interventions: ALH paste was applied to the oral area and topical ALH gel was applied diffusely to facial and trunk open lesions daily. ALH has been shown in multiple studies to facilitate debridement and cleansing, offer antimicrobial benefits, and is safe for oral ingestion.

Evaluation: By the third day of treatment the mouth sores were improving. All areas of debris were beginning to lift from face, orbit, and shoulder. Pain is improving but remained 8 of 10. Odor has significantly diminished. Patient's ability to tolerate PO intake improved as mouth sores resolved. By day 9 patient was tolerating activity and had pain score of 5. On day 12 improvements continue with daily dressing changes with ALH and no odor. On day 15 the time required for dressing changes has been reduced to only 30 minutes. Patient is in great spirits with pain score of only 3.

Discussion: Utilizing ALH has provided patient with pain and odor free dressing changes. Regardless of current medical treatment patients utilizing ALH have the ability to heal. Acting as patient advocate is easier when maintaining wound care knowledge of current products and practices and evidence-based products should be utilized at all times. Having the ability to keep a patient comfortable and improve quality of life are demonstrated in this unique case.

80633 (Poster)

THE KENNEDY HEALTH SYSTEM ONCOLOGY PATIENT NAVIGATION PROGRAM: A COLLABORATIVE ONCOLOGY CERTIFIED NURSE AND ONCOLOGY CERTIFIED SOCIAL WORKER PATIENT NAVIGATION TEAM MODEL.

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Significance and Background: As healthcare becomes more complex, the implementation of navigation programs, specifically oncology navigation programs, is fast becoming a mainstay in many healthcare organizations. The primary goal is to navigate oncology patients faced with increased medical, financial, and psychosocial issues, through the healthcare system. Currently, there are numerous and various models that include nurses, social workers, and/or lay persons but a standard navigator model does not exist with regard to role delineation, requirements and/or credentialing. With healthcare organizations focusing primarily on quality of care, meeting the needs of the patient and ultimately patient satisfaction, having an Oncology Patient Navigation Program that includes

a certified oncology nurse has not only become paramount but is highly recommended or required in accredited cancer care programs.

Purpose: The Kennedy Oncology Navigation Model includes an oncology certified nurse and an oncology certified social worker that work collaboratively as a patient navigation team. This model optimizes the care of the oncology patient, prevents gaps in the treatment planning/implementation process while demonstrating the benefits of an oncology nurse/social worker team that works collaboratively within their individual scopes of practice.

Interventions: The Kennedy Cancer program has been utilizing the Oncology Nurse/Oncology Social Worker Navigator Model since 2010. Each discipline was hired simultaneously to work together as a team to navigate patients from diagnosis to treatment. The benefit of having an oncology nurse and an oncology social worker is that they work within their individual scopes of practice but are able to care for the patient as a whole, addressing medical, psychosocial, and financial concerns positively affecting patient outcomes

Evaluation: The Kennedy Navigator Model has been extremely successful as evidenced by patient and physician satisfaction scores. The implementation of this team model has resulted in positive patient outcomes associated with treatment compliance, financial resolution, symptom experience, functional status and psychological distress.

Discussion: The primary implication in using the oncology nurse/social worker model in a collaborative team effort ensures that all facets of the patient experience i.e. quality of life, performance status, patient satisfaction, and financial need are not only identified but fully addressed utilizing resources throughout the continuum of care.

82158 (Poster)

CAUSES OF CHEMOTHERAPY INFUSION DELAYS: RESULTS OF A TIME STUDY AUDIT IN A COMMUNITY PRACTICE.

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Significance and Background: Chemotherapy administration is a complex process involving multiple steps. A delay in any step can interfere with patients receiving timely treatment. Decreasing patient wait time can improve efficiency, patient safety and satisfaction. There are limited published benchmarks available for comparison.

Purpose: The purpose of this time study was to determine reasons for treatment delays in a rural outpatient infusion center and identify opportunities for improving timeliness of treatment.

Interventions: A nurse practitioner and chemotherapy nurses clinic conducted a retrospective chart analysis including records from 157 patients who received intravenous chemotherapy from January to March of 2011. Patients were selected using two days of the week for the first and second week of each month. Data sources included administrative schedules, infusion records, laboratory reports, and faxed documents sent to and from the pharmacy. Documented times were available for: patient arrival, time seated in infusion chair, IV access, ordering/resulting laboratory specimens, requesting/receiving chemotherapy drugs and start/completion of infusions. There was no documented time for arrival of chemotherapy to the clinic.

Evaluation: The mean time from patients' arrival to start of treatment was 138 minutes, with a range from 28 minutes to 397 minutes. The mean time from administration of premedication to start of chemotherapy was 60 minutes. It was anticipated the majority of reasons for delays were related to laboratory, pharmacy, and patients seeing providers the same day of treatment. On the contrary, results demonstrated patients having labs drawn the same day of treatment only added 33 minutes to the wait time, and seeing a provider prior to treatment added only 27 minutes. The mean drug preparation time was 36 minutes.

Discussion: Nurses are key players in the administration of chemotherapy. Conducting the time study was logistically feasible using available records. A prospective data collection, could increase nurse workload and possibly affect results. Findings demonstrated lab and pharmacy turnaround times were not the main causes of delays as expected, but rather time spent waiting for a chemotherapy chair and time spent waiting for IV access, which are factors within control of nursing. Findings have implications for staffing and scheduling to help improve efficiency, safety, and satisfaction.

85405 (Poster)

QUALITY IMPROVEMENT MONITORING TO PROMOTE PATIENT SAFETY AND ADHERENCE TO ORAL CHEMOTHERAPEUTIC AGENTS. Heejin Kim, RN, MSN, OCN®, Wayne State University, Detroit, Michigan; Nancy George, PhD, FNP-BC, Wayne State University, Detroit, Michigan; Paula Desjardin, RN, BSN, Karmanos Cancer Center, Detroit, Michigan; Jennifer Gideon, RN, MSHSA, CHPN, Karmanos Cancer Center, Detroit, Michigan; Ann Payne, RN, BSN, Karmanos Cancer Center, Detroit, Michigan; Renee Payne, RN, Karmanos Cancer Center, Detroit, Michigan

Significance and Background: Cancer patients receiving oral chemotherapeutic agents face challenges with self-administering anti-cancer drugs and self-monitoring adverse events. Oncology nurses are responsible for promoting the safety of their patients on oral chemotherapy medications and adherence to the treatment regimen. Our previous bench marking data have shown inconsistencies in nursing procedure, adherence monitoring, and documentation of care for patients receiving oral chemotherapy, which suggests needs for a standardized nursing protocol.

Purpose: The objectives of this on-going Clinical Inquiry Project (CIP) are (a) to develop comprehensive Oral Chemotherapy Nursing Practice Protocol for patients undergoing oral chemotherapy and (b) to pilot test the protocol in an outpatient clinic at a university-affiliated cancer center in South-east Michigan using continuous quality improvement monitoring.

Interventions: The CIP was based on the Iowa Model of Evidence Based Practice (EBP) to Promote Quality Care. The EBP team that consisted of five oncology nurses was formed in September 2012. The Oral Chemotherapy Nursing Practice Protocol was developed based on a review of literature and analysis of the current practice patterns. This newly developed evidence-based protocol focuses on patient education, symptom assessment/management with follow-up calls, continuous adherence monitoring, and nursing documentation. The new protocol is being pilot tested in a GI oncology clinic over a two month period.

Evaluation: The protocol is being evaluated by changes in rates of patient education, follow-up calls, early symptom assessment, and adherence monitoring. Data has been collected via retrospective chart audits at the baseline (Oct, 2012; n=50) and the first month after protocol implementation (Nov, 2012; n=57), and is continuing through the second month (Dec, 2012). Preliminary data of the first month show increases in documentation of patient education (84.3%), documentation of follow-up calls and early symptom assessment (67.7%), and documentation of adherence monitoring (42.4%).

Discussion: This CIP demonstrates the process of translating research findings into nursing practice for patients receiving oral chemotherapy. If the trend in quality monitoring continues to improve, the project will be implemented throughout the facility. The findings of the CIP provide evidence in supporting utilization of nursing standards to improve care for patients receiving oral chemotherapy.

86451 (Poster)

ROLE OF NAVIGATION AND PATIENT EDUCATION IN THE TREATMENT OF PATIENTS WITH COMPLEX CANCERS: OUR EXPERIENCE WITH HEAD AND NECK CANCER PATIENTS. Sabrina Mosseau, BS, RN, OCN®, Samaritan Hospital Cancer Center, Troy, New York; Barbara R. McHale, BS, OCN®, CBCN®, Samaritan Hospital Cancer Center, Troy, New York; Anna Feldman, RN, OCN®, Samaritan Hospital Cancer Center, Troy, New York; Kelly Simpson, RN, OCN®, Samaritan Hospital Cancer Center, Troy, New York; Leslie Hurley, RN, Samaritan Hospital Cancer Center, Troy, New York; Jacqueline Hurley, RDCDM, Samaritan Hospital Cancer Center, Troy, New York

Significance and Background: At Samaritan Hospital Cancer Treatment Center, we realized that patients with a diagnosis of head and neck cancer were having trouble navigating the healthcare system prior to starting treatment. These patients were overwhelmed with scheduling consults, tests, and procedures before treatment could even begin. Many patients became frustrated and confused and did not show up for scheduled appointments or went to the wrong appointment. We recognized patients were not starting recommended treatment in a timely manner. The goal of our mission-oriented organization is to keep patients appropriately educated so we can give them the best care possible. In 2010, we started to streamline the process and developed a Head/Neck Cancer Patient Care Plan. At this time, a navigator was assigned to work with these patients, their families, and physicians. The top priority areas of concern were improving patient compliance in attending scheduled appointments, assigning a navigator as point of contact and care coordination, educating the patient and family about the treatment plan, reinforcing chemotherapy education and reviewing side effects and symptoms. Also noted as important was incorporating detection and evidence-based symptom management as part of patient education. It is our goal to assist our patients in receiving treatment services in an equitable and timely manner, to remove barriers to their care, and to educate patients, thereby improving outcomes. This class optimizes the learning experience and standardizes education given to patients.

Purpose: It is our goal to assist our patients in receiving treatment services in an equitable and timely manner, to remove barriers to their care, and to educate patients, thereby improving outcomes. 1) Develop and implement a process to streamline scheduled appointments, tests, and procedures. 2) Incorporate navigator in patient care from time of initial diagnosis through the continuum of care. 3) Encourage compliance through education. 4) Increase the percentage rate of successful treatment through a systematic approach to symptom management.

Interventions: Methods: 1) Implemented a patient care plan for each head/neck cancer patient. 2) Assigned a navigator to each patient diagnosed with head/neck cancer 3) Developed a chemotherapy education bag that each patient received that included an oral care protocol to promote early detection and management of stomatitis; information about chemotherapy-induced peripheral neuropathy and recommendations for management, including safety concerns and prevention of falls; a skin care protocol to promote early detection and management of dermatitis secondary to chemotherapy/biotherapy and radiation treatments; an explanation of neutropenia—what it is

and what it means to patients and their families. 4) Developed a color-coded chart featuring 3 zones to visually indicate for patients and their families what should be done under various circumstances. The green zone indicates being at goal and stable; the yellow zone indicates caution and lists symptoms that mean a doctor should be called; the red zone lists symptoms that require calling 911 or taking the patient to the emergency room. 5) Developed a nutritional tip sheet for patients who are undergoing treatment in order to educate patients in managing taste dysfunction and changes in eating habits. Included is a copy of a BMI chart that nurses use when assessing patients. 6) Implemented a chemotherapy class that patients and families can attend in addition to initial individual chemotherapy instruction. This class optimizes the learning experience and standardizes education given to patients.

Evaluation: Evaluation: Implementation of the Head/Neck Cancer Patient Care Plan closed the information gap, coordinated care, and decreased wait time for treatment initiation. Patient compliance increased, and appointments that were scheduled were attended, enabling patients to complete recommended treatment. Involving the navigator at the initial diagnosis and throughout the care continuum further strengthened this process. Time from diagnosis to treatment initiation decreased from an average of 45.38 days in 2009, to 19.20 days in 2010, and 12.60 days in 2011. The education materials provided with protocols for detection and management of stomatitis, skin care, peripheral neuropathy, and neutropenia provided patients with tools they needed to help be responsible for their own care. We developed and implemented a prechemotherapy and postchemotherapy class survey that further validated the importance of reinforced, standardized education. The creation of consistent messages and patient education and the development of the Head/Neck Cancer Patient Care Plan has led to improved care coordination and better outcomes for our patients.

Discussion: Oncology nurses are at the forefront of care. Working with physicians, navigators, community groups, and most importantly- the patient- to impact care is at the heart of what we do. Identification of a problem such as the lag in time to treatment was done by oncology nurses. Development of educational tools, the care plan, and all materials and programming was also done by oncology nurses. This allowed them to be part of the solution, they were proactive and had ownership of the outcomes. Any oncology nurse can take our educational tools and process and implement in any practice of any size to streamline care and decrease wait time. This all results in better outcomes for our patients.

86691 (Poster)

FALL PREVENTION IN MEDICAL ONCOLOGY. Kathleen Shuey, MS, RN, AOCN®, ACNS BC, Baylor University Medical Center, Dallas, Texas

Significance and Background: Unintentional falls are the most common cause of nonfatal injuries for individuals older than 65. The CDC estimates the cost of falls between \$19 and \$28.2 billion for nonfatal, fall related injuries. Patients receiving chemotherapy are at increased risk of injury due to low platelet count. Side effects of treatment, such as fatigue, may contribute to patient falls. Nursing, as the bedside caregiver, is in a unique position to assess individual patients and implement measures to prevent falls.

Purpose: At Baylor University Medical Center, falls on the medical oncology units were above the National Database of Nursing Quality Indicators (NDNQI) metric. A project was developed to identify interventions that would lead to a decrease in patient falls. An unexpected result was the identification of patient factors that contribute to falls.

Interventions: A team was convened to discuss factors that impact falls. Identified concerns fell into one of four categories:

people (staff), patient/family, medication, and environment. Additionally, staff identified an educational opportunity related to the recent implementation of an alternate fall risk scale. Intervention included (1) hospital implementation of yellow arm bands and yellow socks to identify patients at risk for fall, (2) staff discussion on purposeful rounding, fall risk assessment, polypharmacy, and patient/family implications, (3) follow up meeting to determine next steps based on review of 4 months of falls data, and (4) environmental assessment by safety.

Evaluation: 19 falls were reviewed from May through August 2011. Of the 19 falls, 4 falls had an associated injury. Parameters evaluated included laboratory results, activity at time of fall, medications, and length of stay.

Discussion: Our review of the 19 cases indicated that falls are not occurring early in the hospitalization. Patients become debilitated during hospitalization as a direct result of treatment or due to the effects of immobility. Clinical interventions should focus on prevention and patient education. Further evaluation of timing of education efforts and results of specific interventions is needed.

95960 (Poster)

FERTILITY PRESERVATION: STANDARDIZING EDUCATION AND PATIENT REFERRAL. Rebekah Clark, RN, BSN, Memorial Sloan-Kettering Cancer Center, New York, New York; Abigail Baldwin, MSN, RN, Memorial Sloan-Kettering Cancer Center, New York, New York; Joanne Frankel Kelvin, MSN, RN, AOCN®, Memorial Sloan-Kettering Cancer Center, New York, New York

Significance and Background: Many patients with cancer who receive chemotherapy and radiotherapy are at risk for infertility. Advances in reproductive technology provide fertility preservation (FP) options for many of these men and women. However, patients can only take advantage of these if clinicians discuss the risks of infertility and offer FP education and referrals.

Purpose: Nurses and physicians working in the Sarcoma service at a large NCI-designated comprehensive cancer center identified the need to improve how we address fertility in our practice. This presentation will review the steps we undertook to collect baseline data, identify and implement improvements, and evaluate the outcome of this quality improvement initiative.

Interventions: We first conducted meetings with the physicians and nurses to identify barriers to discussing fertility which included: lack of knowledge, undefined roles, absence of a standardized workflow, no system for documentation, and the difficulty of discussing fertility with poor prognosis patients. Staff was educated about treatment-related causes of infertility and options for FP. We created an algorithm to define the responsibilities of each clinician in discussing fertility, including how to initiate the conversation. Resources were reviewed including patient education materials, electronic orders, and processes for making referrals and documenting care provided.

Evaluation: Baseline evaluation was conducted by auditing charts of 26 male and female patients (18-45 years of age) who started treatment in the one-year period before we began this project. Sixty-nine percent of physicians discussed risks of infertility, but only 54% discussed options for FP and/or made referrals. No nurses documented education of these patients and only 15% documented making a referral. These measures will be re-evaluated three months after implementation of the algorithm.

Discussion: Education of patients about risks of infertility and options for FP is an important aspect of oncology nursing practice. We believe that introducing a standardized approach, and evaluating its impact, is essential to improve how we address this issue. This algorithm can be implemented in other practice settings ensuring that all oncology patients are presented with their options regarding FP, leading to improved quality of life for our patients.

96532 (Poster)

THE LIVED EXPERIENCE OF MEN WITH PENILE CANCER: A PILOT STUDY. Hyacinth Gordon, MSN, MBA, Texas Woman's University/MD Anderson Cancer Center, Houston, Texas; Ann Malecha, PhD, RN, Texas Woman's University, Houston, Texas

Significance and Background: Cancer of the penis is a debilitating malignancy affecting 1 in 100,000 men in Western countries. Phimosis, multiple sexual partners, early age at first intercourse, history of Human Papilloma Virus, and smoking are strong risk factors. There is little in the literature about the psychological and physical consequences of living with penile cancer. Though the disease is rare, consideration must be given to increasing awareness and understanding of the experience of those who are afflicted.

Purpose: The purpose of this study was to gain an understanding of the lived experience of men with penile cancer. Such understanding will help caregivers formulate care pathways to address the holistic needs of patients and stimulate further research queries about penile cancer.

Interventions: A phenomenological design was used for this qualitative study. After informed consent was obtained, a face to face interview with a semi-structured guide was used to interview a purposive sample of 6 men about their experience with penile cancer. Hermeneutic phenomenology was used as the philosophical underpinning and Colazzi's method was used to analyze data.

Evaluation: Four main themes emerged: lack of knowledge, emotional turmoil, relief and gratitude, and coming to grips. Lack of knowledge was evident in participants who had no prior knowledge of penile cancer and opted to delay seeking help. During this waiting period, participants experienced a plethora of emotions; shock, confusion, anger, fear and embarrassment. Relief and gratitude were experienced when they sought help at a large oncology center and received a definitive diagnosis and viable treatment plan. Coming to grips involved moving forward with life, dealing with sexuality, and acknowledging spousal support.

Discussion: The voices of men with penile cancer have almost been nonexistent in the nursing literature and only by hearing their experiences that healthcare providers can truly understand the meaning of the physical and emotional impact of living with penile cancer. Oncology nurses are well positioned to conduct more research and provide education to other healthcare professionals and the public to increase awareness of penile cancer.

96777 (Poster)

USING DIFFERENTIAL TIME TO POSITIVITY (DTP) TO PRESERVE CENTRAL LINES IN NEUTROPENIC PATIENTS WITH BACTEREMIA. Holly Briere, RN, BSN, OCN®, SUNY Upstate Medical University, Syracuse, New York; Bonnie Chapman, RN, MPH, SUNY Upstate Medical University, Syracuse, New York

Significance and Background: Long term neutropenia associated with Bone Marrow Transplant (BMT) and leukemia makes patients at high risk for infection. The source of infection is often illusive. Central lines are commonly removed precautionarily. Research indicates that only about 20% of central lines removed for suspected infections are the source of infection. DTP reliably indicates if the central line is the source of infection.

Purpose: The purpose of this study is to evaluate the use of DTP in neutropenic patients to determine if a line must be removed or if watchful waiting is indicated. Thereby, potentially preserving the line, improving patient satisfaction, and reducing medical resource waste.

Interventions: This year, the BMT nurses requested the times to positivity upon receiving positive blood culture results of

the same organism (with the exception of organisms associated with high mortality such as *Candida* sp and *Pseudomonas* sp) from the line and peripheral sample. A DTP of less than +120 minutes is the recommended standard for preserving the line with watchful waiting. A DTP of greater than +120 minutes indicates that the line is the source of infection. Nurses calculated the DTP and presented that value in combination with the clinical picture to the medical team. A collaborative decision was then made regarding the status of the line. To date, the DTP of 3 patients have been evaluated in real time.

Evaluation: All three patient's DTP was noted to be less than +120 minutes. Watchful waiting was implemented in each case. Two of the 3 cases resulted in a preserved line with resolved symptoms of infection on broadspectrum antibiotics. In the 3rd case, discontinuation of the line occurred despite broadspectrum antibiotics due to continued symptoms of infection after 72 hours. The cost benefits in the 2 preserved lines amounted to \$3,770 per patient. The study of DTP in the clinical setting is ongoing.

Discussion: Although the goal is to reduce and eliminate infections, minimizing unnecessary invasive procedures and cost is the secondary objective. Where DTP indicates the source of infection is at another site, proper maintenance of lines is validated and other factors that lead to bacteremia should be investigated.

97952 (Poster)

HEMATOLOGY/ONCOLOGY REAL TIME STAFFING ACUITY TOOL. Linda Voner, OCN®, RN, Lahey Clinic Medical Center, Burlington, Massachusetts

Significance and Background: A challenge for the ambulatory Oncology Care setting is determining staffing needs. Historically patient census determined staffing, this proved to be an inaccurate method. Appropriate staffing in real time is critical for safe and optimal care. This is magnified as chemotherapy regimens are increasingly complex, with multiple agents and specific sequencing, which require monitoring of the patient. To accommodate these demands, an acuity tool was sought to assist with nursing assignments.

Purpose: Develop a staffing method for an outpatient hematology/oncology clinic showing the essential elements of a real time acuity tool. The specifications are ease of use, regimen complexity, patient co-morbidities, psycho/social needs of patients/families, the learning style/literacy of patients and family, potential for Oncological emergencies, and nurse/patient time vs. chair time

Interventions: A committee of Oncology certified nurses was formed, the literature was reviewed. Research showed that a number of acuity tools have been developed, but no tool had the factors that the committee was seeking: complexity of regimens, patient co-morbidities, and potential clinical emergencies. These factors would help predict intensity of care and patient assignments in real time.

Evaluation: A tool was developed using a point system for treatment modalities. This point system would be in accordance with nurse intensity which measures the amount and complexity of nursing care required by each patient. Point system from 1-6 signifies nurse/patient time. One point for 30 minutes of time or less to a maximum of a 6 for complex regimens, psychosocial issues, oncologic emergencies, etc.

Discussion: Controlled assignment by nursing staff according to acuity and primary patient model has increased nursing satisfaction. Assigned acuity level per nurse has improved wait times for patients, thereby increasing patient satisfaction scores and a decrease in safety reports directly related to equitable nursing assignments. The Acuity tool allowed for flexibility in assignments as condition of patient population changes. The Acuity tool is easily updated and has been accepted by nursing staff as a valid indication of patient acuity in real time. Tool data continues to be collected and analyzed for predicting trends in cancer care and staffing.

98056 (Poster)

ADOPTION OF THE CDC BASIC INFECTION CONTROL PLAN FOR OUTPATIENT ONCOLOGY SETTINGS/UTILIZATION OF THE PREVENT CANCER INFECTIONS WEBSITE: PUTTING EVIDENCE INTO PRACTICE IN AN AMBULATORY COMMUNITY ONCOLOGY SETTING.

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Significance and Background: With improvements in survivorship and the growth and aging of the U.S. population, the total number of persons living with cancer has risen exponentially. Infections remain a major cause of morbidity and mortality for patients with cancer and can be attributed, in part, to immunosuppression caused by the underlying malignancy and chemotherapy. In addition, patients with cancer come into frequent contact with healthcare settings and can be exposed to other patients with infections. In recent years, there has been a shift of cancer care to outpatient settings. The CDC Basic Infection Control and Prevention Plan for Outpatient Oncology Settings was developed for outpatient oncology facilities to serve as a model for a basic infection control and prevention plan. The elements in this document are based on CDC's evidence-based guidelines and guidelines from professional societies (e.g. Oncology Nursing Society). This plan is intended to be used by all outpatient oncology facilities. The content for the 3 Steps website was developed by the Centers for Disease Control and Prevention in collaboration with experts in the fields of oncology and infection control. The website is part of a larger program called Preventing Infections in Cancer Patients, a comprehensive program focused on providing information, action steps and tools for patients, their families, and their healthcare providers to reduce the risk of developing potentially life-threatening infections during chemotherapy treatment. These standards are significant to oncology nursing as they set the stage for best practices in caring for patients with cancer prone to infection due to the tumor itself, pre-existing conditions, chemotherapy related myelosuppression, and other factors.

Purpose: The clinical nursing staff at this community based ambulatory cancer center applied the standards and recommendations from the CDC Basic Infection Control and Prevention Plan for Outpatient Oncology Settings and the 3 Steps website (www.preventcancerinfections.org) to their practice setting. This was a performance improvement project and involved staff nurses, clinical nursing director, and the infection control nurse at the health system. The goal was to adopt these recommendations into the practice setting, track data trends and measure outcomes.

Interventions: The performance improvement team read and critiqued the standards and recommendations from both the CDC, and Oncology Nursing Society (ONS) Putting Evidence into Practice. The team members participated in monthly team meetings, and data collection efforts to assess the following: a) aggregate cleanliness; b) documentation of patient education regarding preventing an infection for patients receiving chemotherapy; and c) verification via patient self report that infection control education was received by their nurse using discharge follow up phone calls. Additionally, this team formulated and implemented plans for development and integration of guidelines into practice in the following manner: fostered collaboration with the health system's infection control committee, development and implementation of

annual infection control education for all medical oncology staff; policy gap analysis and development; infection control and oncology staff nurses' participation in the CDC's "Evaluation of the PreventCancerInfections.org Website" research study; integration of best practices into clinical documentation; development of a patient educational brochure entitled "What to do to prevent an infection during treatment for cancer"; postings within the waiting room regarding infection control prevention; and implemented community education programs in collaboration with Gilda's Club South Jersey for patients and caregivers affected by cancer using the 3 Steps Website. Outcomes included monthly tracking of the following indicators:

1. Aggregate cleanliness of the department.
2. Documentation of prevention of infection by the oncology nurse using the web based educational materials developed by the CDC.
3. Verification via patient self report that infection control education was received by their nurse using discharge follow up phone calls.
4. Offer two educational community programs regarding Prevention of Infection during Cancer Treatment

Evaluation: Outcomes from this project included the following: a) 40% improvement from baseline in the consistent documentation for prevention of infection by the oncology nurse using the web based educational materials developed by the CDC; b) 50% improvement of patient self reporting that infection control education was received by their nurse using discharge follow up phone calls; c) Aggregate cleanliness of the department improved by 95% as measured by using the product Glo-Germ to determine the presence of "uncleanliness" within the department and on health care clinicians' hands post hand-washing, and d) implemented two educational community programs regarding prevention of infection during cancer treatment.

Discussion: Empowering nurses to adopt and implement national evidence based standards promotes a life long learning and professional work environment while making a difference in both patient and work setting outcomes regarding infection control best practices. Oncology nurses are positioned to identify patients at risk for infection and take the lead in educating them and their caregivers regarding this common side effect from cancer treatment. Oncology nurses may apply the lessons learned from this project to their own work settings to continually improve patient care and safety within the arena of infection control.

101080 (Poster)

IMPLEMENTING AN INTERDISCIPLINARY APPROACH FOR SAFE CHEMOTHERAPY ADMINISTRATION.

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Significance and Background: Safe chemotherapy administration involves a unique set of skills. Oncology nurses need to be knowledgeable and up-to-date with trends and information concerning chemotherapy. In addition, we are challenged by the rapid development of new therapies and health-care reform initiatives. Recognizing that other professionals in the institution were struggling with similar issues, we approached pharmacists and physicians to discuss the possibility of working together as a team to standardize and streamline chemotherapy practices within our healthcare system.

Purpose: In an effort to facilitate education, communication and promote safe chemotherapy administration, we formed a "Chemotherapy Council". Our initial work centered on discrepancies between our practice and professional standards, communication issues between pharmacy and nursing, and timeliness of physician orders. Working together, we established a collaborative relationship between oncology physician practices, pharmacy and nursing to begin the process of implementing changes to our practice.

Interventions: In the three years since its inception, the Chemotherapy Council has established safe handling practices for monoclonal antibodies per National Institute for Occupational Safety and Health (NIOSH) hazardous drug guidelines, established guidelines for timing of pre-chemotherapy laboratory studies, coordinated titration guidelines for Taxol administration with private practice physicians, and established a protocol for monitoring of oral chemotherapy administration throughout the institution. In addition we have identified acceptable reference materials used across the system, supported specified quiet areas for drug verification called “Chemotherapy Zones” in all administration areas and are proactively reviewing the American Society of Clinical Oncology (ASCO) and Oncology Nursing Society (ONS) standards, updating policies and modifying our clinical practice to ensure safe administration of chemotherapy.

Evaluation: The development of the Chemotherapy Council has fostered a collaborative relationship between nurses, pharmacists and physician practices, improved nurse satisfaction, knowledge and confidence, and promoted professionalism. Most importantly we established a culture of safe chemotherapy administration.

Discussion: Using an interdisciplinary approach supports nurses, physicians and pharmacists as they develop and implement safe chemotherapy administration practices. This collaboration elevates oncology nursing practice and patient safety, while promoting a culture of professionalism among all disciplines involved.

102778 (Poster)

DEVELOPMENT OF A GUIDELINE FOR THE ADMINISTRATION OF DRUGS CLASSIFIED AS VESICANTS. Julie Griffie, RN, MSN, AOCN®, ACNS-BC, Froedtert Hospital, Milwaukee, Wisconsin; Lynn Czaplewski, MS, RN, ACNS-BC, CRNI, AOCNS®, Milwaukee, Wisconsin; Christine Coyle, RN, BSN, OCN®, Froedtert Hospital, Milwaukee, Wisconsin; Heather Peterson, RN, BSN, Froedtert Hospital, Milwaukee, Wisconsin

Underwriting or funding source: Supported by the ONS Foundation through a grant from the National Philanthropic Trust’s Breast Cancer Fund

Significance and Background: Extravasation of a vesicant agent causes tissue blistering with eventual tissue sloughing as a result of tissue necrosis. This complication of chemotherapy administration causes additional pain and suffering in patients who already are suffering with a diagnosis of cancer. Nursing holds key responsibilities for educating patients about administration issues, and, for minimizing the risk of extravasation. Evidenced based practices support this process.

Purpose: Busy infusion centers that are in different locations from clinic areas where patients are seen by the physician, can experience a disconnect in communication and planning for each patient. Defining a path of shared responsibilities amongst team members is a critical step in assuring safe administration of vesicants.

Interventions: Assessment of peripheral access and patient education is initially done in the clinic setting at the time of consultation and / or the chemotherapy patient education session. Decision making for the use of a central vascular access device (CVAD) is based upon the drugs involved, duration of each infusion, anticipated number of treatment cycles, vascular access alternatives, risk of complications from access devices, and patient preferences. For example, 4 cycles of an IV push vesicant in a patient with minimal risk factors for extravasation and easily palpated veins may be a different decision than a patient with some risk factors for extravasation and a treatment plan requiring a 3 hour infusion of a vesicant in each cycle.

Evaluation: Ongoing access assessments for patients receiving vesicants must be defined, continuous (done with each cy-

cle), and easily communicated amongst nurses delivering care. A guideline of team expectations for the process, increased communication and minimized delays in treatment due to infusion nurses determining access was unsafe on the day of treatment.

Discussion: Unique patient assessment issues, along with risks and benefits of a central line must be discussed and taken into account in the decision about central line placement. Education and decision making needs to happen at the time of consultation and education, rather than the day of administration

102887 (Poster)

ARTISTIC COMMUNICATION: CREATING A MANDALA. Julianna Manske, BSN, RN, ONCC, Froedtert and the Medical College of Wisconsin, Milwaukee, Wisconsin; Carrie Danhieux, LPC, ATR-BC, Froedtert and the Medical College of Wisconsin, Milwaukee, Wisconsin; Jenna Day, RN, BSN, TNCC, Froedtert and the Medical College of Wisconsin, Milwaukee, Wisconsin

Significance and Background: A “Mandala” is a symmetrical circle that represents wholeness, unity, and serenity with oneself and their interconnectedness with the universe. Mandalas are the oldest archetype of religious symbols—they depict existence as beginning in the center of a Mandala and flowing outward, creating intertwining relationships between all other aspects of life.

Purpose: When a person is diagnosed with cancer, it affects everyone around them and the person must engage in life-altering decisions, medical interventions, and changing relationships. Each person interprets and acts upon these emotions differently. The creation of a Mandala allows patients and their family members an outlet to express sentiments of their journey through cancer with art and journaling.

Interventions: We provided the outline of the Mandala as a structural guideline for people to follow. From there, patients drew inside and outside those lines revealing their struggles, hopes, and accomplishments through their journey with cancer. Patients expanded each other’s artwork by adding on to each other’s drawings to create an interactive story. Patients also communicated their thoughts in a journal to accompany their drawing.

Evaluation: Art therapy and journaling create an outlet to express oneself in a non-traditional way and offers subjective evaluation of personal feelings.

Discussion: The Mandala at Froedtert Hospital was largely successful. The drawing attracted people of various backgrounds, cultures, and personalities and was a source of inspiration to others. People oftentimes added to each other’s drawings or linked an already drawn concept to their own. Once finished, we will be displaying the Mandala in our patient art gallery. Healthcare professionals are the catalysts that attend to patients’ psychological and spiritual needs. The use of a Mandala may be an alternative strategy to traditional communication methods and is an interactive project patients and their family members can partake in.

103674 (Poster)

IMPLEMENTING INNOVATION: ADMINISTERING INTRA-PERITONEAL MITOXANTRONE VIA TWO IMPLANTED INTRAPERITONEAL PORTS. Robin Green, RN, MSN, OCN®, New York University Langone Medical Center, New York City, New York; Adrienne Cacavio, RN, NP, OCN®, New York University Langone Medical Center, New York City, New York; Gerald Rosen, MD, New York University Langone Medical Center, New York City, New York; Joseph Raccaia, MD, New York University Langone Medical Center, New York City, New York

Significance and Background: Retroperitoneal sarcomas are rare malignancies. Unlike sarcomas of the extremities they

demonstrate limited responses to systemic chemotherapy; this combined with aggressive intraperitoneal spread and poor prognosis lead oncologists at our academic cancer center to explore novel therapeutic options. Patients with recurrent intraperitoneal sarcoma, post surgical resection, were to receive intraperitoneal (IP) Mitoxantrone administered simultaneously via two bilaterally implanted intraperitoneal ports. The prevention of peritoneal metastasis by improving the intraperitoneal distribution of chemotherapy was the rationale for this approach. However, this differed from the traditional single intraperitoneal port approach and we had no experience with IP Mitoxantrone. The Oncology Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP) were charged with facilitating this regimen from proposal to clinical implementation.

Purpose: To describe how this non-standard approach of administering chemotherapy via two IP ports was successfully implemented in our infusion center.

Interventions: A review of the literature revealed a scarcity of information concerning the nursing management of patients receiving IP Mitoxantrone. The NP and CNS collaborated with physicians to compile information on the feasibility and safety of this regimen. This compiled data was presented to the Clinical Services Committee, a multidisciplinary meeting with medical oncology, pharmacy and nursing representation. Educational sessions for the nurses emphasized the rationale and uniqueness behind this approach. To maintain the integrity of the concept of simultaneous bilateral infusions of IP chemotherapy and ensure nursing compliance a procedure and clinical competency were developed.

Evaluation: Currently, we have treated six patients with this approach following cytoreductive resection. All six successfully completed the two planned cycles of Mitoxantrone. None of the patients exhibited any of the signs and symptoms of systemic toxicity, i.e., pancytopenia. The major complaint was abdominal discomfort during the IP treatment. This was adequately managed by adding narcotic analgesia, up front with antiemetics prior to treatment.

Discussion: This regimen is on-going, with nursing providing much needed encouragement, education and emotional support in addition to clinical expertise. As advanced practice nurses we recognized that knowledge is fundamental to providing the best evidenced-based care available. In today's healthcare environment the oncology nurse is constantly being challenged to keep pace with medical innovations.

106981 (Poster)

IMPROVING OUTPATIENT SAFETY WITH A PATIENT ACUTE CHANGE TEAM. Joy Lombardi, RN, BSN, OCN®, Huntsman Cancer Institute, University of Utah, Salt Lake City, Utah; Bernadette Bitner, APRN, AOCNP®, Huntsman Cancer Institute, Salt Lake City, Utah; Susan Childress, RN, MN, OCN®, Huntsman Cancer Institute, Salt Lake City, Utah

Significance and Background: "Failure to rescue" has spurred the creation of Patient Acute Change Teams (PACT), often called Rapid Response Teams, in hospitals across the country. Studies have shown that these teams reduce mortality, decrease the incidence of codes outside critical care areas, and improves staff and patient satisfaction.

Purpose: Nurses at this academic cancer hospital routinely encounter emergent situations with patients receiving outpatient treatment. Often, these patients present without appointments. Prior to instituting the current PACT program, finding a provider to quickly assess a patient was often difficult, and left nurses feeling frustrated and concerned for patients' safety. By providing access to a PACT team, staff is empowered to act rather than wait for test results, callbacks, or change in condition. This process has also allowed all hospital staff, including medical assistants, registration staff, valets, and cooks, to use

the PACT to get immediate medical attention for patients, visitors and staff. The team was composed of a licensed healthcare provider, nursing supervisor, and transport.

Interventions: Nursing leadership promoted the team thru orientation, posters, pocket cards, and education at staff meetings. The slogan for these has been, "Need a Doc? - Call a PACT!" During the first six months an extensive evaluation process helped refine the program. The team was enhanced by adding an automatic page to respiratory therapy and lab, and Brain Attack evaluation when indicated.

Evaluation: Two years after implementation there has been a significant increase in PACT calls with a 90% decrease in codes. Nurses feel well supported when assessing patients who emergently present with acute changes that have high potential for cardiopulmonary compromise.

Discussion: Implementing the PACT response has been successful in this busy outpatient academic center clinic. Patient emergent needs are met, staff feels well supported and patient satisfaction scores are up. We believe that physician participation on our team has been a key part of our success and would recommend this model for Oncology practice.

107038 (Poster)

INSTITUTIONAL EXPERIENCE MANAGING HEPATIC SIDE EFFECTS ASSOCIATED WITH IPILIMUMAB TREATMENT.

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Significance and Background: Ipilimumab, a fully human, monoclonal antibody that blocks cytotoxic T-lymphocyte antigen-4 to augment an antitumor response, is associated with increased long-term survival in patients with advanced melanoma. Immune-related adverse events (irAEs) are associated with ipilimumab therapy and REMS information for identification and management of these events have been developed. Nurses play a pivotal role in assessment and management of these potential toxicities to enable patients to continue receiving treatment for their disease that has otherwise limited options.

Purpose: Hepatic toxicities associated with ipilimumab treatment can be particularly challenging to identify and manage. We will share our institutional experience including recommendations for assessment, patient education, and management strategies not covered in standard guidelines.

Interventions: Interventions include use of REMS information, patient laboratory findings, and ongoing communication with patients and caregivers regarding hepatic toxicity.

Evaluation: Patients should be contacted weekly to assess for any new signs or symptoms associated with treatment. Intervention should be started quickly to halt the progression from low-grade to high-grade. REMS provides algorithms for treating irAEs, especially once they are serious and life-threatening. Treating with high dose steroids is an effective way of suppressing the immune response once a toxicity escalates to a grade 3-4, however identifying toxicities early and using lower dose steroids may allow for a quicker resolution, shorter duration of steroid use, and for continued ipilimumab treatment. Hepatic toxicities most often are recognized first by elevated liver function values. With steroid treatment we are often able to bring the patient's lab values into the normal range and the patient is able to resume treatment.

Discussion: Most patients experience an adverse event at some point in their treatment course with ipilimumab. While most toxicities are low-grade and manageable, they can become high grade and in rare cases fatal. Nurses play a vital role in community practice settings and can easily learn to recognize the signs and symptoms of the most common toxicities, including hepatic side effects. Closely following management protocols has allowed patients in our institution to avoid more serious higher grade events and remain on treatment in many cases.

107435 (Poster)

MANAGEMENT OF STEROID INDUCED MALGLYCEMIA DURING CANCER TREATMENT. Diane De Vos-Schmidt, RN, MSN, OCN®, PCR Oncology, Pismo Beach, California; Kris Dilworth, RN, MS, FNP, CDE, PCR Oncology, Pismo Beach, California

Significance and Background: The use of steroids is a vital part of many cancer treatment regimens. Steroids cause insulin resistance which, for patients with developing or overt diabetes, can result in markedly elevated blood glucose readings. The term malglycemia is used when non-diabetic patients experience hyperglycemia for short periods of time. Steroid-induced malglycemia occurs, according to published literature, in 2–12% of steroid-treated cancer patients.

Purpose: While malglycemia is a temporary condition, it has significant negative sequale for cancer patients including: cancer cell proliferation, increased risk of infection, increased coagulability, decreased wound healing, and delayed cellular recovery. The effect of unmanaged diabetes has been well documented, however literature describing the recognition and management of malglycemia is sparse.

The project was designed based on published treatment strategies and collaboration with local experts in the field of diabetes.

Interventions: All patients receiving corticosteroids as part of their cancer treatments were screened using a midday meal 2- hour post-prandial glucose the day following the first chemotherapy treatment. Patients with glucose readings of less than 140mg/dL required no intervention. Patients with glucose readings of 140-199mg/dL received a glucose meter and training, along with basic carbohydrate-counting education. Carbohydrates were limited to 30 to 45 grams per meal. Patients with glucose readings of 200mg/dl or higher received the above education and training and either an oral insulin-secretagogue, (Starlix or Prandin) or Humalog insulin.

Evaluation: Twenty patients were screened in our pilot. Six of the twenty, thirty percent, needed intervention. None of these patients were symptomatic, despite having elevated glucose readings. Six of six patients showed improvement in overall glucose control. Three patients required insulin. These patients were effectively managed using an insulin scale designed for this project. One patient was prescribed Prandin; the dose was changed twice due to hypoglycemia. The two dietary carbohydrate control patients were able to keep their two-hour post-prandials between 140 and 170mg/dL.

Discussion: The interventions of basic carbohydrate-counting education and specifically timed glucose monitoring, along with pharmaceuticals when indicated, can positively affect the management of malglycemia and reduce negative sequel.

108470 (Poster)

UTILIZATION OF DEDICATED CENTRAL LINE CARE NURSES TO REDUCE CLABSI RATES ON A BONE MARROW TRANSPLANT UNIT. Renee Spinks, MSN, RN, NP-C, AOCNS®, Emory University Hospital, Atlanta, Georgia; Emily Bracewell, RN, Emory University Hospital, Atlanta, Georgia

Significance and Background: Oncology nurses play a major role in infection prevention for immunocompromised patients. On the BMT unit at Emory University Hospital, the central line associated bloodstream infection (CLABSI) rate was higher than the NHSN average. Several nurses on the BMT unit were interested in becoming central line care experts. They formed a team and became responsible for changing all the central line dressings each Wednesday, as well as patient and family teaching related to central line care. These nurses hold the staff accountable for correct central line assessment, care, and documentation.

Purpose: In September 2011, based on high CLABSI rates on the BMT unit, the decision was made to implement a dedicate central line dressing change team to change all central line dressings each Wednesday. Several other units at Emory University Hospital have implemented this strategy with success. The BMT unit was the first unit comprised of immunosuppressed patients to adopt the test of change. The premise behind the project is to take a nurse or nurses out of staffing so adequate time is available to properly perform sterile dressing changes with minimal distractions. In addition, the nurses who change the dressings each week will become experts on central line care.

Interventions: Three BMT nurses joined the dedicated dressing change team. They each attended an 8-hour central line care class taught by CNSs and the Vascular Access Team coordinator, then were checked off at the bedside on the dressing change procedure. Beginning in October 2011, the team began changing all dressings for patients with central lines on the unit each Wednesday. Typically two of the team members are taken out of staffing to change dressings. The third team member is a back-up. The nurses collect data each week prior to dressing change on the appearance of the site and the previous dressing, and provide education to the patients and families. The nurses have also validated dressing change competency for all nurses on the unit, since dressing frequently become loose or soiled prior to the 7 day dressing change due date each week. The patient's primary nurse is responsible for changing dressings that become loose or soiled on days other than Wednesday. Since implementing the project, the CLABSI rate has trended downward and the unit is below the NHSN average most months.

Evaluation: The goal of the project was to reduce the CLABSI rate to less than the NHSN target (3.5 infections per 1000 line days) on 8E, the bone marrow transplant unit, by August 31st, 2012. In the eleven months prior to the project implementation (October 2010–September 2011), 22 CLABSIs were identified on the BMT unit. In the eleven months following the start of the project (October 2011–September 2012), 15 CLABSI were identified. This represents approximately a 30% reduction in CLABSI. Between October 2010 and September 2011, the BMT unit had a CLABSI rate higher than the NHSN average for four out of those eleven months. Since implementing the project over a year ago, the BMT CLABSI rate has only been higher than the NHSN average one month, with many months at zero CLABSI.

Discussion: This project has empowered the nurses on the BMT unit at EUH to take ownership of central line care and infection prevention. The three dressing change team members take pride in their expertise and serve as resources to the other nurses on the unit. While CLABSI can occur because of issues with both insertion and maintenance of central lines, we found the majority of CLABSI in our hospital to be related to maintenance. Oncology nurses can make a major impact on infection prevention in vulnerable immunocompromised patients.

112151 (Poster)

RUXOLITINIB AND MYELOFIBROSIS: NURSING MANAGEMENT OF A RARE HEMATOLOGIC DISEASE. Andrea Linder, RN, MS, Stanford University, Palo Alto, California; Lenn Fechter, RN, Stanford University, Palo Alto, California

Underwriting or funding source: Daisy Foundation—J. Patrick Barnes Grant for Nursing Research and Evidenced Based Practice (5,000 grant received in January 2011)

Significance and Background: Myelofibrosis (MF) is a rare myeloproliferative disease characterized by progressive anemia, leukopenia, thrombocytopenia and multiorgan extramedullary hematopoiesis that most prominently involves the spleen leading to splenomegaly, severe constitutional symptoms and premature death. Constitutional symptoms include fatigue, loss of appetite, early satiety or abdominal discomfort due to massive splenomegaly, bone/muscle pain, itching, night sweats. MF

is diagnosed in 1/100,000 persons and has a median age at diagnosis of 65. The JAK2 V617F mutation is identified in 50-60% of patients. In November 2011 the FDA approved Ruxolitinib as the first therapy licensed for MF. Side effects include thrombocytopenia, leukopenia, anemia, diarrhea, lightheadedness and rare elevated liver enzymes. Oncology nurses must understand the constitutional symptoms of MF and recognize the side effect profile of Ruxolitinib. Assessing for potential side effects of bleeding and infection and compliance with an oral medication is essential.

Purpose: Ruxolitinib is a novel oral JAK 1/2 inhibitor medication administered twice daily. Nurses must understand and assess the disease related versus ruxolitinib side effects. Compliance with an oral medication must be assessed with close monitoring of blood counts for dose changes indicated.

Interventions: Nursing management includes frequent close monitoring of blood counts for thrombocytopenia, anemia or leukopenia. Nurses must assess for any bleeding or infection due to decreased counts. Compliance with oral therapy is essential. Dose adjustments may be based on the platelet counts or severity of side effects. Tablets cannot be split and symptoms may return within 7 days if stopped.

Evaluation: The goals of nursing management include patient education and the assessment of symptom management for side effects of ruxolitinib treatment. Judging compliance with an oral agent requires excellent patient interviewing and teaching to complement lab monitoring. Awareness of possibility of bleeding is critical as thrombocytopenia must be monitored closely.

Discussion: As a new novel agent in the treatment of myelofibrosis skilled nursing evaluation is required. Patient teaching exploring resources, communication with the health care team and monitoring of lab tests are essential for optimal care. Assessing compliance with oral medication is important for patient understanding of disease and ruxolitinib related side effects.

112196 (Poster)

UPDATING AND STANDARDIZING ONCOLOGY SYMPTOMS IN AN ELECTRONIC MEDICAL RECORD. Laurel Courtney, RN, MS, AOCN®, CNS, The Ohio State University Comprehensive Cancer Center-Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, Columbus, OH

Significance and Background: Electronic Medical Records offer an opportunity to collect and trend data and improve patient care. As healthcare organizations transition to Electronic Medical Records, there is an opportunity to standardize documentation and content. Standardizing the collection of patient symptoms across several infusion sites allow users to speak the same language.

Purpose: A major Medical Center went live with an Electronic Medical Record in Ambulatory in 2009. In 2012 a multidisciplinary group was brought to together and utilizing the DMAIC process improvement model looked at chemo clearance process. A critical element in clearing a patient for chemotherapy includes reviewing symptoms/toxicity patients experience with previous chemotherapy treatment. The group looked to improve the content and data collected with assessment of symptoms and not confuse the nursing assessment with clinical trial toxicity assessment. Not all physicians were aware nursing was collecting and documenting on common chemotherapy symptoms and physicians were collecting the same information.

Interventions: The multidisciplinary group reviewed current symptoms assessed by nursing. The group determined that content needed to be updated to version 4 CTCAE (Common Terminology for Adverse Events). In addition, three additional symptoms were added and two symptoms retired from assessment. The CNS collaborated with specialty pharmacist to develop standardized bisphosphonate assessment. All exam and infusion sites nurses received education on the changes. To dis-

tinguish toxicity nursing assessment from clinical trial toxicity assessment, the tool was renamed Symptom Assessment. The tool focuses on the top sixteen symptoms patients may experience while undergoing chemotherapy.

Evaluation: The Updated symptom assessment tool was successfully adapted into the Electronic Medical Record. Since updating the nursing assessment, we have seen physicians review nursing assessment on symptoms and pull the information into their notes thereby reducing redundancy and collection of data. Clinical Trials toxicity is collected in an additional electronic form for attributions by physicians.

Discussion: Electronic Medical Records and new technology will continue to influence nursing practice. Oncology nursing has the opportunity to standardize documentation and harness gains in efficiencies and quality documentation. Using CTCAE allows standard terminology to assess common chemotherapy side effects.

112612 (Poster)

CLEARING THE MUD: ENHANCING PATIENT SATISFACTION BY RELIEVING CONFUSION RELATED TO TESTS AND TREATMENTS. Yvette Ong, MS, BSN, RN, OCN®, NE-BC, UT MD Anderson Cancer Center, Houston, Texas; Danielle Gorski, BSN, RN, OCN®, UT MD Anderson Cancer Center, Houston, Texas; Julia Sarkar, BSN, RN, OCN®, CHPN, UT MD Anderson Cancer Center, Houston, Texas; Uriel Tapia, BSN, RN, UT MD Anderson Cancer Center, Houston, Texas

Significance and Background: Admission to an inpatient unit can be daunting for oncology patients and caregivers as they face unique challenges related to diagnosis, treatment plan and other disease related factors. There is also the added fear of the unknown that causes anxiety. Thorough explanations provided in a courteous manner are crucial to patient satisfaction and comfort.

Purpose: To describe the interventions, results and recommendations related to enhancing explanations for tests and treatments during hospitalization.

Interventions: Multiple interventions to enhance explanations for tests and treatments were implemented in a medical oncology unit at a comprehensive cancer center. These included: 1) hosting "What Nobody Told Me" sessions for patients and family members to gain insight on what information related to tests and treatments they wish they had known while in the hospital; 2) identifying the three most common diagnostic procedures performed on the unit's population; 3) collaborating with the respective procedural areas to assist with education; 4) team huddles and unit-based competencies on common tests and treatments; and 5) "Back to Basics" population-based skills education. Educational materials were made accessible to nurses through an online academic repository. After the interventions implemented demonstrated benefit over a ten-month period, the division of nursing patient satisfaction team determined that this model would be one of the focus initiatives to be rolled out this fiscal year for the all of the inpatient units.

Evaluation: The unit's patient satisfaction mean scores (Press Ganey) related to explanations happen during tests and treatments have improved from 85.7 (2011) to 88.7 (2012); from 4% (2011) to 63% (2012) as compared with National Comprehensive Cancer Network benchmark; from 49% (2011) to 88% (2012) as compared with Academic Medical Centers; and from 9% (2011) to 61% (2012) as compared to Comprehensive Cancer Center Consortium for Quality Improvement.

Discussion: Oncology nurses play a key role in educating patients and families regarding tests and treatments. This information will empower nurses and nurse leaders to implement strategies that would ensure patients understand what would happen during tests or treatments.

112799 (Poster)

CHEMOTHERAPY OR BIOTHERAPY INSTILLATION VIA NEPHROSTOMY TUBE OR URETERAL CATHETER BY ONCOLOGY NURSES. Christella Witcher, MBA, RN-BC, OCN®, UT MD Anderson Cancer Center, Houston, Texas; Irene Inguillo, CURN, RN, UT MD Anderson Cancer Center, Houston, Texas; Howard Green, MBA, RN, UT MD Anderson Cancer Center, Houston, Texas; Lydia Madsen, AOCNS®, OCN®, RN, UT MD Anderson Cancer Center, Houston, Texas; Surena Matin, MD, UT MD Anderson Cancer Center, Houston, Texas; Benjamin Matin, RPH, UT MD Anderson Cancer Center, Houston, Texas

Significance and Background: This topic is significant to Oncology nursing because there is no standardized nursing procedure or competency for nurses to instill chemotherapy or biotherapy through nephrostomy tubes or ureteral catheters. Medical research supports this topical administration route for treatment of upper tract transitional cell carcinoma. Previously, physicians performed this procedure. As efficacy was established, there was expectation for oncology nurses to perform this in our ambulatory setting. Given the innovative route of administration, an emphasis on nursing competency for patient safety was compulsory.

Purpose: The purpose of this project was to establish an oncology nursing standard of practice for the unique approach of instilling chemotherapy or biotherapy safely via a nephrostomy or ureteral catheter route in the ambulatory setting.

Interventions: An interdisciplinary team consisting of nursing, medical surgery and pharmacy personnel began with a literature review for best practice. The literature search revealed medical support for the intervention but no specific recommendations for nursing. Given the absence of nursing literature for this procedure, a bridge was built that drew from nursing management of renal irrigations. A safe system of delivery using a manometer was coupled with a closed system method for chemotherapy/biotherapy medication instillation. The final policy was written, procedure detailed, and nursing education and competency were completed.

Evaluation: Outcomes included institutional committee approvals for the new policy, training and a competency for skills validation. Target audience was identified and educational training and simulation skills validation sessions were conducted. All nurses performing the procedure on actual patients were evaluated by a trained oncology nurse using a standardized competency verification process that incorporated the use of Oncology Nursing Society sanctioned chemotherapy biotherapy administrative guidelines.

Discussion: Disseminating the results of our evidence-based project is the first step to establish best practice for the oncology community. This abstract offers a nursing clinical practice model for administering chemotherapy or biotherapy via nephrostomy or ureteral catheter and suggests further discussion of this unique treatment route to safely manage patients with upper tract transitional cell carcinoma.

112830 (Poster)

EFFECTS OF BEDSIDE SHIFT REPORT ON THE PATIENT EXPERIENCE. Donna Reinbeck, MSN, OCN®, Community Medical Center, Toms River, New Jersey; Jennifer Priscandaro-Kelly, MS, CPPS, Community Medical Center, Toms River, New Jersey

Significance and Background: Change of shift report traditionally occurs in a conference room or nurses station with no input from the patient or family. Patients are often confused about their plan of care. Bedside shift report was designed to allow active participation in the report process.

Purpose: Traditional practice of one way communication from the off-going provider to the oncoming nurse can be lengthy, incomplete and fraught with interruptions. This hand off occurs with no patient involvement which can lead to errors, confusion about treatments, diagnosis and medications. Moving report to the bedside improves transparency between the healthcare team and the patient.

Interventions: All nurses attended an educational session to learn about bedside shift report. A standardized tool based on the Situation, Background, Assessment, and Recommendation (SBAR) communication structure was developed to encompass all items expected to be reviewed at change of shift. Meetings were held to discuss issues and concerns relating to patient confidentiality, physician buy-in, and focusing the hand-off around the patient.

Evaluation: Immediate and dramatic results were seen related to HCAHPS nursing communication scores in all four domains. The greatest improvement was seen in the “nurses explain things in a way you understand” question which improved from 64 to 71 or 11%. One important indicator of the effectiveness of bedside reporting is the question “nurses treat with courtesy and respect” scores for this question increased 10% from 83 to 91. These indicators validate that nursing staff is building relationships with patients and effectively engaging patients in their care.

Discussion: Moving report to the bedside has impacted patient satisfaction and allows for free flow of information which centers on the patients. Bedside report allows for a mentoring relationship to develop between nursing staff and creates an environment of mutual respect. Nurses are able to visualize patients and implement safety checks at the start of their shift, reducing the length of time they spent at the nurses station and away from the bedside. This helped to create a smoother workflow and improved the reporting process. HCAHPS scores have shown that bedside shift report has had a positive impact of the patient’s perception of effective communication as well.

113142 (Poster)

SUPPORTIVE BENEFITS OF HOLISTIC NURSING MODALITIES FOR ONCOLOGY PATIENTS. Marilyn Haas, PhD, RN, CNS, ANP-BC, Mission Hospital, Asheville, North Carolina; Sheri Denslow, PhD, MPH, Mission Hospital, Asheville, North Carolina; Lourdes Lorenz, RN, MSN, NEA-BC, AHN-BC, Mission Hospital, Asheville, North Carolina

Significance and Background: Holistic nursing defined by the American Association of Holistic Nurses is “all nursing practice that has healing the whole person as its goal”. Holistic nurses (HNs) recognize the interconnectedness to health and illness, striving to facilitate healing through traditional and complementary nursing modalities/interventions. HNs can offer adjunctive, effective and evidence-based techniques to treat symptoms associated with cancer and related treatments. There is a growing body of scientific evidence supporting integrative nursing modalities in oncology. Many modalities fall within the domain of nursing, thus providing opportunities for nurses to engage/support patients at a higher level of care.

Purpose: The purpose of this pilot study was to investigate the effects on the parasympathetic nervous system of four holistic nursing modalities offered to oncology patients by certified HNs. The secondary aims were: to identify which holistic nursing modalities would be chosen by oncology patients during hospitalization or radiation treatments, examine the changes in physiological vital sign measurements (BP/P/R), and to correlate their self reported evaluation of anxiety, nausea, and pain with the modalities received.

Interventions: Holistic nursing consults were offered to oncology patients in the hospital/radiation therapy department by physicians and nurses. Patients could select any or all of the four modalities. HNs obtained vital signs and self-evaluation of

three potential symptoms (anxiety, nausea, pain) prior to beginning the modality and at completion.

Evaluation: A convenient sample of 442 participated in this study after explaining modalities available (healing touch, guided imagery, aroma therapy, massage) and obtaining verbal consent. Sixty-seven percent chose healing touch, followed with guided imagery (23%) and hand/foot massage (21%) with aroma therapy being the least selected (8%). After receiving interventions, statistically significant drops in physiological vital sign measurements were observed with each modality (t-test p-value <0.01) except aroma therapy (p-value 0.49 on diastolic BP). Changes in self-reported improvement in anxiety, nausea, and pain were statistically significant (p<0.01) except aroma therapy (p=0.08 for nausea). RN can offer therapies with confidence to improve patient care.

Discussion: Holistic nursing measures play an increasingly important role in the control of symptoms associated with cancer treatments/hospitalizations. Teaching and incorporating three integrative modalities into patient care can improve symptomatology, promote self-care, and add to nursing intervention toolbox.

113143 (Poster)

TOWARD A BROADER UNDERSTANDING OF FAMILY-CENTERED CARE: PARENTS OF ADULT CHILDREN WITH CANCER. Patricia Beach, MSN, RN, AOCN®, ACHPN, Mercy St. Vincent Medical Center, Toledo, Ohio; Beth White, MSN, RN, Mercy St. Vincent Medical Center, Toledo, Ohio

Significance and Background: Adults are living longer and more often with chronic diseases. Over 50 percent of all adults over the age of 60 have at least one living parent. These parents are often watching their now adult children cope with serious life threatening cancers and don't know how to help. They are relying on healthcare professionals, often nurses, for support. Oncology nurses recognize their leadership role as advocates for patient- and family-centered care. The ONS 2012-2016 Strategic Plan describes the reliance on evidence based care as essential to the transformation of cancer care and quality oncology nursing care. The state of knowledge about the effect of adult child illness on parents is not well researched to provide helpful family-centered nursing interventions. Because of this shallow base of evidence, nurses have had to largely depend on personal opinions and experiences about families when choosing to include or not include parents of adult patients in plans of care.

Purpose: This presentation describes the experiences of a group of parents of seriously ill adult children. The demands of this relationship are discussed.

Interventions: Principles of family-centered nursing are a foundation for respecting the wishes of both adult patients and their parents. Care giving strategies related to identified areas of family support are recommended.

Evaluation: This project recognizes the adult child/parent relationship as an important family dynamic and incorporates helpful interventions in a clinical setting. Appreciation of typical challenges encountered and supportive interventions are keys to family centered support of these parents and patients.

Discussion: This session will use de-identified stories to illustrate how principles of growth and development and parenting theory can be applied to family-centered care of ill adults with living parents. Excerpts from the presenters' book *In the Shadows: Caring for Parents of Seriously Ill Adults* will frame the issues of the interrelatedness of illness and independence, fostering resilience and hope, communication and incorporating parental help to improve care.

113146 (Poster)

CARE OF THE OLDER ADULT WITH CANCER: A 65+ AMBULATORY HEALTH SCREENING TOOL. Lorraine McEvoy,

DNP, MSN, RN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York

Underwriting or funding source: This project has been funded in whole or in part with Federal Funds from the National Cancer Institute, National Institutes of Health, under Contract No. HHSN261200800001E.

Significance and Background: Cancer is a disease of the aged. Today, most cancer care is delivered in an ambulatory setting. Age related physiologic changes, comorbid illnesses, reduced functional reserve and the propensity for decline add to the complexity of managing cancer in older adults. Identifying risk factors, and the specific care needs of the older adult is a vital aspect of the ambulatory nurses' role. The development of a coordinated plan of care is essential to achieving favorable outcomes.

Purpose: This presentation will explain a multidisciplinary collaborative endeavor to identify and manage those older adults at risk for decline during cancer treatment.

Interventions: At our comprehensive cancer center, nurses collaborated with the 65+ Multidisciplinary Team to develop an approach to identify patients with the potential for age related functional, cognitive or physiologic decline during cancer treatment. A tool known as the 65+ Ambulatory Health Screening completed by the patient or caregiver before the initiation of cancer treatment, provides a baseline viewpoint of the patients' status. Positive answers to indicated questions alert the nurse reviewing the form to further query the patient, conduct focused assessments, initiate medical and/or nursing interventions and coordinate referrals to collaborating disciplines. The nurses' electronic documentation and use of electronic order sets summon interdisciplinary support through a referral process specific to the 65+ patient population.

Evaluation: The screening tool was implemented across the institution in 2010. Quarterly, electronic nursing quality data compilation demonstrates substantial user compliance and effectiveness in identifying comorbid conditions, geriatric syndromes, and the initiation of multi-disciplinary collaboration to support the overall treatment plan.

Discussion: For the older adult with cancer, physical, physiologic, and psychosocial capacity needs to be assessed at baseline and throughout the continuum of care. The screening tool presented facilitates the recognition of issues placing the patient at risk and enables the development of an individualized plan as cancer treatment planning is undertaken. With a focus on the practice setting challenges and the needs of older adults, the 65+ Health Screening Tool forms an approach for effective ambulatory care management of this special population.

113155 (Poster)

NURSE NAVIGATION IN OLDER ADULTS WITH CANCER.

Elizabeth Jernigan, RN, MS, OCN®, Central Florida Health Alliance, The Villages, Florida; Nancy Moreland, RN, OCN®, Central Florida Health Alliance, The Villages, Florida; Nichole Kelly, NA, Central Florida Health Alliance, The Villages, Florida; Carol Hutchison, CTR, Central Florida Health Alliance, The Villages, Florida; Deborah Olsen, RN, OCN®, MPH, CCRA, Central Florida Health Alliance, The Villages, Florida

Underwriting or funding source: Office of Academic Affairs, U.S. Department of Veterans Affairs

Significance and Background: 1,638,910 new cancer cases are expected to be diagnosed in 2012 and over 50% will occur in patients over 65 years old. The Moffitt Cancer Center at The Villages Regional Hospital (MCC/TVRH) opened in December 2011. The mean age of residents in The Villages is 66 years old and most are very active. They are concerned with a cancer diagnosis and how it affects their pursuit of hobbies and interests. Nurse navigation programs targeting this population must be sensitive to their needs.

Purpose: Nurse navigation attempts to reduce disparities in cancer care. Our navigator program focuses on adults 65 years of age and older to improve overall patient satisfaction with their cancer journey. The differences in health status and health behaviors found among different groups of older adults provide a better understanding of how health disparities may affect various older adult populations

Interventions: A navigation program was implemented to meet the needs and sensitivities of the older adult with cancer, unique to the retirement population of The Villages, Florida. The community and medical staff were educated about the availability of a Nurse Navigator through marketing efforts. Initial patient contacts with the navigator include walk-ins, physician referrals, community outreach, self- and family-referrals. A navigator database was developed and referrals can be tracked by site, referral type, and volume.

Evaluation: Maintaining independence is a concern to “Villagers” and most moved from other states without a family caregiver. “Villagers” want to maintain independence and prefer golf cart transportation for appointment, which is a factor when selecting physicians. Comorbidities, hearing, vision or driving at night are factors for this population. A phone survey is underway to include between 50 and 100 patients to explore patient satisfaction with the program. Targeted areas include transportation, confidentiality, scheduling, social service support and insurance issues. Early in the program, a need was identified for an oncology social worker to focus on distress management.

Discussion: Older cancer patients have unique needs, mainly communication, safety, trust and sharing control. Further research in this area is warranted to ensure this at-risk population is appropriately served by navigation programs.

113217 (Poster)

PROVIDERS’ PERCEPTIONS TOWARDS SURVIVORSHIP CLINICAL PRACTICE ALGORITHMS. Guadalupe Palos, DrPH, LMSW, RN, The University of Texas MD Anderson Cancer Center, Houston, Texas; Fran Zandstra, MBA, RN, OCN®, The University of Texas MD Anderson Cancer Center, Houston, Texas; Ludivine Russell, MS, The University of Texas MD Anderson Cancer Center, Houston, Texas; Katherine Gilmore, MPH, CCRP, The University of Texas MD Anderson Cancer Center, Houston, Texas; Maria Alma Rodriguez, MD, The University of Texas MD Anderson Cancer Center, Houston, Texas

Underwriting or funding source: Office of Academic Affairs, U.S. Department of Veterans Affairs

Significance and Background: There is growing recognition of the critical need for practice algorithms to guide providers’ clinical decision-making for care of long-term cancer survivors. However, limited data exists on providers’ use and satisfaction with such algorithms. In an institutional-wide initiative to optimize survivors’ outcomes, disease-specific algorithms were developed using a uniform, multidisciplinary approach. As part of quality improvement practice, we were interested in the providers’ views towards the survivorship practice algorithms.

Purpose: Here we present findings from an evaluation conducted to examine providers’ perceptions of the algorithms’ usability and their satisfaction with disease-specific survivorship algorithms.

Interventions: A total of 35 providers were surveyed regarding their use and satisfaction with clinical practice algorithms specifically tailored to their disease-specific survivorship clinic from August 2–6, 2012. Potential respondents received an email from the Office of Cancer Survivorship informing them about the survey, its purpose and instructions on how to access the SurveyMonkey® online survey. Providers were asked to complete a 10-item survey regarding their use, awareness, and sat-

isfaction with algorithms specific to their clinic. To maintain respondents’ confidentiality all data collected including IP addresses were de-identified.

Evaluation: 18 of 35 providers in the survivorship clinics responded, resulting in a 51.4% response rate. A total of 44 algorithms were available in 9 survivorship clinics. Although, the majority of respondents (94.4%) reported being aware of the algorithms, providers use of the algorithms varied as noted by the corresponding percentages (%) including: never (11.1%), seldom (5.6%), occasionally (16.7%), frequently (33.3%), and always (33.3%). The majority of providers (55.6%) preferred digital over printed versions to access the algorithms. Providers disagreed or strongly disagreed that the algorithms provided adequate information on depression/anxiety (50.0%) or sexual dysfunction (62.5%). Providers’ rated their overall level of satisfaction with survivorship algorithms designed for their clinical setting as neither satisfied nor dissatisfied (12.6%), satisfied (62.4%), or very satisfied (25.0%).

Discussion: Oncology nurses can use such data to develop educational interventions to address providers’ barriers in using survivorship algorithms in their practices. Data may also be used to tailor survivorship services, such as indicated by providers’ identifying a need for additional information on depression/anxiety, and sexual dysfunction.

113296 (Poster)

STANDARDIZATION OF NEUROLOGICAL ASSESSMENTS FOR PATIENTS RECEIVING HIGH DOSE CYTARABINE. Barbara Bigelow, RN, BSN, OCN®, University of Maryland Marlene and Stewart Greenebaum Cancer Center, Baltimore, Maryland; Karen Kaiser, PhD, RN, OCN®, University of Maryland Marlene and Stewart Greenebaum Cancer Center, Baltimore, Maryland; Laura Hearson, MSN, RN, OCN®, University of Maryland Marlene and Stewart Greenebaum Cancer Center, Baltimore, Maryland; Stephanie Channing, BSN, RN, OCN®, University of Maryland Marlene and Stewart Greenebaum Cancer Center, Baltimore, Maryland; Laura Lunz, BSN, RN, OCN®, University of Maryland Marlene and Stewart Greenebaum Cancer Center, Baltimore, Maryland; Jessica Lunz, RN, OCN®, University of Maryland Marlene and Stewart Greenebaum Cancer Center, Baltimore, Maryland

Significance and Background: Patients receiving high dose cytarabine have 7%–28% incidence of neurotoxicity. Timely recognition and intervention may reduce the severity of and the potential for long term neurological complications. The bedside nurse plays a critical role in prompt identification and reporting of neurologic symptoms, minimizing neurologic damage. A Nursing Journal Club presentation about assessment and documentation of high dose cytarabine (greater or equal to 1Gm/m²) prompted the University of Maryland Marlene and Stewart Greenebaum Cancer Center Clinical Practice Council to review their practices. Inexplicit and inconsistent orders for “neuro checks before high dose cytarabine” meant assessment and documentation practices varied among nurses and physicians.

Purpose: The purpose of this project was to create a comprehensive standardized neurologic assessment process for patients receiving high dose cytarabine infusions that enabled prompt identification and treatment of adverse neurologic symptomatology and efficient documentation.

Interventions: A review of literature resulted in identifying essential components of a neurologic assessment pertinent to high dose cytarabine administration and documentation tool examples. Subsequently, a double-sided “High Dose Cytarabine Neurological Assessment” guide and documentation form was developed. The guide identifies risk factors associated with neurotoxicity and use of high dose cytarabine. It also

provides directions on how to perform the various components of the assessment including cerebral status (level of sedation, mentation, cognitive status, presence of headache and seizure activity) and cerebellar function (gaze, speech pattern, hand writing, arm tremor, upper and lower extremity coordination, gait and balance). Documentation of adverse assessment findings on the reverse side of the form facilitates prompt recognition of neurotoxicity. The form instructs the nurse to stop the infusion for abnormal findings and to contact the prescriber. Nurses use the form prior to administering sedation medications and each cytarabine infusion.

Evaluation: Findings from a before and after staff survey about the clinical utility (ease of use, thoroughness of neurologic assessment, prompt identification of neurotoxicity, etc.) of the guide and documentation form will be presented.

Discussion: This comprehensive form outlines process and content that can easily be adapted for use in other settings to assist with prompt identification and reporting of neurologic symptoms with high dose cytarabine.

113460 (Poster)

USE OF CHLORHEXIDINE-IMPREGNATED DRESSINGS ON TUNNELED CENTRAL LINES—WHAT DOES THE EVIDENCE SAY? Misty Lamprecht, MS, RN, CNS, AOCN®, The Ohio State University CCC—The James, Columbus, Ohio; Carol Colussi, MHA, BSN, RN, NEA-BC, The Ohio State University CCC—The James, Columbus, Ohio; Sharon Steingass, RN, MS, AOCN®, The Ohio State University CCC—The James, Columbus, Ohio; Janine Overcash, PhD, GNP-BC, The Ohio State University CCC—The James, Columbus, Ohio

Significance and Background: As many oncology patients required long term central venous catheters (CVC's) during the same period in which they are most susceptible to infection, the concern for central line associated bloodstream infections (CLABSI's) is ever present in oncology care. Nurses provide the care to CVC's, so they are suited to identify best practice.

Purpose: Chlorhexidine (CHG)-impregnated dressings were implemented for use on all CVC's in our hospital. After reports of possible skin reactions in the oncology population, the use of these dressings on tunneled CVC's was discontinued. Nursing shared governance committees brought forth the concern of whether this was truly the best practice choice. This question was forwarded to the Clinical Nurse Specialists (CNS's), regarded as evidence-based practice (EBP) mentors in our institution.

Interventions: Following review of the literature, a synthesis table was constructed and presented back to the councils who had posed the question. This table showed that although there is limited evidence for the use of CHG-impregnated dressing on tunneled CVC's, the evidence for its use with temporary CVC's is overwhelming. Based on these findings, the expert opinion that accompanied the synthesis table recommended that a CHG dressing be used on tunneled CVC's. With the assistance of the Nursing Education Department and the support of the Management Council, this change was implemented in mid-October.

Evaluation: CLABSI rates are continuously monitored as a nursing sensitive indicator. Ongoing review of each identified CLABSI is conducted, evaluating aspects of care including dressing maintenance, tubing changes and patient hygiene. Each suspected CHG skin reaction is also evaluated by a project team member from epidemiology and nursing. At submission of this abstract CLABSI rates have decreased from 4 in September (pre-implementation) to 1 in November (post-implementation). At least a quarter of data will be available before poster construction is due.

Discussion: Although it was felt that the proper EBP decision was to implement the use CHG-impregnated dressings on tun-

neled CVC's, it was also apparent from the literature review that better evidence is needed. A recommendation has been brought forth to research the effectiveness of Tegaderm CHG vs. Bio-patch vs. non-CHG dressings in preventing CLABSI's related to tunneled CVC's.

113940 (Poster)

SAFE HANDLING OF HAZARDOUS DRUGS: THE IMPLEMENTATION OF A CLOSED-SYSTEM DRUG TRANSFER DEVICE TO REDUCE HAZARDOUS DRUG RELATED OCCUPATIONAL EXPOSURE IN A RESEARCH ENVIRONMENT. Amy Callahan, RN, MSN, CRNP, AOCNS®, National Institutes of Health, Bethesda, Maryland; Helen Mayberry, MSN, RN, National Institutes of Health, Bethesda, Maryland; Daniel Zlott, PharmD, BCOF, National Institutes of Health, Bethesda, Maryland

Significance and Background: The Oncology Nursing Society, the National Institute for Occupational Safety and Health, and the American Society of Health-System Pharmacists recommend using closed-system transfer devices (CSTD) to decrease exposure to hazardous drugs (HDs) during preparation and administration. A CSTD is a device that mechanically prevents contamination of the care environment by HDs via the release of HD-containing droplets, aerosols, or vapors.

Purpose: Nurses at the National Institutes of Health Clinical Center administer an average of 1,100 HDs, including both FDA-approved and investigational drugs, each month placing them at high risk for HD exposure. The purpose of this intervention was to limit occupational exposure and standardize the administration of HDs. An interdisciplinary team, including nursing, pharmacy, and hospital epidemiology evaluated four CSTD products for safety, infection-control properties, cost, and versatility. The system had to accommodate the variety of administration techniques required by various investigational drugs.

Interventions: Nursing and pharmacy assessed current HD administration processes and identified the spiking of IV bags on nursing units as a potential source of HD exposure. To minimize risk during spiking, pharmacy agreed to spike all HD IV bags and prime selected HDs in the controlled environment of the biological safety cabinet. It was also determined that the use of a CSTD would decrease nursing exposure when administering HDs. The system that was selected for evaluation included a male luer-locking device, which is applied by pharmacy to all HDs, and a female luer-locking device applied by nursing to the vascular access device. A three month pilot in high-volume areas was followed by hospital-wide implementation. CSTD implementation has minimized variability in HD infusion setup.

Evaluation: Through the first year of use, including the pilot, voluntary reporting of HD spills increased from 13 to 37 spills. This is attributed to heightened reporting during implementation. Since hospital-wide implementation, there have been 10 spills, 80% < 5mL in volume.

Discussion: User error accounted for 60% of spills and was addressed through follow-up education. Stakeholder satisfaction surveys, including nursing and pharmacy, were completed, and a staff led committee was created to review HD spills, ongoing product concerns, educational needs, and future initiatives.

113952 (Poster)

ONCOLOGY EVALUATION AND TREATMENT CENTER. Elaine Hawes, BSN, RN, Baylor University Medical Center, Dallas, Texas

Significance and Background: The OETC is the first joint collaborative approach to urgent oncology care in the North Texas healthcare market. The OETC provides care to oncology patients who require specialized care but have not had access to urgent

non-emergency room specialized care outside of the physician office. The National Cancer Comprehensive Network's (NCCN) symptom management guidelines are utilized to guide practitioners in the management of oncology patient care. The OETC is staffed with experienced oncology and urgent care trained nurses and supported by physicians and an oncology medical director.

Purpose: The OETC, which is located within the Cancer Hospital, is a place for established oncology patients at BUMC to seek prompt urgent medical care as an alternative to the physician office or emergency room. Established oncology patients experience a decreased wait time for evaluation of urgent oncologic complications. On arrival patients are immediately placed in an exam room for evaluation. If the OETC is full, there is a private waiting area designated for oncology patients only.

Interventions: The OETC provides environment focused on the specific needs of the immunocompromised patient. The center provides urgent and emergent care in collaboration with our emergency room colleagues. Patients who arrive by ambulance or are experiencing a stroke or MI are diverted to the emergency department. Urgent care is provided utilizing NCCN symptom management guidelines for palliative care, chemotherapy-related breakthrough nausea and vomiting, and febrile neutropenia.

Evaluation: The average length of stay in the OETC is 3.75 hours compared to the national average for an emergency department of 5.5 hours. For patients experiencing complication of neutropenia, the average time from arrival to antibiotic is 56 minutes. Hospital admission rate in the OETC is approximately 36%, which is 50% lower than what has been recently reported for oncology patients in the ED at Baylor University Medical Center(63.2%)

Discussion: The OETC is a vital component in the development of a comprehensive acute cancer care model that provides cost efficient, evidence based care for the established oncology patient. As markets become more competitive, an urgent care oncology center can provide a means for decreasing readmission rates and containing cost while improving patient satisfaction in the depth of services available.

114012 (Poster)

DECREASING HARMFUL PRACTICES AND PREVENTING MEDICATION ERRORS. Torina Lane, RN, BS, MSN, CCRN, MD Anderson Cancer Center, Houston, Texas; Jennifer Ketchum, RN, BSN, OCN®, MD Anderson Cancer Center, Houston, Texas; Celine Chucko, RN, BSN, MD Anderson Cancer Center, Houston, Texas; Brittany Veselka, RN, BSN, MD Anderson Cancer Center, Houston, Texas; LillyKutty Thomas, RN, BSN, MD Anderson Cancer Center, Houston, Texas; Laly Thomas, RN, BSN, MD Anderson Cancer Center, Houston, Texas; Sheena Hernandez, RN, BSN, MD Anderson Cancer Center, Houston, Texas

Significance and Background: The number of medication errors resulting in a harm score 3 and above (events that reached the patient) continued to increase among four oncologic surgical areas, over a 3 month span at a large comprehensive cancer center. Medication administration continues to be a primary nursing responsibility and nurses are the last to check for errors prior to administration. Medication errors may have a profound impact on patients, those caring for the patient, and the healthcare facility. A retrospective analysis of patient safety network (PSN) reports for four surgical units over a 13-month period identified that 61% of errors resulted in a harm rating of 3 and above.

Purpose: The purpose of this initiative is to standardize the current medication administration process using a buddy system and improve communication among the team to decrease medication errors.

Interventions: Several clinicians reviewed the literature, current process, and identified four key causes of the surgical medication errors: dosing, timing, unordered drug, and frequency.

Using a medication champion and a train-the-trainer process, quiet time for medication review and a buddy-double check process, will be developed and implemented. Re-education of the PSN event reporting system and associated harm levels will also occur.

Evaluation: The number of medication events with a 3 or greater level of harm will be collected one month after implementation of the interventions and compared with baseline data for the four surgical units involved. Additional data collection will be on-going, with particular attention to 3 and 6 month intervals post implementation.

Discussion: The volume and complexity of medications received by oncology patients creates more opportunities for error. It is critical that strategies be developed to decrease such errors and harm to patients. Utilizing a buddy system to provide a second check prior to medication administration may increase safety medication practices for nurses and patients.

114042 (Poster)

STANDARDIZING THE PROCESS OF INFORMED CONSENT IN CLINICAL TRIALS. Patricia Hinckley, RN, MSN, OCN®, Hartford Hospital, Hartford, Connecticut; Camille Servodidio, RN, MPH, OCN®, CCRP, Hartford Hospital, Hartford, Connecticut; Paul Bassett, RN, BSN, Hartford Hospital, Hartford, Connecticut; Danytza Ward, RN, BS, OCN®, Hartford Hospital, Hartford, Connecticut; Karen Cuddy, RN, BSN, MS, Hartford Hospital, Hartford, Connecticut; Katherine Cuddy, CRA, Hartford Hospital, Hartford, Connecticut; Rachel Opito, BS, Hartford Hospital, Hartford, Connecticut

Significance and Background: The informed consent process is an important component of the research nurse's role in oncology clinical research. The development of a standard operating procedure (SOP) to standardize documentation of all pertinent information in the informed consent process is essential. The use of such an SOP can ensure that the research nurse will include and document the important components of patient teaching during their encounter as well as the patient's verbalized understanding of the oncology clinical trial.

Purpose: The goal of this project was to improve and standardize the research nurses documentation of the informed consent process for oncology research trials through the use of an informed consent template. The template included all the components of the standard operating procedure (SOP) for the informed consent process.

Interventions: The Cancer Clinical Research Office research team developed an informed consent template that included all the components of the SOP for documentation of the informed consent process. A checklist was created that listed eighteen components of the informed consent SOP. The checklist was utilized to evaluate the research nurse's progress notes in the use of the standardized template to determine if key components were present when consenting patients for oncology clinical trials.

Evaluation: Thirty-five patient charts were randomly screened within a 12 month time frame after the SOP was implemented.

Discussion: The SOP for documentation of the informed consent process served as a guide and reminder for the research nurses to include the important elements when consenting patients. Prior to the use of a standardized informed consent template based on the SOP, each of the four research nurses documented their encounter when consenting patients for oncology clinical trials in different ways. Within two months of the creation of the standardized informed consent template all research nurses utilized the template when consenting patients for oncology clinical trials. The most startling change noted was that prior to the use of the template, the patient's verbalized understanding of the clinical trial was rarely captured in the documentation; after the use of the template this information was discussed with the patient and

documented 100 % of the time. Other elements included in the checklist were: the length of time spent with the patient during the encounter; that the patient freely signed the informed consent document; the patient's questions were answered to their satisfaction; and the patient's performance status.

114070 (Poster)

STRAIN COUNTERSTRAIN: A NON-INVASIVE PROCEDURE ALLEVIATING ONCOLOGY RELATED PAIN. Marilyn Haas, PhD, RN, CNS, ANP-BC, Mission Hospital, Asheville, North Carolina; Danna Park, MD, Mission Hospital, Asheville, North Carolina

Significance and Background: Strain and Counterstrain (SCS) is gaining in popularity as a method to treat painful areas of the body without prescribing medications. This gentle, non-invasive method can safely be used on a wide range of patients and conditions, with very few side-effects or contraindications. Small randomized controlled studies and well-designed patient case studies have shown positive effects on pain reduction and, increased muscle strength and range of motion (ROM). However, SCS is understudied in the oncology population and SCS may be utilized to help with neck stiffness discomfort after head/neck irradiation, provide greater ROM for women after breast surgeries, or relieve painful areas from stress. Oncology physicians and nurse practitioners can offer SCS, a benign and evidence-based practice, as an alternative method to alleviate cancer-related pain.

Purpose: The purpose of this pilot study will be to investigate the short-term effects of SCS on the mechanoreceptors in the fascia to relieve pain experienced by oncology patients post treatments. The secondary aim will be to measure changes in patient satisfaction and mood prior and following the SCS intervention.

Interventions: Oncology practitioners will refer oncology patients who are experiencing post-treatment related pain to an advance nurse practitioner (APN) and/or a physician trained in SCS. After obtaining verbal consent, patients will be offered a passive positional procedure that places the body in a position of greatest comfort, thereby relieving pain by reduction and arrest of inappropriate proprioceptor activity that maintains somatic dysfunction. Each tender point will be held for 90 seconds while in a flexion, extension, rotation, or sidebending position.

Evaluation: A convenient sample of 40 oncology patients will be asked to participate in this study from Dec–February, 2013. Location of target muscles and single or multiple tender point(s) will be identified and comfort positions documented. Patients will be asked about their levels of pain on a visual analogue scale prior to and following SCS applications. Self-reports of mood will be collected at the same time. Data assessment of frequencies, t-test analysis, and odds ratios will be performed using the SPSS program.

Discussion: SCS manipulation is a safe and cost-effective way to relieve myofascial patterns of pain with reduced medication use. Oncology patients may physically and emotionally welcome the addition of SCS to their treatment options that is offered by APNs.

114113 (Poster)

PAIN CONTROL, INTERDISCIPLINARY PROCESS FOR IMPROVING PAIN MANAGEMENT ON AN ONCOLOGY UNIT IN A MULTI-SPECIALTY TEACHING INSTITUTION.

Diana Karius, RN, MS, AOCN®, CHPN, Cleveland Clinic, Cleveland, Ohio; Kathy Day, BSN, RN, OCN®, Cleveland Clinic, Cleveland, Ohio; Anne Fitz, MSN, MBA, RN, CHPN, Cleveland Clinic, Cleveland, Ohio; Patti Akins, BSN, RN, OCN®, Cleveland Clinic, Cleveland, Ohio; Julie Fetto, Nursing Director, Cleveland Clinic, Cleveland, Ohio

Significance and Background: Good pain management is imperative for patients with malignant pain. This management is

also challenging due to chronic pain syndromes and complex pain presentations in these individuals. Our scores in the pain domain revealed that our pain management success was highly variable. All health-care providers agreed that good pain management is an essential component of patient care in the oncology setting. Issues and challenges identified included lack of pain management knowledge and expertise on the part of both nurses and physicians. This included a lack of assessment skills and a lack of comfort for all providers in pain management.

Purpose: The purpose of this initiative was to improve pain control on the oncology unit reflected by scores in the 90th percentile.

Interventions: All nurses on the oncology unit were required to attend a mandatory educational curriculum on malignant pain management. Nurses were paired together each shift to provide better coverage of patients pain episodes and pain medication access was prioritized. Nurses were required to initiate the discussion of pain management for their patients on daily rounds and in patient hand-off communication. An algorithm for pain control was developed by nursing leadership and incorporated the responsibilities of the nurses and physicians including a time line for intervention and escalation. Residents rotating onto the unit where required to attend a mandatory pain management class in malignant pain control. They were formally oriented to the unit by nursing leadership and expectations for pain control including available resources were included. Inadequate pain control events were formally reported by nursing into the institution event reporting system. A Palliative Medicine expert physician resource was identified. Their role included daily rounds, education and physician support for off shifts.

Evaluation: All initiatives were implemented in September of 2012. Pain HCAP scores rose from 61.9% in September to 72.7% in October.

Discussion: Implications for nursing: Development of an interdisciplinary approach is essential for the management of the complex pain issues in the oncology patient population. Our initial data supports that a cohesive educational and support plan improves pain control for oncology patients.

114139 (Poster)

UTILIZING NOVEL TECHNOLOGY IN ADULT ONCOLOGY PATIENTS TO ACCURATELY POSITION THE DISTAL TIP OF PERIPHERAL INSERTED CENTRAL CATHETERS TO ELIMINATE POST INSERTION RADIOGRAPHY AND REDUCE COMPLICATIONS. Mikaela Olsen, MS, RN, AOCNS®, JHH, Baltimore, Maryland

Significance and Background: Central venous catheter tip location plays a significant role in the incidence of catheter related complications including malposition, thrombus, and infection. The Oncology peripherally inserted central catheter (PICC) Team, at this NCI-designated comprehensive cancer center, places approximately 700 PICCs per year in patients with all cancer types. Standard practice is to obtain a chest X-ray post placement of a PICC to verify placement. Historically the patient's arm and chest are measured to estimate catheter length and tip position prior to the PICC insertion. This approach is less than ideal and post placement catheter reposition and additional imaging are sometimes required.

Purpose: The purpose of this pilot project was to evaluate the effectiveness of a new FDA approved device using electrocardiography (ECG) technology for the placement of PICCs in adult oncology patients and to ensure accurate CVC tip location at the time of insertion, eliminating the need for chest X-rays.

Interventions: ECG technology for PICC placement was implemented for all oncology patients, with the exception of those with unidentifiable P-waves, from August 2012 to present. A chest-X-ray was obtained to compare radiographic findings with ECG tracings obtained during PICC insertion.

Evaluation: Initiation of this technology resulted in a complete elimination of malpositioned PICC lines at the time of insertion, decreasing the need for chest x-ray(s). PICC RNs were satisfied with this technology and were able to leave the procedure knowing the CVC was properly placed and would not require readjustment.

Discussion: The implementation of a novel PICC tip location technology led to improvements in procedural success and reduced cost, while decreasing radiographic exposure to Oncology patients. This project eliminated the use post-placement chest X-rays in the majority of oncology patients at our center. The PICC RN is able to accurately place the tip of the catheter in the ideal location to improve catheter longevity and decrease associated complications.

114330 (Poster)

REDUCING UNPLANNED READMISSIONS TO ACUTE CARE ONCOLOGY UNITS AT HUNTSMAN CANCER HOSPITAL: A NURSE-LED PROCESS IMPROVEMENT. Jennifer Kelley, RN, OCN®, MSN, Huntsman Cancer Hospital, Salt Lake City, Utah; Susan Childress, RN, OCN®, MSN, Huntsman Cancer Hospital, Salt Lake City, Utah; Danielle Sinischalchi, Huntsman Cancer Specialist, Salt Lake City, Utah; Klay Keeling, MBA, Huntsman Cancer Hospital, Salt Lake City, Utah; Shirleen Gamonal, RN, OCN®, MSN, Huntsman Cancer Hospital, Salt Lake City, Utah; Marina Gamonal, RN, BSN, Huntsman Cancer Hospital, Salt Lake City, Utah; Camila Vargas, RN, CCRN, BSN, Huntsman Cancer Hospital, Salt Lake City, Utah

Significance and Background: Readmission rates within 30 days are publically reported, tracked by CMS (Center for Medicare Services), and most likely most private insurances in the future. Reducing readmissions will help fund healthcare reform. Unplanned readmissions impact patient satisfaction and clinical outcomes for the oncology population. Oncology nurses across an organization's continuum are in a unique position to reduce readmissions by assisting with care transitions from one stage of treatment to the next.

Purpose: Huntsman Cancer Hospital, a NCI designated Cancer Center, set out to improve processes to reduce readmissions by 20% in 2013 as compared to 2010.

Interventions: A multidisciplinary team developed a database to track and trend unplanned potentially preventable readmissions to acute care units. Unplanned readmissions included: infections, treatment complications, gaps in care, and uncontrolled symptoms from cancer or cancer treatments. All readmissions were reviewed. Readmitted patients were interviewed to determine the root cause of the readmission. A process improvement task force involving inpatient and outpatient staff was formed. Improvements were guided by six sigma methodology and modeled after best practices endorsed by the Society for Hospital Medicine. Interventions implemented include: consistent pharmacy coverage, standard medication counseling at discharge, improved patient education using teach-back methods, email alerts, risk assessment tools, and standard outpatient follow up phone calls.

Evaluation: Readmissions were tracked by surgical service and unit. This tracking made forecasting education needs possible both for patients and nurses. The process improvement made it acceptable to talk about patient access issues and gaps in care which improved provider relations. Compliance with follow-up phone calls increased. Patient satisfaction measures were found to correlate with readmissions providing a metric that resonated with clinical care staff. Readmission rates are trending down.

Discussion: Through this process improvement bedside clinicians are recognizing and addressing patterns of care. Communication between outpatient and inpatient areas has improved.

Inpatient and outpatient staff demonstrated forward thinking alerting each other of patients who had difficult transitions in care. This process improvement work adds to the work of Weaver and her colleagues at Fox Chase Cancer Center published in *Oncology Nursing Forum* in 2006.

114525 (Poster)

EARLY INTEGRATION OF PALLIATIVE CARE IN THE BONE MARROW TRANSPLANT SETTING. Samantha Sturch, RN, BSN, Duke University Hospital, Durham, North Carolina; Lauren Conroy, RN, BSN, Duke University Hospital, Durham, North Carolina

Significance and Background: Due to the nature of bone marrow transplant treatments, these patients often experience high symptom burden and decreased quality of life. Nurses tend to underestimate symptom burden and many symptoms are left inadequately managed. Initiating palliative care (PC) intervention early on in the transplant process has been shown to increase patients' perceptions of quality of life while decreasing hospital length of stay, saving an average of \$2.2 million dollars annually. Because nurses are closely involved in daily care, interdisciplinary collaboration can improve quality of care while simultaneously decreasing hospital expenses.

Purpose: This project will help better identify which patients would benefit most from a PC consult by quantifying subjective data. Nurses can bring a new perspective to the interdisciplinary team when determining whether or not a PC consult would be beneficial.

Interventions: After consulting the PC Team, a nurse-led screening tool was developed to be completed for each patient upon admission. A scoring system regarding the patient's hospitalization history, functional status, basic disease process, and comorbidities was used. Points per symptom ranging from 0-3, depending on severity, were assigned and then totaled. After 45 days of data collection, the tool was tailored to better meet the needs of the patients without consulting PC unnecessarily.

Evaluation: Initial review of the data collection revealed that many patients qualified for PC consults, but this rarely occurred. Additionally, patients with high scores were occasionally managed without consultation and had much lower scores after several days of treatment by the Primary Care Team. Score parameters were consequently increased. It was decided that the tool should not only be completed on admission, but also every two weeks, or as needed depending on patient condition.

Discussion: Due to advances in medicine, oncology patients are opting for more aggressive, curative regimens. As a result, quality of life may be compromised and PC is often not consulted until end of life is imminent. Assessing patients early on enables nurses to identify which patients would benefit most from earlier PC intervention. Nurses are patient advocates. Using a universal, nurse-led screening tool will allow every patient to be assessed objectively.

114799 (Poster)

QUIET HOUR IN THE INTENSIVE CARE UNIT. Michelle Commander, RN, BSN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Patricia Spellman, RN, MSN, Memorial Sloan-Kettering Cancer Center, New York, New York; Joyce Kane, RN, MSN, CCRN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Jane Heddal-Siegal, Memorial Sloan-Kettering Cancer Center, New York, New York

Underwriting or funding source: This work was supported by JSPS. KAKENHI Grant-in-Aid for Young Scientists(B) 21792240.

Significance and Background: Intensive care units are filled with disturbing sights and sounds; these have been identified

by patients and shown in the literature to be significant stressors. Sleep deprivation has also been implicated as a possible contributing factor in the development of delirium in the critically ill patient. It may also affect quality of life in these patients. It has been shown that noise decibels are modifiable and can be significantly decreased by behavior modification by the staff. Thus sleep deprivation has been identified as a potentially modifiable problem. This topic is relatively new, but emerging data suggests positive feedback from both staff and family members regarding quiet hour in intensive care units.

Purpose: The intervention of a "quiet hour" was implemented in order to provide peace and quiet to our patients, who are likely to be sleep deprived. It also offers respite to our patients' family members, who are invited to go to the lounge during this time and listen to relaxing live music, which is offered many days. We also now offer tea service to them.

Interventions: Staff members were educated regarding quiet hour. At three p.m. each day, a polite announcement is made indicating that it is time for visitors to make their way to the lounge. At this time, lights are dimmed and loud conversations are discouraged. Patients are left to rest and a calm environment is provided.

Evaluation: The goal of this project was to increase patient rest time and improve satisfaction among staff and family members. According to surveys passed out in the visitor lounge, the overwhelming majority of visitors feel that music in the waiting area during quiet hour offered stress relief. The nursing staff has also informally responded very positively to quiet hour and thus it has been implemented permanently on our unit.

Discussion: Quiet hours might be considered in intensive care units as a way to increase rest for patients and decrease stress for family members. This may also be relevant to other types of units, as the same concepts of rest and peace could be applied to patients in a less critical setting.

115489 (Poster)

REDUCING NOSOCOMIAL "CULTURE" ON A BONE MARROW TRANSPLANT INTENSIVE CARE UNIT. Michelle Ranaghan, RN, BS, OCN®, Brigham and Women's Hospital, Boston, Massachusetts; Aliesha Wisdom, RN, BSN, Brigham and Women's Hospital, Boston, Massachusetts; Candace Hsieh, RN, BSN, CIC, Dana-Farber Cancer Institute, Boston, Massachusetts; Cynthia Jodoin, MHA, BSN, RN, OCN®, Brigham and Women's Hospital, Boston, Massachusetts

Significance and Background: Infections in bone marrow transplant (BMT) patients lead to increased morbidity and mortality rates. Prevention of nosocomial infections is a priority for oncology nurses and should start at the primary nursing level. Monthly infection audits revealed a progressive increase in nosocomial infections on a 10-bed (BMT) intensive care unit prompting staff to look for probable sources.

Purpose: This work seeks to investigate how possible sources of cross-contamination on a single BMT unit can lead to interventions that reduce nosocomial infections.

Interventions: A unit-wide investigation was conducted including email surveys and staff discussions to produce a list of suspected areas of cross-contamination. From this list, nine areas were cultured onto blood agar plates before and after being disinfected for two minutes. Two samples came from the room dividing curtains: both at waist level and an out of reach level. All plates were incubated at 37 °C for 96 hours and photographed to record growth. A UV marking was made for later observation (48 hours) to determine if cleaning protocols were observed during that timeframe. The results were compiled and pictures posted in the staff break room to share the findings. The areas with the most microbial growth were the curtain at waist level, Omnicell, and medication computer. Intervention

suggestions from staff included: a monthly cleaning schedule for curtains, updated list of areas to be cleaned daily, collaboration with pharmacy to keep the Omnicell clean, service-wide reminders to clean shared equipment and reinforced education of staff, patients and visitors.

Evaluation: The project is ongoing and outcomes have yet to be evaluated. Review of monthly infection rates and three-month follow-up culture sampling and UV marking will be performed. We expect the rate of nosocomial infections to decrease on the unit and follow-up cultures to have little to no growth.

Discussion: Nurses have the unique opportunity to provide continuous surveillance of compliance to infection control policies. Reduction of nosocomial infections will improve overall morbidity and mortality rates and patient outcomes. The findings of this investigation can be applied not only to BMT units but oncology units as well.

115786 (Poster)

LISTENING CLOSELY: AN EVALUATION OF HOSPITAL NOISE ON AN ONCOLOGY UNIT. Keri McDevitt, BSN, RN-BC, OCN®, The Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania; Sarah H. Kagan, PhD, RN, University of Pennsylvania School of Nursing, Philadelphia, Pennsylvania; Emily R. Hyman, BSE Candidate for Systems Science and Engineering, University of Pennsylvania: School of Engineering and Applied Science 2014, Philadelphia, Pennsylvania

Underwriting or funding source: Inform Genomics, Inc

Significance and Background: Research has demonstrated that increased levels of hospital noise have effects on both patients and hospital staff. For example, negative effects on patient outcomes include delay in healing time and increased stress on the body. Current research is limited to medical floors and intensive care units. Little research was found on how hospital noise affects the oncology patient population.

Purpose: The purpose of this project was to determine the nursing staffs' knowledge and perception of hospital noise on an inpatient medical oncology unit at an academic medical center. Literature suggests there are a variety of types of noise within the hospital, whether it be voice-related or technology-related. Detail was provided on how nursing staff could assist in decreasing current noise levels. In addition, partnership was developed with engineering students to more effectively evaluate the noise types and levels on the unit.

Interventions: To begin the project, a pre-test was administered electronically to the nursing staff to determine baseline knowledge of hospital noise standards. Education was given to nursing staff including, impacts of hospital noise on patients and staff and the standards of noise levels set by the World Health Organization (WHO). Quantitative measurements of noise levels were collected using a decibel meter to monitor the oncology unit at various points in time.

Evaluation: An electronic post-test was administered to the nursing staff following the educational interventions. Through these learnings, the goal of decreasing the amount of noise that impacts patients and families on the unit will be evaluated through patient satisfaction scores. Comparisons will be made to other inpatient medical oncology patient care units and hospital-wide.

Discussion: Oncology patients experience stress from many aspects related to diagnosis and treatment. The inpatient nursing staff has the ability to improve their overall hospital experience by being mindful of various types of noise and the decibel level. Different initiatives can be introduced from this data in areas that need improvement to reduce noise levels. An important next step is translating this information to the ambulatory care setting as the attention to the outpatient care center should be equal to that of that inpatient care units.

115788 (Poster)

MAKING A SAFE TRANSITION: THE USE OF AN INTER-HOSPITAL TRANSFER DOCUMENT IN MEDICAL ONCOLOGY. Karen Arnold-Korzeniowski, BSN, RN, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania; Mary Denno, MSN, RN, CMSRN, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania; Kristen Maloney, MSN, RN, AOCNS®, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania

Significance and Background: The oncology patient population consists of highly acute and complex disease and symptom management. Patients are frequently transferred to a large, academic medical institution from outside facilities for a variety of reasons. Nursing handoff is an extremely important part of patient quality and safety. It was noted that the report received does not always match patient condition on arrival. In addition, the accepting physician/nurse practitioner receives information at various times resulting in potential inaccuracies. Data supports that some patients are transferred to a higher level of care within hours of arrival.

Purpose: To address growing concern for patient safety on transfer, a standard report sheet was developed by clinical nurses. This sheet was created to be used by the nurse receiving report from the outside facility. Input for the content of the document was obtained from fellow clinical nurses, nursing leadership and physician/nurse practitioner teams. For example, the document contains areas for reason for transfer and important test/culture results. Specific to oncology are blood product transfusion and chemotherapy received.

Interventions: An eight week pilot was completed by clinical nurses on three inpatient oncology units. After report was received, the covering provider was notified of the available information. Receiving nurse and provider discussed plan of care based on report given. Team discussions were held for concerns related to patient condition. A brief survey was submitted by the nurse after patient arrival to determine effectiveness of the document.

Evaluation: Surveys submitted were evaluated. All nurses who used the survey felt that the document was helpful in supporting a safe transition in care. From a nursing perspective, all patients were appropriate for the current level of care. Suggestions regarding the formatting of the document were taken into account and portions of the document were reformatted.

Discussion: The Inter-Hospital Transfer Document assists in the standardization of nurse to nurse handoff from an outside facility. Vital information is reported to ensure the best care possible is available to the patient upon arrival. The document makes this information available to all members of the patient care team to reduce unnecessary variations in care.

116149 (Poster)

THE FECAL TWINS: REDUCING THE TRANSMISSION OF VANCOMYCIN RESISTANT ENTEROCOCCUS AND CLOSTRIDIUM DIFFICILE ON AN INPATIENT ONCOLOGY UNIT. Tracy Weddle, MS, RN, CNS, OCN®, Sharp Memorial Hospital, San Diego, California

Significance and Background: Vancomycin Resistant Enterococcus (VRE) and Clostridium difficile (C-diff) are two nosocomial pathogens associated with fecal contamination. These pathogens have increased in prevalence and severity in the United States and are associated with longer lengths of hospital stay and increased healthcare costs. In 2010, the 30 bed oncology unit at Sharp Memorial Hospital (1West) had 27 VRE and 3 C-diff transmissions with subsequent interventions implemented to reduce these numbers. In 2011, the VRE transmission decreased slightly to 21; however, there were 19 C-diff transmissions.

Purpose: Although multiple interventions had been implemented during the previous two years, the transmission rate of VRE only slightly decreased and the C-diff transmission increased dramatically. In 2012, an aggressive performance improvement project was initiated to decrease the transmission numbers of both pathogens.

Interventions: A work group met to analyze the issue in depth and a 3 phase program was designed and implemented.

Phase I encouraged and empowered patients and families to take control of their infection prevention through a program called "W.A.S.H. away infection!" Multiple strategies included brochures, scripting for nurses, hand wipes accessible to the patient and staff buttons encouraging patients to ask them if they washed their hands. Phase II focused on healthcare providers. The program "Infection Prevention is Everyone's Business" included a positive reward system to encourage compliance with hand hygiene and infection prevention practices. Phase III, the Volunteer Infection Prevention (VIP) team, used volunteers to wipe down high touch areas with bleach in patient rooms and throughout the unit. Volunteers also completed a training program for infection prevention in the oncology patient.

Evaluation: The Fecal Twins performance improvement project is a concentrated effort to reduce the transmission of VRE and C-diff. Based on efforts to date, transmission numbers have decreased. Since January 2012, 1West has 8 VRE transmissions and 9 C-diff transmissions.

Discussion: Oncology nurses play an important role in partnering with patients and families to educate and role model infection prevention strategies. This multi-phased program resulted in substantial decreases in transmission of VRE and C-diff.

116246 (Poster)

IMPROVING END-OF-LIFE CARE WITH A NURSE DRIVEN PATHWAY. Diana McMahon, MSN, RN, OCN®, OSU Comprehensive Cancer Hospital–The James, Columbus, Ohio

Significance and Background: Addressing symptom management and end of life (EOL) care are priorities set by national organizations for improving quality of cancer care. The Institute of Medicine and Oncology Nursing Society Position Statement on Quality Cancer Care include comprehensive symptom management and EOL care as priorities. In the United States, the most frequent place of death is in an acute care facility, with cancer the most common cause of death.

Purpose: An EOL Task Force was appointed to recommend, create, and implement an intervention to improve EOL care for our 500 inpatients who die annually. Research shows improved quality of care, more effective use of resources, and enhanced satisfaction with a formalized EOL protocol. Since nursing care of the patient and family provided the most significant opportunity for enhancement of care, this multidisciplinary project was heavily geared towards a nursing intervention.

Interventions: The EOL Care Pathway development included a computerized order set, electronic nursing flow sheet, and nursing care plan. Education sessions for nurses and advanced practice professionals were provided, along with individualized education to physicians. A pilot of the Pathway intervention began on the unit with the greatest burden of deaths and discharges to hospice in late 2010. The EOL Task Force periodically convened focus groups of nurses to seek input for modifying the pathway process. Monitoring tools in the project included a family satisfaction survey and a financial and resource data query report. Nursing contributed to the Pathway at every step through envisioning, design, education and implementation.

Evaluation: After implementation, 33% of eligible patients were enrolled reflecting increasing acceptance of the pathway. In addition, the average length of stay was reduced and family satisfaction showed significant improvement for patients enrolled in the Pathway. Initial nursing education efforts

demonstrated nurses were eager to enhance their knowledge about symptom control at the EOL.

Discussion: The goal is to spread the pathway throughout the medical center and create a modified version for ambulatory clinics. With the addition of an electronic medical record, exploring patient-centered outcomes such as symptom management will help improve patient care and define nursing educational needs.

116540 (Poster)

IS SITZ BATH EFFECTIVE FOR PREVENTING INFECTION IN NEUTROPENIA PATIENTS? EVIDENCE-BASED PRACTICE IN KOREA. Youn Suk Doo, RN, MSN, KOAPN, Asan Medical Center, Seoul

Significance and Background: Prevention of infection to cancer patients is significant because of its association with the patient's mortality and cost effective care. The nursing protocol for infection prevention at ASAN medical center included sitz bath as one of methods which was particularly for the peri-anal area infection prevention if absolute neutrophil count of patients decrease below 1,000/UL. However, there were many differences in indication and sorts of disinfectant for sitz bath when we surveyed the standard of sitz bath application in Korean tertiary hospitals. We found that our sitz bath protocol for neutropenia patients did not provide reliable data to nurses, patients, and caregivers as a standardizable nursing practice.

Purpose: We aimed to find evidences for sitz bath to prevent infection in neutropenia patients through searching literatures, guidelines and protocols in this study.

Interventions: Our EBP team searched references through PubMed, CINAHL, CCRCT and RISS 4 U. We explored the terms that were tumor, neoplasm, BMT, hematopoietic stem cell transplantation, neutropenia, chemotherapy, immune suppression, neutropenic, perianal bath, warm bath, hot bath, water cure, hydro, hip bath, bath and sitz bath, pain, and infection. The literature search included citations from January 2001 to December 2011. Neither relatable data about sitz bath that was applied to the neutropenia patients nor records of sitz bath for preventing infection were found in guidelines of Center for Disease Control and Prevention and Oncology Nursing Society. We reached the conclusion that there was no literature discussing the evidence of effectiveness of sitz bath in infection prevention for neutropenia patients

Evaluation: Based on evidence, the practice committee recommended that sitz bath is not a standardizable nursing practice to prevent infection in neutropenia patients. The committee decided to exclude sitz bath in the nursing protocol and erase paragraphs dictating sitz bath in patient's education materials.

Discussion: The result about sitz bath to prevent infection in neutropenia patients helped hemato-oncology nurses to perform evidence based practice as well as excluded unnecessary nursing practice in our hospital. We will continue finding evidences about nursing practices concerning cancer treatment trajectory in clinical setting.

116570 (Poster)

IMPROVING CLINIC OUTCOMES THROUGH AN RN/MD PARTNERED AMBULATORY CARE MODEL. Robert Davis, RN, MS, BC, The Ohio State University Medical Center–Arthur G. James Cancer Hospital, Columbus, Ohio; Katie Sanders, RN, The Ohio State University Medical Center–Arthur G. James Cancer Hospital, Columbus, Ohio; Debbie Noble, RN, The Ohio State University Medical Center–Arthur G. James Cancer Hospital, Columbus, Ohio

Significance and Background: Over the past 20 years, a number of health care services have transitioned from the inpatient

to the outpatient setting. From 1988 to 2008 total hospital revenues associated with outpatient care rose from 20% to 39% and is expected to grow another 20% by 2019. Complex multidisciplinary ambulatory services will need to be coordinated to ensure optimal patient outcomes. According to the AAAC (American Academy of Ambulatory Care) 25% of registered nurses in the United States are employed in the ambulatory care setting. RN/MD partnered ambulatory nurses provide regular, consistent relationships with patients and their families, improves safety, increase quality of services and improve patient outcomes. Prior to implementing an RN/MD partnered ambulatory nursing model of care in this clinic, medical secretaries/assistants were responsible for coordinating patient care. Nurses primarily served as clinic triage- assessing and rooming patients. Evaluation of this identified deficiencies including a lack of patient education, coordination of care, outcomes management, clinical procedure support, patient advocacy and critical thinking skills. The RN/MD partnered model was intended to provide continuity of care through a single non-physician provider while affording a more direct means of communication between all providers.

Purpose: To institute a new model of nursing care in the ambulatory clinic.

Interventions: The RN/MD partnered care model began by pairing a nurse with a physician. The role of the nurse includes serving as the primary clinic contact, assisting with procedures and specialized care, communication with the healthcare team and coordination of patient care.

Evaluation: Press-Ganey and NDNQI surveys were utilized and a physician survey tool was developed. Data was collected, measured and monitored showing patient and staff has risen since this model was implemented. Physicians also report being highly satisfied with this model of care. Patient, staff and physician satisfaction will continue to be monitored on an on-going basis with changes implemented, as needed.

Discussion: Utilizing the RN/MD partnered nurse model results in improved outcomes including patient, staff and physician satisfaction.

116590 (Poster)

HEALING CLINICALLY COMPLEX WOUNDS IN A CANCER TREATMENT CENTER USING ACTIVE LEPTOSPERMUM HONEY. Patrice Dillow, RN, CWOCN, MSN, APRN, Cancer Treatment Center of America, Zion, Illinois

Significance and Background: Nurses in the oncology setting, particularly WOCN's, are often the primary resource for managing skin or integumentary issues. Resolving those issues requires the use of advanced wound care products. Having ALH available in different formats makes it a valuable and versatile tool as part of the total wound care treatment plan. The combined mechanism of actions of ALH: creating an osmotic potential which decreases edema, stimulating cytokines which promotes normal healing and bringing the pH level into balance, are all key factors for the nurse when making this clinical decision.

Purpose: To evaluate the clinical effectiveness of ALH dressings in a variety of formats, by assessing the outcomes for our oncology patients with clinically complex wounds.

Interventions: 6 patients with varying wound/integumentary issues were treated using a variety of ALH dressings after failure to heal with traditional wound care. Age range: 39-64, 5 female and 1 male, most had 2-3 comorbidities in addition to cancer diagnosis, chronic wounds included surgical sites, radiation dermatitis and tumor presence. 4 of 6 were treated with a new hydrogel colloidal sheet (MH-HCS) impregnated with ALH. 2 were treated with ALH gel and absorbent dressings or negative pressure therapy for excessive exudates.

Evaluation: All wounds exhibited signs of decreased inflammatory response, increase in healthy tissue or wound closure. All patients initially reporting pain on evaluation reported a

decrease in their pain levels. Promotion of normal wound healing progression and pain control are key issues for oncology nurses.

Discussion: ALH is a scientifically proven advanced wound care product that is growing in use within the oncologic patient population. There is a growing number of peer reviewed publications and research presentations that support the results of this case series. Oncology nurses should consider this evidence based alternative when dealing with clinically complex or chronic wounds.

116605 (Poster)

PATIENT SATISFACTION ASSOCIATED WITH USE OF FENTANYL SUBLINGUAL SPRAY FOR THE MANAGEMENT OF BREAKTHROUGH PAIN IN PATIENTS WITH CANCER OF DIFFERENT TYPES AND STAGES. Michelle Rhiner, RN-BC, MSN, GNP-BC, ACHPN, CCM, Loma Linda University, Loma Linda, California; Neal Slatkin, MD, Hospice of the Valley, San Jose, and El Camino Hospital, Mountain View, California; Lisa Stearns, MD, Center for Pain and Supportive Care, Scottsdale, Arizona; Larry Dillaha, MD, INSYS Therapeutics, Scottsdale, Arizona; Neha Parikh, MS, INSYS Therapeutics, Scottsdale, Arizona

Significance and Background: Breakthrough cancer pain (BTCP) is often inadequately treated with short-acting opioids and negatively impacts quality of life. Oncology nurses are ethically and morally mandated to assess the multifaceted components of pain and advocate for improved comfort and satisfaction while maintaining patient safety.

Purpose: This analysis examines patient satisfaction in a multicenter, randomized, double-blind, placebo-controlled clinical trial of fentanyl sublingual spray for BTCP in patients with different types and stages of cancer.

Interventions: Opioid-tolerant adults (aged 18 years or older) receiving around-the-clock opioids for baseline pain and with 1-4 episodes/day of BTCP were enrolled in a 26-day open-label titration phase (N=130). Those who successfully titrated to a stable, effective dose (100-1600 mcg) of fentanyl sublingual spray were eligible for enrollment in the 26-day double-blind phase (n=96), during which patients received 7 active doses of fentanyl sublingual spray and 3 placebo doses. Patient satisfaction was assessed using the Treatment Satisfaction Questionnaire for Medication (TSQM; 0-100 scale, higher scores indicate greater satisfaction). Patients were instructed to base responses on usual medication at baseline (before titration) and study medication post-titration (before randomization). Adverse events (AEs) were recorded.

Evaluation: The mean (SD) age of patients in the titration phase was 55.6 (12.2) years. The most common cancers were reproductive (30.0%), breast (17.7%), lung (17.7%), skin (12.3%), and head/neck (12.3%). The mean (SD) duration of cancer was 7.5 (9.4) years; 59.2% of cancers were stages 2 (10.8%), 3 (17.7%), and 4 (30.8%). TSQM scores improved after titration; mean (SD) change from baseline to post-titration was 26.1 (20.9) for Effectiveness, 12.5 (30.8) for Side Effects, 8.0 (21.2) for Convenience, and 20.5 (23.1) for Global Satisfaction. Post-titration, 88.5% of patients were satisfied with treatment versus 40.8% at baseline. AEs were reported for 60.0% of patients during titration; nausea (13.1%) was the most common.

Discussion: These results suggest that the use of fentanyl sublingual spray for BTCP leads to a high degree of patient satisfaction across a heterogeneous cohort of cancer patients. This is particularly important to oncology nurses who care for patients with cancer and to patients who struggle to achieve BTCP relief.

116697 (Poster)

THE EVOLUTION OF AN INPATIENT NURSE PRACTITIONER HEMATOLOGY SERVICE. Gretchen McNally, ANP-BC, James Cancer Hospital, Columbus, Ohio; Kathy Florence,

MSN, BC-ACNP, James Cancer Hospital, Columbus, Ohio; April Logue, MSN, CNP, James Cancer Hospital, Columbus, Ohio

Significance and Background: Little information exists on the inpatient role of the nurse practitioner in hematology/oncology. A nurse practitioner (NP) dedicated hematology service first opened in January of 2007 at The James Cancer Hospital, with the role/scope expanding over the past five years. Initially the purpose was to care for hospitalized patients receiving routine chemo immunotherapy. The team consisted of two NPs and an attending physician, who was shared with the inpatient hematology teaching service. Anecdotally the census ranged from 2-8 patients the first year, and most recently averages 18 patients daily. Currently the hematology nurse practitioner (HNP) service is multidisciplinary and includes an unshared attending physician, pharmacist, 2 patient care resource managers and 5-6 NPs. HNP provides high quality care for a wide variety of hematology/oncology patients including the workup of newly diagnosed or relapsed lymphoma patients, administering treatment regimens requiring hospitalization and management of treatment/disease complications such as febrile neutropenia. The nurse practitioners independently perform procedures including lumbar punctures, intrathecal chemotherapy administration, bone marrow biopsies and aspirates, and access ommaya reservoirs. As the service evolved educational gaps were met through personalized training and mentorship. HNP is detail oriented and customer service driven. It provides continuity for patients requiring multiple cycles of treatment, as the attending physicians rotate every two weeks in comparison to the teaching service, where the fellows, residents and interns change every month.

Purpose: To detail the successful expansion and advanced training of the HNP service, ensuring safe and high quality care is provided to a variety of hospitalized hematology/oncology patients.

Interventions: Not applicable

Evaluation: Not applicable

Discussion: Nurse practitioners are in a unique position to positively impact the care of hospitalized hematology/oncology patients. Little has been published on how to successfully implement a highly functioning and independent inpatient nurse practitioner hematology service. Suggestions are provided for achieving this outcome.

116938 (Poster)

CAREGIVER BURDEN AND STRAIN: IDENTIFYING THE RIGHT TOOL TO ASSESS CAREGIVER NEEDS. Gayle Ann Carmina, MSN, RN, ANP-BC, GNP-BC, UT MD Anderson Cancer Center, Houston, Texas; Cynthia Murphy, MS, RN-BC, OCN®, UT MD Anderson Cancer Center, Houston, Texas; Yvette Ong, MS, BSN, RN, OCN®, NE-BC, UT MD Anderson Cancer Center, Houston, Texas

Underwriting or funding source: Financial support for this study was provided by INSYS Therapeutics, Phoenix, AZ.

Significance and Background: Patients' caregivers face unique challenges because they often assume roles without adequate preparation. This is especially true among oncology patients' caregivers. The nature of treatment and disease progression prompts constant physical and emotional support. Currently, our primary nursing care focuses on the patients, and less attention is given to burden and strain experienced by their caregivers.

Purpose: To describe a QI project that compared two valid and reliable tools in assessing and measuring burden and strain among oncology patients' caregivers.

Interventions: A team of clinical nurses, nurse educators, nursing leaders, and research mentors was developed to ad-

dress the issue of caregiver burden and strain. After reviewing the Oncology Nursing Society's meta-analysis study of Putting Evidence into Practice: Nursing Assessment and Interventions to Reduce Family Caregiver Strain and Burden, a literature review was conducted to identify valid and reliable assessment tools used to evaluate caregiver burden and strain. The team compared several tools introduced between 1980 and 2011 and selected two tools that best captured the burden and strain oncology patients' caregivers experience. The Caregiver Quality of Life Index-Cancer (CQOLC) and the Caregiver Demand Scale (CDS) were the two tools that had the most votes among the team members and hence, were selected. The CQOLC and CDS tools were then distributed to 54 caregivers who were chosen to participate based on established criteria.

Evaluation: Each participating caregiver was asked to provide answers to a short demographic questionnaire and indicate which of the tools best addressed the issues that they experienced as a caregiver. The CDS was the most preferred tool among the survey participants. The results of key findings, the correlation between the assessment tools, and the demographic information of the survey participants will be presented.

Discussion: As advocates, oncology nurses must recognize the importance of caregivers and their effect on patient outcomes. It is crucial to accurately assess and address caregivers' burden and strain during cancer treatment and develop aides to assist them. Future steps should include utilizing a caregiver assessment at specified intervals and implementation of interventions focused to decrease caregiver burden and strain.

117091 (Poster)

THE USE OF FAMILY MEETINGS AND SUPPORTSCREEN TO IMPROVE COMMUNICATION AND PATIENT SATISFACTION IN AN ONCOLOGY ICU ENVIRONMENT.

Regina, RN, MSN/ED, CCRN, City of Hope Medical Center, Duarte, California; Jeseo Castro, RN, BSN, City of Hope Medical Center, Duarte, California

Significance and Background: Having an extended stay in an ICU can be challenging for cancer patients and their families. The ICU team of physicians, professional nurses and social workers are faced with many questions from patients and their caregivers. The responses to these questions are insufficient and/or inconsistent across the treatment team. This communication breakdown leads to undue stress on the patient and their caregivers as well as the patient care team. Research shows that planned meetings within 48 to 72 hours of ICU admission and again at regular intervals improves communication and assists with shared decision-making. Assisting the families in identifying values that inform decision-making can significantly improve a family's experience in the ICU environment.

Purpose: To improve communication and ultimately patient care satisfaction, an oncology ICU multidisciplinary team, including physicians, professional nurses, and social workers, was charged with developing a structure for family meetings. This ICU Family Meeting will assist in identifying the goals and plan of care in the ICU and will provide the patient and their family support from admission to the ICU to the completion of their ICU stay.

Interventions: Pamphlets specifically designed to explain the purpose of ICU Family Meetings are given to all patient families after admission to the ICU. The need for a family meeting is determined during daily bedside multidisciplinary rounds and the social worker then coordinates the meeting with the family, nurse and physicians involved. The RN's role during these meetings is essential to provide support and reinforcement of the discussion with the family. Nurses also provide SupportScreen to caregivers which provide an automated touch-screen communication tool for them to express the practical and psychosocial needs of the patients. The information collected from SupportScreen is elec-

tronically sent to the appropriate discipline for follow-up and can be also be addressed during family meetings.

Evaluation: After implementation of family meetings and SupportScreen, lengths of stay in the ICU should continue to decrease and patient satisfaction scores from Press Ganey will continue to improve.

Discussion: SupportScreen summaries show an increase in communication and satisfaction. It allows for opportunities addressing concerns in a multidisciplinary approach.

117149 (Poster)

CARDIOTOXICITY FROM CANCER THERAPIES: NURSING KNOWLEDGE AND MONITORING STRATEGIES.

Mary Elizabeth Davis, RN, MSN, AOCNS®, MSKCC, New York, New York

Significance and Background: Cardiovascular disease is the leading cause of death in the United States, followed by cancer. In many cases, the toxicity of cancer modalities leads to cardiovascular disease. These cardiac effects may cause temporary or permanent disability. Chemotherapy agents such as anthracyclines and anthraquinones can be associated with type one dysfunction with the potential to cause cumulative, permanent damage including congestive heart failure. Type 2 dysfunction, associated with agents such as trastuzumab, can cause contractile impairment, but is more often reversible. Hypertension is a side effect of many newer agents such as bevacizumab and sunitinib; other cardiotoxic effects such as thromboemboli and dysrhythmias may occur. Radiation therapy to the thorax, a common modality for lymphomas, breast and lung cancers, is also associated with increased cardiac risk. Oncology nurses should understand the impact of cancer treatment on cardiac function and recognize the associated symptomatology.

Purpose: This presentation will provide an overview of cancer-related cardiotoxicity, risk factors, cardioprotection, monitoring, and nursing care strategies. Development of an ambulatory nursing surveillance program will be presented.

Interventions: Knowledge of the risk factors and etiology of cardiotoxicity can guide nursing assessment, enhance patient education and improve care management. Assessment of patient risk via thorough review of the cancer and family history is essential. Evaluation of baseline and ongoing diagnostics with the management team and development of patient specific goals is also paramount. Oncology nurses can monitor and educate patients to recognize symptoms, reinforce targeted goals for weight and blood pressures and suggest self care activities to promote health.

Evaluation: Research clearly supports comprehensive ambulatory management programs improve quality of life and reduce cardiac-related hospital lengths of stay and readmissions. Our program will facilitate early recognition and nursing management of toxicity and cardiac decompensation.

Discussion: As more patients are living with and surviving cancer, cardiac effects need to be recognized and addressed. Establishment of targeted goals for vital signs and close monitoring of adherence to medication regimes is vital. The oncology nurse, knowledgeable about the potential cardiac effects of cancer modalities, can closely monitor, intervene and educate patients at risk to promote well-being, self care and healthy lifestyle modifications.

117177 (Poster)

PULMONARY TUBERCULOSIS: A FORMIDABLE CHALLENGE FOR THE ONCOLOGY NURSE.

Alice, RN, BSN, BS, MBA, MSKCC, New York, New York

Significance and Background: Over one third of the world's population is infected with tuberculosis (TB). Eight million new cases are diagnosed with over one million deaths annually. Immigration patterns and multiculturalism in the United States

are bringing the issue of TB to the forefront of oncology nursing. Those at increased risk include immigrants from countries with high rates of TB, individuals with hematologic disorders, cancer of the head and neck, compromised immune systems and the elderly. Latent TB can convert to active stage during chemotherapy, especially with the use of high dose steroids. Active TB, in the cancer population, contributes to patient morbidity and mortality and presents significant risk to other patients and hospital staff.

Purpose: This presentation provides an overview of the complex needs and nursing challenges in the management of cancer patients with active or latent TB.

Interventions: Oncology nurses need to incorporate TB risk assessment into initial visits. Screening should include a clinical assessment with review for active symptoms of TB. An epidemiologic assessment including exposure history, birthplace in or travel to a high prevalence area is especially important as is review of diagnostic imaging with the pulmonologist. Tuberculin testing remains a significant and simple screening tool. Education about safety precautions and the importance of adherence with the multiple drug therapy helps prevent spread of this highly infectious disease as well as the development of resistant TB strains. The nurse must be knowledgeable of the treatment and related side effects, especially those that complicate cancer therapies such as gastrointestinal and hepatic toxicity. Aggressive assessment and symptom management is a crucial part of effective and on-going nursing care.

Evaluation: Proactive nursing education and symptom management, promoting compliance to assist cancer patients to complete their prescribed TB therapy can diminish morbidity and mortality associated with active TB and reduce its spread.

Discussion: Knowledge and use of safety precautions for both patients and clinicians is essential. Screening and early clinical recognition of active disease could reduce exposure and healthcare-associated transmission of TB. TB is a very formidable and deadly disease, BUT with proper detection, skilled nursing, combined with patient education and compliance, it is treatable and curable.

117196 (Poster)

COMPASSION FATIGUE: ACKNOWLEDGING GRIEF AND LOSS INHERENT IN THE ONCOLOGY NURSE ROLE.

Wanda Strange, RN, OCN®, Mary Crowley Research Center, Dallas, Texas; Cindi Bedell, MSN, RN, ANP-C, Mary Crowley Cancer Research Center, Dallas, Texas; Kimberly Reed, RN, Mary Crowley Cancer Research Center, Dallas, Texas; Tricia McCord, RN, OCN®, Mary Crowley Cancer Research Center, Dallas, Texas; Jeanne Jones, MSN, RN, Mary Crowley Cancer Research Center, Dallas, Texas

Significance and Background: Every oncology nurse identifies with the grief and pain of losing a beloved patient. Often the notification of one death followed closely by another compounds and complicates the grieving process. Failure to acknowledge multiple losses makes us vulnerable to compassion fatigue and burnout.

Purpose: After the loss of several special patients in a short time period, the staff was emotionally exhausted. Discussions with the hospital chaplain and social worker led to the development of regular remembrance celebrations. Semi-annual events proved too infrequent and yielded long, overwhelming lists of patients. Meeting too frequently diminished the significance. Every four months proved to be the appropriate time frame. The conference room provided a safe environment to share memories and express emotions.

Interventions: Over the past year each remembrance had two components. The consistent component was a time for sharing memories. Power point slides presented the names, date of birth,

and date of death of each of the patient. Following the time of quiet reflection on the individual patients, the staff shared specific thoughts and memories. Some memories bring tears, but more often the shared stories evoked smiles and laughter. The other component changed from session to session. Chaplains and administrators shared perspective on the contribution the staff made to the lives of those we serve. Presentations on compassion fatigue benefited the staff. Other elements included music and poetry as well as the lighting of candles, presentation of carnations in memory of each patient. Art therapy allowed individual staff members to create images representing individual patients.

Evaluation: The cancer research environment requires the staff to give of themselves. It is critical that nurses and non-clinical staff support each other as we care for the patients and their families.

Discussion: As oncology nurses we must be aware signs of distress in our co-workers and in ourselves. In airplane emergency you must put on your own oxygen mask before helping others. In much the same way we can only care for others when we first care for ourselves.

117202 (Poster)

KEEPING IT SAFE: MEASURING THE SAFETY IMPACT OF A NURSE-DRIVEN CHEMOTHERAPY POLICY. Karen Donato, RN, BSN, OCN®, UHCMC Seidman Cancer Center, Cleveland, Ohio; Amy Wakeling, RN, BSN, OCN®, UHCMC Seidman Cancer Center, Cleveland, Ohio

Significance and Background: Chemotherapy consists of multiple high-risk, high-alert medications given throughout a continuum of care spanning inpatient, outpatient, and multiple ambulatory settings. Any mistakes may have devastating effects on patients and their disease outcomes. Review of errors and near misses demonstrated patterns and identified pivotal points in the chemotherapy process as opportunities for improvement.

Purpose: The purpose of this project was to design and implement a nurse-driven chemotherapy policy that integrated stringent practices which address these safety issues and to evaluate the impact. Guidelines from the Oncology Nursing Society (ONS), recommendations from the Institute of Safe Medication Practices (ISMP), and our institution's High Alert Medication policy were incorporated.

Interventions: A mechanism to verify all previously administered cycles of chemotherapy was developed. Oncology nurses collaborated with the electronic medical record team, creating the Oncology Medication Report by Date, which is accessible from any location in the system, regardless of the method of documentation used. Policy mandates review of this report by the physician, pharmacist, and nurse prior to prescribing, preparing and administering all chemotherapy. The previous cycles are compared to the current cycle for dosing, sequencing, and timing. Oncology nurses created chemotherapy checklists highlighting critical policy changes which serve as documentation tools noting all steps were followed. They indicate the more rigorous verification process for nurses administering chemotherapy, encompassing review of previous cycles, verification of parameters, indications, calculations, patient identification, pump programming and comparison of medication against physician order. Physicians are responsible for writing/entering chemotherapy orders. RN's are not permitted to fill in dosages or dates, even if cosigned by the physician. Pre-printed chemotherapy order sets are considered best practice. Chemotherapy medications that are changed by a dose increase or frequency outside of the normal range are not acceptable. Implementation included developing tools, educational presentations, bi-weekly meetings, and careful monitoring. Input from all oncology nurses was sought and actively encouraged.

Evaluation: Evaluation of the safety impact (errors and near misses) is underway and will be presented.

Discussion: This policy highlights a culture of safety, in which chemotherapy administration is a core domain. Success is dependant on the expertise and guidance of experienced oncology nurses and nursing leaders.

117265 (Poster)

APPLYING EVIDENCE-BASED PRACTICE: THE USE OF GUIDED IMAGERY FOR PAIN CONTROL. Peggy Burhenn, MS, RN, AOCNS®, City of Hope National Medical Center, Duarte, California; Griselda Villegas, RN, OCN®, City of Hope National Medical Center, Duarte, California; Kate Kravits, RN, MSN, City of Hope National Medical Center, Duarte, California; Jill Olausson, RN, MSN, CDE, City of Hope National Medical Center, Duarte, California; Carolina Uranga, RN, BSN, OCN®, City of Hope National Medical Center, Duarte, California

Significance and Background: Guided imagery draws attention from physical and psychological discomfort and refocuses on pleasant images and has been shown to be effective for pain control in patients with cancer. It is recommended as an option to control pain by NCI, NCCN and ACS. Our team participated in the ONS Institute for Evidence-Based Practice Change and performed a literature search on the use of guided imagery for pain management. Our institution policy recommends use of non-drug interventions such as imagery for pain relief. However, nurses were not trained in the use of guided imagery. Review of baseline hospital data noted deficiencies in the application of non-pharmacological methods to control pain.

Purpose: Develop a guided imagery script and teach nurses to deliver a guided imagery intervention to patients for pain control.

Interventions: Together with a senior research specialist trained in guided imagery, a group of nurses (n=7) were educated in providing this intervention to patients. A one day course covered the scientific rationale for guided imagery and hands on experience providing the intervention. At the conclusion each nurse was able to perform a 15 minute guided imagery intervention and was competent to offer guided imagery to patients on the medical oncology units.

Evaluation: A pilot offered guided imagery to 20 patients with uncontrolled pain using pharmaceuticals. Positive feedback was elicited from the patients regarding the intervention. Interestingly, the nurses also benefited from providing the guided imagery, noting calming effects, a stronger therapeutic relationship with the patient receiving the intervention and success of the intervention for pain management.

Discussion: Oncology nurses are in a unique position to intervene on behalf of patients in pain. Nurses who are not familiar with this intervention can be successfully trained to provide guided imagery for pain control. However, even a 15 minute intervention was time consuming and challenging to schedule. Our future plan includes creating a video that can be downloaded onto inpatient television.

117348 (Poster)

MOVING CYTOXAN MOBILIZATION TO OUTPATIENT SETTING. "SAVE MY INPATIENT BED." Gerardo Gorospe III, RN, BSN, PHN, MSN, City of Hope, Duarte, California; Shirley Johnson, RN, MS, MBA, City of Hope, Duarte, California; Kimberly Carli, MSHS, CSSBB, City of Hope, Duarte, California; Brenda Williams, RN, BSN, City of Hope, Duarte, California; Amin Rabiei, BA, City of Hope, Duarte, California

Significance and Background: Cytosin mobilization (CM) is used for Autologous stem cell transplants. City of Hope is one of the few hospitals that admit patients to their hospital for CM prior to a HCT transplant. At COH 94% of all CM are performed

in an inpatient setting. The standard of care at most NCI centers is to perform this procedure in an outpatient setting. By maintaining this as an inpatient process we are continually using an average of 10 inpatient beds per month, averaging 27.5 hours per stay, and costing excess dollars per case.

Purpose: Create a process that allows as many as possible CM in an outpatient setting for those patients that are medically and logistically appropriate. Perform at least 70% of all CM in an outpatient setting.

Interventions: Through Accelerating City of Hope Excellence (ACE), in a 5 consecutive day improvement event, a multidisciplinary team of physicians, hospital administration, nurses, case managers were assembled to look into a process that will move all CM of autologous stem cell transplant patients to be performed as an outpatient (OP).

Evaluation: In order for a seamless process several items were created, planned and standardized: physician CM OP orders; patient OP discharge plan and instructions; engage case managers earlier in the process for authorization clarity around medications, planning and coordination of discharge supplies; established criteria for determining outpatient versus inpatient CM; optimal patient sequence of scheduling appointments pre and post CM; housing availability in Hope Village; and realized ideal days of the week for patients to receive CM.

Discussion: Multidisciplinary team created a new process that allowed for smooth transition performing CM as an outpatient and improved patient experience. They created capacity in the OP department and freed up bed space in the inpatient hospital. The target goal of performing 70% of all CM was met within the second month from the initiation of the project. We continually meet and sustain our goal with 100% in the last several months. With this new process, we have saved total of 102 bed days, an average of 14.6 bed days per month.

117361 (Poster)

TELEPHONE CALLS POST-DISCHARGE FROM HOSPITAL TO HOME FOR PATIENTS WITH CANCER. Kristin Erika Hand, BSN, RN, OCN®, The Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania

Significance and Background: Telephone calls post-discharge from hospital to home represent one low-capital solution to aid in care continuity from hospital to home. The oncology population represents one patient group that remains particularly affected by re-admissions. Patients with cancer have varying information and medical needs depending on type of cancer, treatment, and disease stage; all making every discharge extremely unique. Oncology nurses have the skill set needed to perform these discharge telephone calls with quality and confidence, and the literature shows that patients have reported satisfaction with nurse-led telephone follow-up. However, further research is needed with quality study design and validated outcome measurement tools in order to prove statistical significance.

Purpose: Although telephone intervention proves to be low-capital; the process involves many factors, making it rather complex. With the goal of successfully implementing post-discharge telephone calls to patients with cancer discharged from hospital to home, a comprehensive review of the literature was done to aid in the design of an informed pilot project.

Interventions: The literature review included searching Cochrane Database and EBSCO MegaFile for systematic reviews about discharge telephone calls, including reviews non-specific to cancer patients. For individual journal articles, a search was done of several databases including: CINAHL, EBSCO MegaFILE, EMBASE, MEDLINE, and Scopus. Articles were marked for retrieval after reviewing the title and abstract and placed into a table of evidence.

Evaluation: After implementing a pilot project, longitudinal evaluation of the effect of post-discharge telephone calls made to

patients with cancer will be done. Some of the outcome measures will be patient satisfaction, symptom distress, self-care, and need for intervention. Validated measurement tools will be used such as the Functional Assessment of Cancer Therapy-General (FACT-G) and the M. D. Anderson Symptom Inventory (MDASI).

Discussion: With increasing awareness and knowledge of re-admissions, the health care team is challenged to intervene in the time period post-discharge with the goal of preventing re-hospitalization. The post-discharge telephone pilot project will allow assessment of the physiologic and psychological issues of complex cancer patients after hospital discharge, with the goal of preventing re-admissions in this growing population.

117390 (Poster)

SENIOR ONCOLOGY CARE: SEVENTY IS THE NEW FIFTY.

Joann Moore, RN, BSN, OCN®, Paoli Hospital Cancer Center, Paoli, Pennsylvania; Meghann Horst, RN, BSN, OCN®, Paoli Hospital Cancer Center, Paoli, Pennsylvania; Susan Zuk, RN, MSN, AOCN®, Paoli Hospital Cancer Center, Paoli, Pennsylvania

Significance and Background: As incidence of cancer increases with age, the toxicities associated with the cancer treatment can be significant for the older patient over age 70 years. The effect on quality of life and ability to continue through therapies and endure side effects and manage symptoms can be difficult and be obstacles in completing and tolerating the necessary treatments. Evaluating patients on parameters that effect seniors can provide insight into potential issues and predict tolerance of cancer therapies.

Purpose: Taking the results of a research study evaluating tolerance to systemic chemotherapy in seniors and translating the findings to a systematic program was the goal in developing a Senior Oncology Program. The program utilized clinical practice guidelines and validated geriatric assessment tools and integrated a process for all patients 70 years and older. The program incorporated interventions to effect patient outcomes related to quality of life, functional and nutritional assessment and pharmacology review of medications.

Interventions: The Cancer Center initiated a team which included oncology nurses, physician, social worker, dietician, pharmacist, and physical therapist. The team met monthly to create a plan of care and tools that were successful in identifying patient needs throughout treatment. A procedure, careplan and tool kit were finalized. A staff competency was designed to educate staff on the process and assessment completion. Timing of the re-assessments were enhanced through communication on the nurse's schedule and the use of blue labels became a visible sign of our senior VIP.

Evaluation: The past year has been exciting in the growth of our program and our patient's positive outcomes. The social work and pharmacy interventions were so positive that they are now included for all patients. Nutrition and physical medicine referrals promoted wellbeing and tolerance to treatment and the program has expanded to radiation patients. The multidisciplinary team continues to meet quarterly to review patient outcomes throughout the cancer journey.

Discussion: Oncology nurses will understand the unique needs of the geriatric oncology patient and validated assessment tools to identify needs that could benefit from early and timely intervention. The value of a multidisciplinary team approach to care and utilizing team resources in reaching optimal outcomes

117426 (Poster)

A COMPREHENSIVE INITIATION OF CLINICAL TRIAL NURSES.

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New York, New York; Crystal Escano, RN, BSN, NYU Langone Medical Center, New York, New York; Claire Stein, RN, BSN, OCN®, NYU Langone Medical Center, New York, New York; Kathleen Madden, MSN, RN, FNP-BC, AOCNP®, NYU Langone Medical Center, New York, New York

Significance and Background: Innovations in oncology care rely heavily upon research and clinical trials. The arena of clinical trials is a complex milieu where most nurses have little or no research experience upon hire into the specialty. Competent CTN's are essential in delivery of safe and efficient care of patients participating in clinical trials. Proper training and orientation is necessary to foster the new CTN. Due to retention and role satisfaction concerns, our 8 member group conducted a survey, assessing current members concerns. Our compiled experiences suggested the need for a more comprehensive introduction after hire to CTN. This has led to creating a more structured orientation process.

Purpose: Role satisfaction, competency, safety and retention are all motivating factors to support our CTN's from the outset of their training. This structured process will provide continuity from introduction to immersion into CTN thereby, decreasing and eliminating gaps in knowledge relating to role function.

Interventions: In collaboration with our Nurse Educator and utilization of the ONS CTN Competencies, we have concept developed a structured orientation program for new CTN's. The theoretical concept is based on Benner's: From Novice to Expert. An orientation timeline will be established and goals set for the nurse to meet on a weekly basis throughout orientation. The ONS Oncology Clinical Trial Nurse Competencies of 2010 will serve as the guidelines for this program. Educational training modules and a clinic visit simulation will be developed to educate the novice CTN on how to analyze and interpret a new protocol.

Evaluation: An evaluation will be set up for the new CTN at time of orientation completion, allowing for collaborative feedback. Success of the program will be measured by comparing CTN retention rates, clinical trial accrual rates, number of protocol deviations and reporting of serious adverse events will also be evaluated.

Discussion: The oncology CTN plays a pivotal role in facilitating trial recruitment, retention and protocol compliance. By ensuring the proper level of educational support and competency during the orientation process the CTN will help maintain or enhance patient safety, protocol integrity, role satisfaction and nurse retention.

117533 (Poster)

IDENTIFYING APPROPRIATE PATIENTS FOR THE INTERMEDIATE CARE UNIT (IMCU): AN ACUITY SYSTEM AND TRANSFER ALGORITHM TOOL.

Michelle Wild, RN, BSN, OCN®, Roswell Park Cancer Institute, Buffalo, New York; Susan Koch, RN, Roswell Park Cancer Institute, Buffalo, New York; Diane Kessler, RN, BSN, Roswell Park Cancer Institute, Buffalo, New York; Deanne Rozak, CSA, Roswell Park Cancer Institute, Buffalo, New York

Significance and Background: Current limitations exist in the body of nursing literature regarding the types of patients who should be admitted to an Intermediate Care Unit (IMCU). This level of care is often identified at a 1:3 nurse/patient ratio. There are often times when a patient in the IMCU becomes more acutely ill and requires more intensive nursing care before they can be physically transferred to the Intensive Care Unit (ICU). The nurse patient ratios in IMCU may not provide for this escalating level of care, thus creating strain on the IMCU as it challenges the nurses to maintain quality of care in a dynamic and fast paced environment. Adjustments to assignments and patient care requirements provided the impetus to develop an acuity system and transfer algorithm.

Purpose: The purpose of this project was to develop an acuity scoring system that objectively defined patient acuity, ratios and most appropriate unit. The purpose of the algorithm was to have a descriptive tool to identify a plan of action for transfer to ICU for a sudden increase in patient acuity requiring 2:1 or 1:1 nursing care.

Interventions: The acuity system has categories that score patients from 1-5 based on their complexity. The score then correlates with a nurse to patient ratio and defines unit appropriateness. This system has helped in creating fair, equitable and appropriate assignments for each nurse in the IMCU. The algorithm outlines which administrators and physicians should be notified in order to facilitate and expedite patient transfer to ICU when necessary.

Evaluation: Since implementation of the scoring system and algorithm, all patients that have become acutely ill have been transferred to ICU as soon as possible and without delay. The quality of patient care has been maintained, all patients in IMCU are receiving consistent care, IMCU nursing satisfaction has increased and transfer time has decreased.

Discussion: Critical care oncology patients have unique characteristics that need to be taken into consideration when determining acuity. A detailed acuity scoring system and algorithm can help determine appropriate classification.

117636 (Poster)

DIMENSIONS OF CLINICAL TRIAL NURSE COORDINATOR'S SKILLS AND COMPETENCIES: RESULT OF SKILLS SELF-ASSESSMENT SURVEY, NOVICE TO EXPERT. Bernadette Pulone, RN, OCN®, BSN, City of Hope Medical Center, Duarte, California; Gerardo Gorospe, RN, BSN, PHN, MSN, City of Hope Medical Center, Duarte, California

Significance and Background: The clinical trial nurse (CTN) coordinator is a specialized role in nursing. CTNs coordinate patient care surrounding clinical trial enrollment and participation. CTNs organize the management of clinical trials while maintaining the regulatory requirements of proper research conduct. This includes preserving human subject's rights, and upholding Institution Regulatory Board (IRB), Federal Department Administration (FDA), and sponsor regulations. City of Hope contributes to innovations in science by participating in pre-clinical and phase I-III clinical trials. Based on the Oncology Nursing Society's "Oncology Clinical Trials Nurse Competencies in 2010," COH set out to revise its coordinator job description to align with these CTN core competencies. From this, COH developed a CTN skills self-assessment survey to analyze practice gaps in the coordinator role.

Purpose: To report the results of our skills self-assessment survey, in follow-up to our 2012 ONS abstract #1341734. To report the skills inventory gap analysis data related to the roles and responsibilities of the COH CTN.

Interventions: A collaborative nursing effort designed a role-specific, detailed skills inventory list: skills matrix tool. COH CTNs (n=31) completed an online self-assessment inventory to rate their skills, using a novice to expert scale.

Evaluation: The purpose of the survey was to gain an understanding of how to improve our nursing operations related to oncology research protocol operations. 5 CTN competency domains with 42 corresponding skill competencies were measured: 1) Study initiation: 9 skills; 2) Screening and consenting: 6 skills; 3) Management of patient on clinical trials: 13 skills; 4) Communication and documentation: 8 skills; and 5) Protocol compliance and management: 6 skills. Averaging the COH CTN results over the 5 domains, we identified 16% novices, 10% advance beginners, 26% competent, 26% proficient, and 22% experts among our group.

Discussion: Data collected from skills competency matrix tools can be used to analyze practice gaps, identify staff devel-

opmental needs, manage staff assignments, hire new staff, and select key nurse preceptors. Skills competency documents can help clarify staff competence related to activities necessary for CTN independent practice, professional decision-making and the provision of safe research-driven patient care.

118142 (Poster)

GETTING PATIENTS ACTIVE: USING QUALITY MEASURES TO DRIVE PRACTICE CHANGES. Leah Scaramuzzo, MSN, RN-BC, AOCN®, The Cancer Institute of New Jersey, New Brunswick, New Jersey; Jane Fischer, RN, BSN, OCN®, CCRC, The Cancer Institute of New Jersey, New Brunswick, New Jersey

Significance and Background: Based on the ONS Breast Cancer Care Quality Measures National Pilot Data, nurses at an ambulatory care, NCI-designated Comprehensive Cancer Center identified the need for practice changes regarding interventions for patient reported symptoms of fatigue. Data revealed less than 4% of our Institute documented fatigue management interventions. Knowing that fatigue is the most common side effect cancer patients experience and its management is a nursing sensitive patient outcome, it was evident that nursing staff needed to take the lead in a practice change.

Purpose: The project's purpose was to increase documentation of fatigue interventions including exercise recommendations. Providing evidence-based exercise recommendations to patients is greater than ever; literature supports the benefits of regular exercise on decreasing fatigue and risk of recurrence as well as improving physical health and quality of life. The Steps of Evidence-Based Practice Process from Melnyk and associates was used as the guide for the project.

Interventions: The research nurse clinician (RNC) and nurse educator met and assessed current practice (few reviewed the sixth vital sign; fatigue assessment) and identified potential factors related to poor documentation (no prompt in RNCs documentation note for fatigue interventions). After searching/critiquing the evidence, exercise resources were identified including the American College of Sports Medicine ProFinder tool, Livestrong programs at the YMCAs, and the General Exercise Guidelines for Cancer Survivors patient education document. Local resources were identified and included as patient handouts. Staff was educated regarding the pilot data and evidence-based fatigue management interventions/resources. Brainstorming sessions are planned regarding additional opportunities for inserting fatigue interventions into care. A revised RNC documentation form will be developed with staff input.

Evaluation: Anecdotal feedback from staff regarding the practice change project has been overwhelmingly positive. The revised RNC documentation form will launch the beginning of 2013. Charts will then be audited for documentation of fatigue interventions. The change project will then be rolled out in our inpatient partner hospital.

Discussion: Nurses should consider taking the lead in making practice changes based on evidence. Exercise resources identified in this project can be adapted to any geographical area and then incorporated into each patient interaction, thus providing the best quality care.

118184 (Poster)

CHLORHEXADINE GLUCONATE BATHING TOLERANCE IN BONE MARROW TRANSPLANT AND LEUKEMIC PATIENTS. Holly Briere, RN, BSN, OCN®, SUNY Upstate Medical University, Syracuse, New York; Bonnie Chapman, RN, MPH, SUNY Upstate Medical University, Syracuse, New York

Significance and Background: Catheter infection commonly occurs when skin organisms travel through catheter insertion

sites and colonize the tip. In an effort to reduce Central Line Associated Blood Stream Infections (CLABSI), the Centers for Disease Control recommends daily bathing with 2% CHG to reduce skin flora decreasing the risk of migrating bacteria. The use of CHG bathing in ICU and medical patients to decrease CLABSI events is well documented. However, there is little research supporting CHG use and tolerance among oncology populations.

Purpose: The purpose of this study is to evaluate the tolerance of CHG daily bathing, using impregnated CHG cloths, in BMT and leukemic patients who frequently experience skin toxicities from treatment.

Interventions: A modified Skin Toxicity Assessment Tool (STAT) was used daily with each patient on our 6 bed BMT unit prior to bathing with CHG cloths. The STAT was previously validated in a trial of breast cancer patients undergoing radiotherapy. Patients were monitored closely for changes in skin condition not attributable to their treatment.

Evaluation: Upon admission, education about CHG was provided. Twenty-seven of 32 patients chose to participate in CHG bathing at least once. Of possible bathing days, 47% chose to use CHG. CHG was used by each patient for an average of 9 days. There were 12 patients with skin abnormalities over the course of their stay. Of these, 3 were drug rashes; 2 were the result of Cytarabine, and 1 Thiotepa. A fourth received Melphalan and after 3 CHG baths discontinued use due to the appearance of a severe generalized rash of unknown origin. Other causes of rash were, adhesive tape, engraftment syndrome, GVHD, or preexisting skin issues. CHG baths were accepted by 11 of 13 active BMT patients. Of those, 64% had a skin abnormality, compared to 31% of nontransplanted patients.

Discussion: In the 4 months of CHG use, most skin abnormalities are attributable to causes other than CHG. Those with skin abnormalities often tolerated continued use to unaffected areas. BMT patients are prone to skin changes; therefore, thorough skin assessment is required as the evaluation of CHG continues. Data collection will continue for a total of 1 year.

118212 (Poster)

PANCREATIC NEUROENDOCRINE TUMOR, INSULINOMA: A CASE STUDY. Natasha Ramrup, RN MSN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Nina Sohn-Bachmann, RN, MSN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York

Significance and Background: Pancreatic neuroendocrine tumors are islet cell tumors of the pancreas that secrete insulin, causing hypoglycemia. Insulinoma is a rare form of pancreatic islet cell tumor with an annual incidence of 1/100,000. Ten percent of cases are metastatic at diagnosis, causing debilitating symptoms. Symptom management of insulinoma is of utmost importance in prolonging survival and presents a challenge for inpatient oncology nurses.

Purpose: This is a case study of a 58 year old male (MC) diagnosed with treatment refractory neuroendocrine cancer with liver metastasis. Initial treatment included Xeloda and Temozolomide. After three years, MC reported having symptoms of hypoglycemia and night sweats. Further diagnostic testing delineated the extent of his disease, confirming insulinoma. Treatment options changed immediately to different oral chemotherapy agents and Hepatic Arterial Embolization. Most recently, MC received chemotherapy Gemcitabine and Oxaliplatin. Clinical and radiographic response was noted with current regimen. MC has stated that he has occasional episodes of diaphoresis and was found to have low blood sugar, which is controlled with diet.

Interventions: Once diagnosed with pancreatic neuroendocrine, patients are instructed to monitor, treat neuroglycopenic and neuropsychiatric symptoms, including visual disturbances, headache, lethargy, altered consciousness and confusion. Hy-

poglycemic episodes are recurrent, unpredictable, and may increase in frequency and severity: as such, it is imperative the inpatient nurse teaches the importance of frequent blood glucose monitoring.

Evaluation: For patients with unresectable metastatic diseases, ablative procedures and drug therapies, such as diazoxide and octreotide acetate, are used to prevent hypoglycemic episodes. Optimal education and management are essential to improve patient outcome. MC has surpassed life expectancy for this disease. Conventional therapies offer MC the greatest opportunity to optimal health for his refractory hypoglycemia.

Discussion: At our NCI-designated comprehensive cancer center, we have treated many patients with pancreatic neuroendocrine tumors. Thorough assessment, anticipatory symptom management, and complete patient teaching are essential to maintain optimal functioning. A better understanding of this disease process will help to further refine our nursing care for MC.

118286 (Poster)

A NURSE-LED SYMPTOM MANAGEMENT CLINIC: SERVING CANCER PATIENTS ACROSS THE CONTINUUM.

Alison Weber, BSN, RN, Billings Clinic, Billings, Montana; Kathryn Waitman, DNP, AOCNP®, Billings Clinic, Billings, Montana; Karyl Blaseg, RN, MSN, OCN®, Billings Clinic, Billings, Montana; Jeannine Brant, PhD, APRN, AOCN®, Billings Clinic, Billings, Montana

Significance and Background: Deleterious symptoms and psychological, social, and spiritual distress are common in patients with cancer. The National Comprehensive Cancer Network (NCCN) recommends distress screening in ambulatory cancer settings using a 0-10 distress thermometer. Patients who score 4 or greater should be further evaluated. Data show that the medical oncology visit consists of discussing the treatment plan and disease progress; however little time is available to delve into a comprehensive symptom, psychosocial, and spiritual assessment.

Purpose: The Symptom Management Clinic provides a specific venue for patients to discuss physical, psychological, social, and spiritual concerns with management via an interdisciplinary symptom management team.

Interventions: An interdisciplinary symptom management team comprised of a symptom management nurse coordinator, oncology nurse practitioner, physician assistant, social worker, chaplain, pharmacist, dietitian, physical therapist, and pain specialist was developed to address these gaps in care. Prior to ambulatory visits, patients rated their distress using the NCCN distress thermometer in the waiting room. The Symptom Management Nurse called patients with distress score was 6 or greater on a 0-10 scale. Telephone triage symptom management protocols were developed, and the Symptom Management Nurse resolved some problems according to protocol. Many patients, however, had multiple problems, requiring a Symptom Management Clinic visit. Prior to the visit, the interdisciplinary care discusses concerns of each individual patient and strategizes interventions to alleviate physical, psychosocial, and spiritual suffering.

Evaluation: Distress screening has been successfully incorporated into the outpatient workflow. Referrals have increased during the program's inception 18 months ago. Approximately 80 patients were seen in the Symptom Management Clinic during its first year. On average, over 100 patients are referred to the symptom management RN monthly. Patients report high satisfaction with the clinic and an improvement in symptoms. As one man stated, "I never miss my symptom management visit, because the team helps with the things that give quality to my life."

Discussion: Nurses play a primary role in the management of distress and symptoms. This presentation will address distress

tool implementation, referral thresholds, protocol development, process flow for referrals, clinic development, and marketing of services. In addition, data tracking and outcome metrics for program evaluations will be reviewed.

118343 (Poster)

BRONCHOBILIARY FISTULA, A RARE LIFE THREATENING COMPLICATION FROM CANCER: IMPLICATIONS FOR ONCOLOGY NURSING. Natasha Ramrup, RN, MSN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York

Significance and Background: Bronchobiliary fistula (BBF) is a relatively rare entity which can be life threatening. BBF can be caused by malignant biliary obstruction and its symptoms are multifaceted. The cardinal symptom of BBF is recurrent biliopytysis (coughing of bile stained sputum). This serious complication is associated with significant morbidity and mortality for oncology patients. Prompt diagnosis and treatment is imperative for optimal outcome and intense supportive therapy is vital to improve survival.

Purpose: At this NCI-Designated Comprehensive Cancer Center, BBF is an uncommon complication secondary to hepatic malignancy and resultant biliary obstruction. Continual occlusion of the biliary tract may increase bilious pressure which may lead to erosion into the bronchial tree thus causing abnormal passage of bile between the biliary system and the bronchial tree. Clinical presentations are biliopytysis, bacterial pneumonitis, necrotizing pneumonia, fever, cough, chest pain and sepsis.

Interventions: Definitive management or uniform treatment guidelines are not well established for malignant BBF. Interventions are focused on relief of the biliary obstruction and to drain the abscess to obliterate the fistula tract. Surgery is usually the treatment of choice, but for patients with end stage cancer, conservative management is the best approach. Conservative treatment methods include biliary drainage with stent or catheter placement, pleural drainage and appropriate antibiotics. Biliary stenting will allow for the normal flow of bile into the duodenum. Unfortunately, if bile leakage is not well controlled, complications ensue and death becomes imminent as a result of sepsis or respiratory complications.

Evaluation: Collaboration and communication among the multidisciplinary team, including Surgery, Interventional Radiology, Gastroenterology, Nursing, Palliative care, Social work and Nurse Case Managers are essential in implementing an optimal treatment plan. Since there is no optimal therapy for BBF, recognizing complications of BBF requires astute nursing assessment to anticipate complications and adapt an appropriate treatment plan.

Discussion: Oncology nurses are in a pivotal position to identify symptoms of this rare entity and intervene appropriately. An understanding of this complication can lead to prompt diagnosis and treatment to prolong survival and improve quality of life.

118372 (Poster)

ONCOLOGY UNIT-BASED CONVERSATIONS IN ETHICS: A COLLABORATIVE APPROACH. Mary Callaghan, RN, MN, AOCNS®, APN, Northwestern Memorial Hospital, Chicago, Illinois; Kathy Neely, MD, Northwestern University, Chicago, Illinois; Jeanne Wirpsa, MA, BCC, Northwestern Memorial Hospital, Chicago, Illinois

Significance and Background: Being present with patients and families as they face life-threatening illnesses and care decisions, places oncology nurses on the front lines of ethical decision-making. As part of oncology leadership engagement discussions with staff at an urban academic medical center, it

became apparent that dealing with ethical issues was distressing to staff and impacted their professional satisfaction.

Oncology focus groups identified the following issues: Increased moral distress, knowledge deficit for addressing ethical issues, lack of a safe forum to discuss moral distress, and low numbers of formal ethics reviews. A team including the clinical nurse specialist, chair of the medical ethics committee and oncology chaplain met to develop an intervention to meet nurses' needs.

Purpose: A review of the literature identified an approach described as Unit-based Ethics Conversations. The premise is that story telling and discussion increase ethical knowledge, bridge philosophical understanding of ethical principles to clinical practice, increase ethical discussion at the bedside and provide nurses with problem-solving strategies.

Interventions: The Oncology Unit-Based Conversations in Ethics were implemented in January, 2012. The meetings were held monthly alternating among the three oncology units on days and nights. Objectives were to discuss cases of ethical concern, apply ethical principles to clinical situations, identify strategies and improve staff ability to recognize and manage ethical issues.

Evaluation: Outcomes of the sessions have been promising with attendance ranging from 10-20 on days to 5-12 on nights. The implementation of Ethics Conversations has created more awareness of ethical issues and more timely ethics consults as evidenced by an upward trend in formal consults. Three formal ethics consultations were requested over 12 months in 2011. In just the first 6 months of 2012, however, three formal ethics consults have been requested. We will update the outcome measures in a future analysis.

Discussion: The intervention of unit-based discussions can be implemented in any unit. Evaluation can not only include number of nurse-initiated ethics consultations but a more in depth investigation evaluating moral distress could be implemented. This program has broad applicability beyond oncology and can be tailored to any unit struggling with ethical issues.

118400 (Poster)

DPYD GENE MUTATIONS ARE MORE PREVALENT IN PATIENTS EXPERIENCING GRADE 3-4 5-FU TOXICITY. Laurie Korst, RN, BSN, Myriad Genetic Laboratories, Inc., Salt Lake City, Utah; Jennifer Saam, MS, CGC, PhD, Myriad Genetic Laboratories, Inc., Salt Lake City, Utah; Karla Bowles, PhD, Myriad Genetic Laboratories, Inc., Salt Lake City, Utah; Colleen Rock, PharmD, PhD, Myriad Genetic Laboratories, Inc., Salt Lake City, Utah; Kendel Kline, BS, RN, OCN®, Myriad Genetic Laboratories, Inc., Salt Lake City, Utah; Rajesh Kline, MS, Myriad Genetic Laboratories, Inc., Salt Lake City, Utah

Significance and Background: Dihydropyrimidine dehydrogenase (DPYD) is the major enzyme that metabolizes 5-Fluorouracil (5-FU), a component of many chemotherapy regimens. Patients with a DPYD gene mutation have higher 5-FU plasma levels, leading to a 50-60% risk of grade 3-4 toxicity. DPYD mutations have an estimated prevalence of 3-5% in the general population, but full sequencing is rarely performed in published studies. Analyses of the largest set of full DPYD gene sequencing test results from a commercial laboratory database are presented.

Purpose: To demonstrate the relationship between DPYD mutations and grade 3-4 5-FU toxicity.

Interventions: A set of 3083 patients was analyzed. Patient demographics (age, gender, ethnicity) and pre-test toxicity status (none, 5-FU related, other) were obtained from the test request form. Descriptive analyses were performed to compare mutation prevalence overall, and by toxicity and ancestry classifications, as well as to characterize mutations of interest. A subset of 24 patients tested for DPYD mutations in response to high 5-FU exposure levels was also analyzed.

Evaluation: The overall DPYD mutation prevalence was 7.3%. Mutations were present in 4.7% and 10.3% of patients experiencing none and at least one 5-FU related toxicity pre-test, respectively. Among patients with toxicities pre-test, the prevalence increased from 7.8% to 31.6% for those experiencing a single to all four toxicity types. Among 5-FU related toxicities, mutation prevalence was highest for hematopoietic events. The previously reported founder mutation IVS14+1G>A had a relative prevalence 42.7%, but 30.9% of these mutations were seen in patients not reporting a Western/Northern European ancestry. Among the subset of patients with high 5-FU exposure levels, 29% had a DPYD mutation showing a genetic cause for the high plasma levels.

Discussion: 5-FU in chemotherapy regimens remains widespread, yet DPYD gene testing utilization remains minimal. Most testing occurs post-treatment in response to a severe toxicity rather than pre-treatment, which would allow for treatment adaptation to reduce toxicity risk. Compared to previous studies, this study using full sequencing data from 3083 patients provides robust estimates of DPYD mutation prevalence and helps characterize DPYD mutations of particular interest.

118443 (Poster)

IMPLEMENTATION OF A BEDSIDE HANDOFF TOOL TO PROMOTE PATIENT SAFETY AND NURSING ACCOUNTABILITY. Maegan Katleen Chmura, RN, BSN, MS, CMSRN, Roswell Park Cancer Institute, Buffalo, New York; Kathleen O'Hearn, RN, BSN, Roswell Park Cancer Institute, Buffalo, New York

Significance and Background: The Joint Commission identified communication failures during shift reports as a cause of sentinel events in the United States. Evidence suggests a link between bedside rounding and improved patient safety and communication among nursing staff. The significance of utilizing the bedside handoff communication tool is to improve patient safety and satisfaction hospital wide.

Purpose: The purpose of this bedside handoff communication tool is to improve patient safety, communication between nursing staff and patients, help the nurse prioritize patient care, and improve overall patient and nursing satisfaction. Bedside handoff is a process that occurs at change of shift at the patient's bedside. Both the oncoming nurse and offgoing nurse visualize the patient and communicate information, while involving the patient in his or her plan of care for that shift. An increased awareness in patient safety and accountability is accomplished when nurses are able to visualize patients immediately after they receive change of shift report to confirm health status of the patient, assess any safety concerns, and involve the patient with their individualized goals and anticipated plan of care.

Interventions: The intervention was that the nurses were provided with a standardized report communication tool to be discussed at the patient's bedside. The standardized communication tool includes assessing IV access, IV fluid solution and tubing date, pain level, safety concerns, and answer any questions the patient may have at the time of handoff.

Evaluation: The process of using a communication tool to implement bedside handoff is being evaluated through staff questionnaires and patient questionnaires. The information collected is being evaluated using a national benchmark database.

Discussion: Implications for oncology nursing practice include an increased awareness for nursing accountability and patient safety. Suggestions for using this tool are to continuously monitor nursing staff compliance as well as making necessary modifications to the program based on the bedside nurses input. Each nursing unit has individualized patient needs and staffing requirements therefore each communication tool should reflect the specific needs of each unit.

118630 (Poster)

ONCOLOGIC IMPROVEMENT: OUCC, THE ONCOLOGY URGENT CARE CLINIC. Kristen Johnson Reeb, MS, CRNP, Johns Hopkins Hospital, Baltimore, Maryland; Katharina Violette, MSN, RN, Johns Hopkins Hospital, Baltimore, Maryland; David Ratkoff, BS, RN, Johns Hopkins Hospital, Baltimore, Maryland; Patricia Brothers, RN, OCN®, Johns Hopkins Hospital, Baltimore, Maryland

Significance and Background: The goal of the outpatient oncology center at this National Cancer Institute designated comprehensive cancer center is to provide total patient care. Often oncology patients experience unplanned complications and emergencies. Overcrowded emergency rooms with long wait times can be dangerous for immunocompromised patients. Most non-life-threatening oncological emergencies are best managed by specialized oncology nurses and providers. Adding these unplanned patients to the clinic schedule strains resources, disrupts flow and causes overall delays. An urgent care clinic for unscheduled ambulatory oncology patients was designed to address these issues.

Purpose: The OUCC was established to meet the needs of acute, unscheduled, ambulatory oncology patients with the added benefit of improving the patient flow by removing unscheduled patients from the nurse's schedules.

Interventions: A literature review and data collection informed the planning process. The OUCC opened in June 2012 within the Oncology Outpatient Center staffed with a nurse and a nurse practitioner. Additional resources are readily available should the need arise. Referrals arise from telephone triage, physicians and nurses within the outpatient center. The OUCC is open Monday through Friday from 8am to 7pm and is supported by the outpatient pharmacy as well as all ambulatory services offered throughout the clinic.

Evaluation: Since the opening in June 2012, the OUCC has seen 437 patients. 65% of the patients had a solid tumor diagnosis and 35% had a hematological oncology diagnosis. Common presenting conditions range from gastrointestinal issues, neutropenic fevers, dehydration, pain and respiratory complaints. 80% of the patients were discharged home with the remaining 20% being admitted to the hospital. Three patients were transferred to the emergency department.

Discussion: The OUCC provides specialized, appropriate, safe care to the ambulatory oncology patient. Patients, family members and providers recognize the benefit of having a designated clinic with specialized, trained staff to support their needs and they report feeling safe and well cared for in the OUCC. In the future, the potential to reduce readmission and negate one day admissions is paramount. Our plan is to expand hours to better meet the acute needs of our oncology patients, regardless of time of day.

118676 (Poster)

MY CHOICES, MY WISHES: ADVANCED PRACTICE NURSES LEADING ADVANCE CARE PLANNING IN COMMUNITY-BASED ONCOLOGY. Sabrina Mikan, PhD, RN, ACNS-BC, Texas Oncology, Austin, Texas; Russell Hoverman, MD, PhD, Texas Oncology, Dallas, Texas; Debra Patt, MD, MPH, Texas Oncology, Austin, Texas; Brian Turnwald, BSBA, McKesson Specialty Health, The Woodlands, Texas; Deb Harrison, MSN, RN, McKesson Specialty Health, The Woodlands, Texas

Significance and Background: Working through end of life care (EOL) issues with patients is one of the most challenging aspects of cancer care. Although EOL care intervention studies that are patient-focused and result in high-quality EOL experiences are increasing, most patients still do not achieve an EOL experience consistent with their preferences.

Purpose: The aim was to provide an Advanced Practice Nurse (APN) led intervention for standardized advance care planning (ACP) education and Advance Directive (AD) documentation to improve quality of life (QOL) for patients with terminal cancer (TC).

Interventions: Patients with TC (defined as stage IV cancer or metastatic disease for this study) were evaluated retrospectively through the EMR iKnowMed (iKM) before and after an ACP education intervention and documentation. Education on ACP tool documentation occurred in early 2012 through an ACP office visit conducted by an APN with ACP training. During the 3 month intervention period, a culture change in ACP awareness at all levels of the Cancer Center took place. This change was facilitated through APN implementation and staff education regarding the importance of ACP and ADs.

Evaluation: Descriptive statistics were used to identify and measure utilization of ACP introduction and charting as well as completion of AD documentation. Within iKM there are discrete fields for EOL data including ACP discussion, ACP facilitation, and documentation of ADs. Through a historical chart review 2009–2011, 82 (5.1%) of 1613 patients, had ADs on file. AD documentation between Nov 2011 and Feb 2012 showed 4.6% had ADs on file. This resulted in proper identification and use of iKM fields, resulting in 90 ADs on file; a 400% increase from baseline. By incorporating these strategies with definable metrics, strategic intervention can be measured and reported.

Discussion: Oncology APNs can facilitate ACP conversations to assist in identifying patient values and improve end-of-life care satisfaction. Implementation of a standardized ACP program improves utilization and documentation of ADs which is essential to provide seamless transitions in medical care. These interventions improve QOL and health literacy for patients with TC. Further study of the relationships between ACP documentation and patient outcomes is necessary for comprehensive, patient-directed oncology care.

118717 (Poster)

AN EVIDENCE BASED PRACTICE PROJECT TO IDENTIFY THE BEST INTRAVENOUS NEEDLELESS CONNECTOR.

Marie Swisher, MSN, RN, AOCNS®, Johns Hopkins Hospital, Baltimore, Maryland; Kelly Weaver, BSN, RN, University of Delaware, Newark, Delaware; Mikaela Olsen, MS, RN, AOCNS®, Johns Hopkins Hospital, Baltimore, Maryland

Significance and Background: The design of intravenous needleless connectors (NCs) plays a substantial role in hospital acquired- catheter related blood stream infection (HA-CRBSI) risk. NC technology has changed greatly in the past twenty years. Approximately ten years ago our National Cancer Institute-Designated Comprehensive Cancer Center (NCI-CCC) made the decision to use a conventional open system based on increasing HA-CRBSI rates associated with the introduction of a positive pressure NC and lack of alternative NCs.

Purpose: The purpose of our Evidence Based Practice (EBP) project was to determine the best design of needleless connectors to reduce HA-CRBSI in all populations.

Interventions: The advanced practice group (APN) and a graduate clinical nurse specialist student, completed the EBP project. A literature review was conducted using the following MeSH terms: needless connector, IV connector, positive pressure, valve negative pressure valve, neutral pressure valve, and biofilm, infection / contamination rates. Twenty-five articles were reviewed utilizing the Johns Hopkins Nursing EBP model. Thirteen were included in the EBP review.

Evaluation: Evaluation Increased infection rates were identified with the use of negative pressure NC. Decreased infection rates were identified in positive pressure NC compared to negative pressure NC, but inferior rates when compared to split septum and neutral devices. The FDA has issued an alert

regarding the use of positive pressure NC devices and increased HA-CRBSI rates. The literature supported decreased infection rates in split septum devices, but increased risk for inappropriate use with blunt cannula access. Of the devices identified in the literature, infection rates were lower in neutral pressure NCs, which are designed with an internal split septum as opposed to a mechanical NC.

Discussion: The use of a systematic evidenced based practice review is an appropriate strategy for product evaluation. This approach helps to remove product bias when choosing to use a new device in healthcare. Based on our EBP review a neutral split septum design NC was successfully piloted in our NCI-CCC. The project is currently being piloted in a non-oncology setting. Pending these results, full institutional implementation is planned. Results of the pilots will be presented.

118732 (Poster)

PAIN PREVENTION: IS IT POSSIBLE IN THE PATIENT RECEIVING ACTIVE TREATMENT FOR CANCER?

Erin McMenamin, MSN, CRNP, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania

Significance and Background: Pain is one of the most prevalent and feared consequences of cancer. Little progress has occurred in the area of pain management to avoid the undertreatment of pain due to a multitude of reasons. Would providers be more comfortable with the idea of preventing/minimizing pain from occurring as a result of the disease or its treatment? The literature abounds with references regarding the need for a multi-pronged approach to the treatment of complex pain syndromes with medications from several different classes. A body of literature is emerging explaining that some AEDs, a class of adjuvant medications commonly used for the treatment of neuropathic pain, prevent the development of new ectopic synapses in the central nervous system (synaptogenesis). As a result, some AEDs may be used as a method to prevent/minimize pain associated with the treatment of cancer. Nursing has a unique role of in the care of the patient with pain as they are the front line of care. They have the opportunity to assess the patient for pain and relay findings to the team along with appropriate recommendations for the treatment of the pain as a knowledgeable member of the treatment team. Nurses also have an opportunity to educate colleagues and move the field of pain management forward as a change agent.

Purpose: Treatment for cancer often involves surgery, chemotherapy (CT) and/or radiation therapy (RT). Head and neck cancer patients often experience pain of a neuropathic origin from all of these interventions. The emerging literature suggests that anticipating and treating neuropathic pain may be more effective than treating it reactively, that is, after it occurs. Patients undergoing chemo/radiation for head and neck cancer develop mucositis as a result of the treatment. The mucositis has a component of neuropathic pain. Patients receiving treatment for HandN cancer at the Hospital of the University of Pennsylvania are routinely started on an escalating dose of neurontin during week 2 of treatment prior to the development of painful mucositis. The expectation is the need for lower amounts of opioids as a result of the pretreatment with neurontin.

Interventions: Two specific studies will be highlighted in the presentation as a foundation for the assertion that pain may be prevented/minimized in some patients receiving active treatment for their cancer. Both studies involve patients undergoing treatment for oropharyngeal cancer with CT and RT. In the both studies, patients were provided with an AED starting at week 2 of RT prior to the development of painful mucositis. Patients were titrated to maximum doses of gabapentin dependent on their age and renal function. The first study was a retrospective review of patients receiving gabapentin vs. patients receiving standard therapy for pain. The second study was a prospective study of patients undergoing active treatment.

Evaluation: The primary outcome measure in both studies was opioid use. A secondary outcome was quality of life in the second study. Bar Ad et al (2010) reported that in the retrospective review, patients used less opioids when they received gabapentin preemptively compared to those that did not receive gabapentin during their treatment. Data for the second study has been collected but not finalized. The final data analysis will be presented. Outcomes are applicable in oncology nursing in that many patients are expected to experience pain as a consequence of treatment. Nurses have the opportunity to act as change agents and provide patients with a therapy that may impact their quality of life as a result of anticipating symptoms associated with treatment.

Discussion: Pain may be prevented or minimized by the use of AEDs prior to the development of pain in patients expected to develop side effects as a result of their treatment. Nurses have an opportunity to provide interventions preemptively to patients resulting in a decreased incidence and/or severity of pain, therefore decreased utilization of opioids. Nurses also have the opportunity to educate colleagues regarding a new paradigm in pain management; pain prevention.

118761 (Poster)

PROMOTING COMMUNICATION AND PATIENT EDUCATION ACROSS THE CONTINUUM OF CARE. Catherine Wickersham, BSN, RN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York

Underwriting or funding source: Roswell Park Cancer Institute Alliance Foundation Quality of Life Grant

Significance and Background: Annually, the incidence of lung cancer and surgical candidates continues to increase. Nurses play an integral role in preparing patients for lung resection, as well as delivering care during and after surgery. Nearly 800 patients undergo lung resection yearly at this NCI-designated comprehensive cancer center; communication across the continuum of care is a presenting challenge.

Purpose: A task force was formed to identify communication issues potentially impacting the provision of care for patients undergoing lung surgery. Led by thoracic nurses, the task force identified two overarching goals: provide a forum to share concerns and ideas across inpatient and ambulatory care and improve the processes surrounding patient education.

Interventions: The task force meets monthly and ultimately expanded to include representation with case management, nursing leadership, and patient education to address specific issues falling within the realm of its goals. Information sharing has been a standard agenda item at each meeting, and members are expected to share information both from and to their colleagues. A new model to address the patient educational needs was adopted, which includes a pathway and comprehensive binder designed as a guide from preparation to recovery.

Evaluation: The pathway provides a standardized overview of the perioperative period organized chronologically and categorically. The binder was designed to streamline the 14 educational materials currently provided to patients into one resource. This resource will be utilized throughout the continuum of care so that patients, caregivers, nurses, and other providers are all pointed to the same information. The pathway and binder will be piloted over the next four months using rapid-cycle prototyping. Evaluation criteria include nursing, patient and caregiver satisfaction with the guide and nursing time spent teaching. These evaluation tools target specific aspects of the guide including illustrations and usability issues.

Discussion: This task force has proven to be a meaningful communication strategy for nurses across the continuum of care. The major tangibles stemming from the task force are the pathway and educational binder, which combine design principles with nursing care to optimize patient education. The

learning's from the project will inform the development of educational materials for other surgeries and practices within the institution.

118986 (Poster)

INTEGRATING AN EVIDENCE-BASED ASSESSMENT TOOL FOR THE OLDER ADULT INTO AN ELECTRONIC MEDICAL RECORD SYSTEM. Darryl Somayaji, PhD, RN, CNS, CCRC, Roswell Park Cancer Institute, Buffalo, New York; Maureen Rogers, RN, Roswell Park Cancer Institute, Buffalo, New York; Erin Mouyeos, BSN, RN, OCN®, Roswell Park Cancer Institute, Buffalo, New York; Abigail Killion, BSN, RN, Roswell Park Cancer Institute, Buffalo, New York; Leslie Espe, RN, Roswell Park Cancer Institute, Buffalo, New York; Meghan Espe, BSN, RN, Roswell Park Cancer Institute, Buffalo, New York; Teresa Brzozowicz, RN, Roswell Park Cancer Institute, Buffalo, New York

Significance and Background: More than 60% of cancer diagnoses occur in people who are 65 years of age and older. The Fulmer SPICES tool (S-sleep; P- problems with eating or feeding; I - incontinence; C - confusion; E- evidence of falls; and S- for skin breakdown), was developed to evaluate common conditions that occur in the older adult that require nursing assessment and intervention. The needs of older adults are unique and different from those of middle-aged or younger adults. In a NCI NCCN designated Comprehensive Cancer Center, it is critical to evaluate specific conditions and activities of the older adult cancer patient to prevent avoidable iatrogenesis and promote safety.

Purpose: The purpose of this project is to incorporate the Fulmer SPICES Tool into an electronic medical record (EMR) clinical summary to provide a snapshot view for ease of nursing and healthcare provider patient assessment.

Interventions: Patient data is drawn from existing assessment flow sheets into a clinical summary that can be accessed by nurses and the healthcare team within the patient's EMR. This process provides a central location to view patient information and reduces the need to look for patient data in a variety of locations within the EMR. The summary is available for all inpatients using a drop down menu and labeled "Older Adult Assessment". The patient data can be evaluated from the beginning of the patient chart to provide a historical record, and to note changes of the patient status in each of the significant categories of sleep, nutrition, incontinence, mental status, evidence of falls, skin breakdown, and pain.

Evaluation: The assessment tool was presented to nursing and clinical staff for two inpatient units. Nurses and healthcare providers will be surveyed on the pilot units to assess the utility of the EMR tool. Nursing-sensitive patient outcome measures for evidence of falls and pressure ulcers will be monitored by using The National Database of Nursing Quality Indicators (NDNQI).

Discussion: Monitoring potential problems in the older adult more efficiently provides an opportunity for the oncology nurse to effectively implement preventative and therapeutic interventions to provide optimum cancer care for the older adult.

119264 (Poster)

IMPLEMENTING A REVISED NEUTROPENIC PRECAUTIONS POLICY: PROTECTIVE ISOLATION. Ellen Barrett, RN, OCN®, Henrico Doctors Hospital, Richmond, Virginia; Emily Gilbert, RN, BSN, OCN®, Henrico Doctors Hospital, Richmond, Virginia

Significance and Background: In addition to our outpatient infusion services, we are administering more frequent chemotherapy to our inpatient population, so it is prudent to review

our policy. We conducted an initial search of our policy and procedures handbook and found no definitive protective isolation policy. An informal survey of our oncology staff revealed they practice some form of precautions in this patient population by utilizing nursing critical thinking.

Purpose: We want to ensure that we put the most recent evidence into practice, as well as standardize our facility's recognition of neutropenia in all levels of care, not just our two oncology units. We will review our current policy and procedure in conjunction with the latest research available to ensure our policy is up to date.

Interventions: We will submit our revised policy via the policy group of our Nursing Congress for review and approval. Our goal is by ONS Congress to have a new Protective Isolation Policy and Procedure in place for our facility that is fully current and evidence-based, as well as accompanying education for each unit.

Evaluation: This education is important since our facility is small and occasionally oncology patients are placed on other units, or in higher levels of care for a portion of their stay.

Discussion: A possible limitation to this project includes a potentially slow review process that could delay administrative approval of the policy before ONS Congress in April. We will present the new policy for review and acceptance by the March 2013 Nursing Congress meeting for our facility.

119401 (Poster)

ENHANCING PATIENT COMFORT AFTER PROSTATE HDR PROCEDURE. Praphasiri Luangruangrong, RN, BSN, BA, CRNI, St. Joseph's Hospital of Atlanta, Atlanta, Georgia; Diane Atkinson, RN, BSN, St. Joseph's Hospital of Atlanta, Atlanta, Georgia; Carolyn Capleton, RN, AAS, St. Joseph's Hospital of Atlanta, Atlanta, Georgia; Cynthia Fallon, RN, BSN, OCN®, St. Joseph's Hospital of Atlanta, Atlanta, Georgia; Beverley Griffith, RN, AAS, St. Joseph's Hospital of Atlanta, Atlanta, Georgia; Debbie Griffith, RN, AAS, OCN®, St. Joseph's Hospital of Atlanta, Atlanta, Georgia

Significance and Background: In 2010, 36 patients received HDR. Movement restriction time averaged two hours; with one Percocet 5/325 and 50 mcg of Fentanyl given. All patients described pain scores as >3. After documenting that back pain was primary pain source, literature review was completed and Flexeril added to pain regimen. In 2011, 38 patients received HDR; one Percocet 5/325 and 25 mcg of Fentanyl given and Flexeril added for pain score >3. All patients described pain scores as < 3 after addition of Flexeril.

Purpose: The purpose of this project was to test the addition of a muscle relaxant to the standard pain control protocol to reduce the discomfort associated with HDR for prostate cancer patients.

Interventions: Retrospective chart audit of pain scores and opioids in patients receiving HDR in 2010. In 2011 Flexeril added to pre-procedure protocol for all HDR patients. Pain scores, nausea, opioid doses were monitored.

Evaluation: Nursing care includes assessment and management of pain. HDR treatment requires the placement of template with needles, immobility, transfers via stretcher and foley catheter with resultant discomfort. While HDR is effective for prostate cancer, discomfort from treatment can deter completion. Nurses act as patient advocates through identification and implementation of alternative treatments which result in a balance between comfort and treatment efficacy.

Discussion: Adding muscle relaxant to the pain management protocol was effective in decreasing the pain scores and use of opioids. Side effects of muscle relaxants include drowsiness, dry mouth and dizziness. All patients described drowsiness after Flexeril. The Cancer Committee recommended a change in protocol to include muscle relaxants with HDR procedure.

120169 (Poster)

COMPREHENSIVE PATIENT NEEDS ASSESSMENT: HOW ARE WE DOING? Trish Gallagher, BSN, RN, Seidman Cancer Center, University Hospitals, Cleveland, Ohio; Wendy Miano, DNP, MSN, AOCN®, RN, Seidman Cancer Center, University Hospitals, Case Medical Center, Cleveland, Ohio; Susan Mazanec, PhD, RN, AOCN®, Seidman Cancer Center, University Hospitals Case Medical Center, and Case Western Reserve University, Cleveland, Ohio; Barbara Daly, PhD, RN, FAAN, University Hospitals Case Medical Center and Case Western Reserve University, Cleveland, Ohio

Significance and Background: Oncology patients have many needs throughout the care continuum. Identification of the most salient needs is critical for targeted program planning in an environment where resources are limited. A comprehensive assessment can also assist oncology nurses in anticipating patients' needs.

Purpose: The purpose of this project was to establish and evaluate a method to measure patients' perceptions of their needs and the extent to which the cancer center services met those needs.

Interventions: A team of nurses was assembled to create the needs assessment survey, which required patients to rate their physical, social, emotional and spiritual concerns from cancer on a six point scale. Questions were added to obtain information about the cancer center's effectiveness in meeting the needs. The Patient and Family Advisory Council had input. After IRB approval, surveys were mailed to a sample of patients.

Evaluation: Of the 2750 surveys mailed, 1005 (37%) were returned and 42 (2%) patients called in to discuss the survey. Results included a number of important findings. Most patients (87%) preferred to receive follow up care from their cancer care team rather than another primary care provider. Written information was the most preferred source for patient education. Patients felt connected to the cancer center staff and coordination of care and changing providers were most challenging for patients. The greatest physical concerns were fatigue, changes body image, and trouble sleeping. Social concerns were financial, health insurance, and genetic counseling for children. Emotional Concerns were fear of recurrence, managing stress, fear of developing a new cancer, and managing difficult emotions. Spiritual concerns included isolation, end-of-life, loss of faith, and spiritual support. Patients felt that emotional and spiritual concerns were least often addressed by staff

Discussion: A comprehensive needs assessment can be a valuable tool for providing real baseline data about patients' needs and how we are doing in meeting them. The project cost was reasonable (\$7,000) and it was accomplished over two years. Results have important implications for education and process improvements. This method of obtaining patient feedback can be used to guide targeted patient support services that can improve well being and influence patient satisfaction.

120187 (Poster)

USING QUALITY MEASURES DATA TO IMPROVE NURSING PRACTICE: ARE YOUR PATIENTS GETTING A GOOD NIGHT'S SLEEP? Janet Gordils-Perez, MA, RN, APN-C, AOCNP®, The Cancer Institute of New Jersey, Plainsboro, New Jersey; Jacquelyn Lauria, RN, APN-C, AOCNP®, The Cancer Institute of New Jersey, Plainsboro, New Jersey; Carla Schaefer, BSN, RN, OCN®, The Cancer Institute of New Jersey, Plainsboro, New Jersey; Patricia Dennigan, BSN, RN, OCN®, The Cancer Institute of New Jersey, Plainsboro, New Jersey

Significance and Background: Thirty to 75% of cancer patients report sleep-wake disturbances that have a negative impact on their quality of life. Compared to the general population,

studies have revealed that cancer patients have twice the incidence of sleep disturbances. At an ambulatory care NCI-designated Comprehensive Cancer Center, nurses identified the need to improve their assessment, documentation and management interventions of sleep-wake disturbances based on the ONS Breast Cancer Care Quality Measures National Pilot Data. This data revealed less than 55% of our healthcare providers assessed and/or documented sleep-wake disturbance management interventions. Knowing that management of sleep-wake disturbances is a nursing sensitive patient outcome, it was evident that the nursing staff needed to take the lead in this practice improvement.

Purpose: The project's purpose was to improve assessment, documentation and interventions of sleep-wake disturbances to ensure quality nursing care by using the strongest level of evidence on which to base nursing practice intervention. Integrated were the ONS PEP® resources into the documentation tool for evidenced-based interventions and evaluation.

Interventions: After review of current nursing documentation, modifications were made to our electronic documentation tool that prompts the nurse to complete an in-depth assessment and provide evidence-based interventions and evaluation. Staff was educated regarding the pilot data and brainstorming sessions are planned regarding opportunities for incorporating interventions into practice. Revisions to documentation forms will be developed with staff input. Patients experiencing sleep-wake disturbances will be encouraged to complete the Insomnia Severity Index at various time points to evaluate the effectiveness of interventions.

Evaluation: Formal evaluations are planned with audits to ensure documentation is complete, standards of oncology nursing practice are met and how interventions have impacted this nursing sensitive patient outcome. To improve continuity of care, our partner hospital's oncology outpatient area will implement the improvements as well.

Discussion: Nurses should consider taking the lead in making practice improvements based on evidence. It is important for nurses to understand the importance of screening and effective interventions for sleep-wake disturbances in patients with cancer. Modifications to existing evidence based documentation tools may be adapted for use by all ambulatory care nurses nationally with the goal of improving nursing sensitive patient outcomes.

120353 (Poster)

THE RELATIONSHIP AMONG ADVERSE EVENTS, EFFICACY, AND NURSING INTERVENTION FOR SORAFENIB TREATMENT IN JAPANESE PATIENTS WITH ADVANCED HEPATOCELLULAR CANCER. Masako Shomura, Tokai University, Isehara-city; Atsuko Otsuka, Tokai University Hospital, Isehara; Yukiko Dozono, Tokai University Hospital, Isehara city; Asako Murakoshi, Tokai University, Isehara city

Significance and Background: Sorafenib therapy for advanced HCC often causes adverse events (AE), especially for patients who can't continue with the long-term medication. In this condition AE prognosis may be more likely to get worse. Possible occurrence of AE will lead to attenuation of the treatment effect. On the other hand, there are reports which show that good therapeutic result can be obtained if more serious cases of AE occurred.

Purpose: In this study, we examined the expression status of AE, treatment period, effectiveness, and overall survival(OS) of patients who were dosed with sorafenib in our hospital. In addition, we examined the results depending on the presence or absence of nursing intervention from the time of introduction if there is a significant effect in the varying treatment conditions.

Interventions: In October 2009 until August 2012, we studied 38 patients with advanced HCC which were treated with

sorafenib. We were able to observe these patients and at the same time conducted series of nursing intervention programs to some of these patients at random.

Evaluation: I checked AE based on the CTCAE ver4.0. Efficacy is evaluated by m-RECIST initiation of treatment at 8-24 weeks. We compared the results using chi-square measure of the relationship between the expressions AE. On the hand, OS was compared using a log-rank test to Kaplan-Meier curves. Characteristics of 38 cases are median age 72 years (36-83), 31 males (83%), Child-Pugh A 34 cases (89%), B 4 cases(11%), HCV 21 cases(55%),HBV 11 cases(29%), TNM Stage III 15 cases(40%),IVa 9 cases(24%), IVb 14 cases(37%), ECOG-PS 0-1 37 cases. 24 cases(63%) received nursing interventions from the start of medication. About the initial amount of sorafenib which is 800mg was given to 22 patients (61%), 600mg 4 cases (8%), 400mg 11 cases(29%), and 200mg 1 case (3%). The median of the duration of medication was 95 days (4-461), AE was expressed in all cases. Especially over G3 AE experienced hand-foot syndrome (HFS) and 11 cases (29%) suffered anorexia, and 9 cases (24%) experienced general fatigue. Reduction or interruption of medication was required in 41% of the cases by AE. In 25 cases, the treatment effect can be verified, which showed effective rate of 56% (CR4% + PR12% + SD40%). The effective rate of the patients with over HFS G2 12/16 (70%) was significantly higher compared to the other 2/9 (22%), and also experience significantly longer OS. The effective rate of the patients with over G2 rash (erythema multiforme, urticaria, rash poisoning) 5/5 (100%) was significantly higher the other cases 9/20(45%), and also significantly longer OS. There was no significant difference in the average period between with / without nursing intervention (118/92 days, $p = 0.06$). However, with over 95 days of medication, the number of cases were significantly higher in the nursing intervention group(67 % vs 21%, $P < 0.01$). No significant differences were observed in the effectiveness level, the OS is relative to the presence or absence of nursing intervention.

Discussion: High response rate in the above sample expression of HFS and rash G2 is likely related to the efficacy and the occurrence of adverse events has been suggested. It was observed that the long period of medication, in patients with nursing intervention from the time of introduction of sorafenib, nursing intervention has contributed significantly. For the most effective dose of sorafenib treatment, it is an important factor in the long-term medication management and with the use of appropriate AE of nursing intervention from the time of introduction.

121123 (Podium)

GENE MODIFIED T-CELL INFUSIONS FOR CHRONIC LYMPHOCYTIC LEUKEMIA: INNOVATIONS IN OUT-PATIENT NURSING CARE DELIVERY. Cheryl Caravano, BSN, RN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Christopher Brooks, MS, RN, Memorial Sloan-Kettering Cancer Center, New York, New York

Significance and Background: Chronic Lymphocytic Leukemia (CLL) is the most commonly diagnosed leukemia in the United States. Treatment includes chemotherapy, radiation, monoclonal antibody therapy, and allogeneic stem cell transplantation. Treatment combinations continue to evolve. While survival has improved, CLL remains an incurable disease. A recent and exciting trend in CLL treatment is gene-modified cell therapy. This technology allows for a patient's own T-cells to be modified such that they recognize leukemia cells as foreign. The first patients treated with gene-modified T-Cells had a high disease burden. Side effects of the infusion were severe and hospitalization for treatment was required. Data from clinical trials suggested an enhanced anti tumor efficacy in adoptive T-cell therapy in the setting of minimal residual disease and increased progression free survival associated with consolidative therapy

to treat residual disease. Patients with minimal residual disease tolerated the infusions well and the treatments were safely transitioned to the outpatient setting.

Purpose: At this NCI designated comprehensive cancer center, a process was implemented to support the outpatient infusion of genetically modified T-cells. In order to be eligible for outpatient treatment, patients must have achieved a partial or complete response with minimal residual disease after treatment with combination chemotherapy. Nursing played a significant role in helping to assure this cutting edge therapy was delivered to patients safely in the outpatient setting.

Interventions: All nurses in the infusion and office practice areas were educated on the disease, eligibility for treatment, side effect profile, and nursing interventions. Office practice nurses were involved in screening for eligibility, education of patients and families about the treatment, and actively participated in patient follow up care. Standard Operating Procedures (SOPs) were developed for infusion and management of acute infusion related side effects. An educated nursing staff, SOP's for cell infusion, clear side effect management strategies and modified staff ratios significantly contributed to ensuring safety during the T-Cell infusions.

Evaluation: To date, three patients have been successfully treated in the outpatient setting with no significant events or readmissions to the inpatient unit. Strong multidisciplinary collaboration ensures the safe care of patients receiving this cutting edge therapy.

Discussion: Innovative cancer treatment approaches are dependent on skilled nursing care management to insure safe and successful outcomes. Our experience can serve as a model for other oncology nurses as this new treatment for CLL becomes more widespread. This presentation will provide oncology nurses with patient and nursing education tools, infusion SOP's and a case study demonstrating the patient experience.

126693 (Poster)

RESEARCH WITH THE LITTLE "R": SMALL RESEARCH PROJECTS HELP PROPEL NURSING SCIENCE. Janine Overcash, PhD, The Ohio State University Comprehensive Cancer Center, Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, Columbus, OH

Significance and Background: The goal of this presentation is to illustrate the benefits and tips to creating and completing small, often unfunded research projects in nursing clinical practice. Many small research projects are often not performed because they are unfunded, lack mentorship, time or general resources to complete the project. Small research projects are different than evidenced-based-practice projects in that they generate new knowledge instead of reviewing existing published data. This project is significant in this time of limited research funding by providing information concerning the necessary of developing projects that generate new knowledge yet limited in scope so they are feasible to perform in a clinical setting.

Purpose: The purpose of this presentation will be to discuss the development of small research projects that are feasible to perform in a clinical setting.

Interventions: Interventions: Issues such as mentorship, research support activities, research compliance and dissemination will be addressed. Examples of small research projects that have contributed to nursing practice will be presented. Tips on the development of a successful research project will be offered.

Evaluation: This presentation is applicable to oncology nursing in that many nurses have the skill and desire to construct and complete clinical oncology nursing research, however lack some of the resources necessary. The factors discussed can be evaluated for each clinical facility and type of unit. The content of this presentation will be evaluated on the speaker evaluation in the articulation of goals and objectives associated with discussing tips to creating and completing small research projects.

Discussion: Innovation: This project is innovative in that it will address some of the real barriers to nursing research and steps to successful completion of a project. Clinical nurses should be empowered with the support to develop, complete and disseminate clinical research findings. Practical tips and recommendations will be presented and discussed.

127991 (Poster)

BRIDGING THE GAP: ROLE OF ACUTE PALLIATIVE CARE NURSE LIAISON. Julieta Fajardo, RN, BSN, CHPN, MD Anderson Cancer Center, Houston, Texas; Stacy Hall, RN, MSN, NE-BC, MD Anderson Cancer Center, Houston, Texas; Chanelle Clerc, RN, BSN, CHPN, MD Anderson Cancer Center, Houston, Texas

Significance and Background: In an effort to improve communication among staff, patients, and family members during the transition from curative cancer treatment to palliative care; the role of the palliative care nurse liaison was introduced. Although patients and family members have been seen by the mobile team, palliative nurses felt overwhelmed when confronted with issues that should have been addressed prior to being transferred to the inpatient acute palliative care unit (APCU). Evidence supports that accurate communication of information to families regarding the transition from curative cancer treatment to palliative care can alleviate anxiety and distress, and enhance the quality of life.

Purpose: The purpose of this presentation is to (1) describe how the role of a palliative care nurse liaison facilitates the establishment of a relationship between the nursing staff, patients and family members, and (2) bridges the gap of the missing links of communication to family members on how palliative care can help patients and family members at the end of life.

Interventions: Eight palliative care nurses who are certified in hospice and palliative nursing were selected to take on the role as a palliative care nurse liaison (PCNL). The PCNL meet the patient and family members after orders for transfer to the service are written to explain the role of the members of the interdisciplinary team in the patient's plan of care, and answer their questions regarding palliative care. The different services and what they can expect during their stay in APCU is also discussed.

Evaluation: The role of PCNL reveals improved communication amongst staff, patients, and families regarding end-of-life care when transferred to the palliative care service.

Discussion: The stress experienced by the APCU nurses in the care of the terminally ill and dying cancer patients has been widely recognized. The role of a PCNL facilitates a more consistent, and supportive experience for patients and families at the end of life as well as, lessen the stress of the APCU nurses in dealing with patients' and families' emotions, and concerns that spring from advancing illness. Overall, the PCNL program involve in the program has received positive feedback from family members during weekly unit leadership rounding with patients.

128011 (Poster)

MANAGEMENT OF MEN POST RADICAL PROSTATECTOMY (RP) THAT DEVELOP A DETECTABLE PROSTATE-SPECIFIC ANTIGEN WHILE ENROLLED IN A NURSE PRACTITIONER LED PROSTATE CANCER SURVIVORSHIP PROGRAM. Mary Schoen, MSN, MPH, NP-C, Memorial Sloan-Kettering Cancer Center, New York, New York; Anthony De LaCruz, NP-C, Memorial Sloan-Kettering Cancer Center, New York, New York; Robin Rawlins-Duell, NP-C, Memorial Sloan-Kettering Cancer Center, New York, New York; Melanie Bernstein, CCRP, Memorial Sloan-Kettering Cancer Center, New York, New York

Significance and Background: It is estimated that there are nearly 2.8 million men living with prostate cancer in the United States. More than 90% of prostate cancers are discovered in the

local or regional stages, for which the 5-year survival rate approaches 100%. At this large NCI-designated cancer center, men who undergo a radical prostatectomy (RP) are eligible to enter a NP led survivorship program. While many patients are cured, some will develop a detectable PSA. Lack of standardized management of these patients led to a collaborative effort between survivorship NPs and the surgeons to establish an algorithm to guide practice.

Purpose: The purpose of this review is to examine current practice in managing post prostatectomy patients with a rising PSA who were enrolled in a prostate cancer survivorship program and to establish a standardized approach to care.

Interventions: A total of 2,551 men were enrolled in the prostate cancer survivorship program from January 2007 to July 2012, each undergoing a RP at this high volume institution. The patient's PSA was evaluated by the NP at each visit and entered into a secure database. Undetectable PSA was defined as a value of $<0.05\text{ng/ml}$. Patients with a PSA value of $\geq 0.05\text{ng/ml}$ were considered to have a detectable PSA.

Evaluation: 155 (6.1%) patients had a confirmed detectable PSA. The NP, in collaboration with the patient's surgeon, determined the appropriate follow up for each patient. 63 (41%) patients were referred to radiation oncology for consideration of salvage therapy; 17 (11%) referred to medical oncology and 37 (24%) referred to both radiation oncology and medical oncology for consideration of additional therapy. The total number of patients referred was 117 (75%) while 38 (25%) of patients remain in the survivorship program for continued surveillance with the NP.

Discussion: NPs play a critical role in the management of prostate cancer survivors with rising PSAs. Through collaboration with physician colleagues, NPs can establish guidelines to ensure a consistent approach to patient counseling, clinical trial enrollment and referrals for secondary therapies. Further research is recommended to determine the optimal management of patients with a detectable PSA.

128263 (Poster)

COORDINATION OF CARE: AMBULATORY ONCOLOGY TREATMENT NURSES MANAGING PHASE I CLINICAL TRIAL PATIENTS. Vivian Dorsey, RN, BSN, MBA, OCN®, MD Anderson Cancer Center, Houston, Texas; Portia Tse, RN, BSN, MS, OCN®, MD Anderson Cancer Center, Houston, Texas

Significance and Background: Treatment nurses are expert in their field of chemotherapy administration. However, there is much more involved in Phase I drug administration. There are regulatory issues and specific protocol compliance measures.

The Clinical and Translational Research Center nurses developed a protocol champion process. This process improved patient safety, and improved outcomes in the clinical treatment arena.

Purpose: The purpose of the protocol champion's process is to facilitate the clinical nurse's comprehension of the protocol requirements. Having direct access to the research information empowers the nurse to treat and manage the clinical trial population. Effective communication between clinical and research nurses is essential for patient safety, improved outcomes and coordination of care.

Interventions: The first step was to identify protocol measures the clinical nurse needed to know to treat the patient. Next, the clinical nurse gained direct access to the protocol, and the opportunity to participate the research protocol activation process. The team developed unit based guidelines to support the research and clinical processes. The final step involved implementation of an in-service with nursing, lab, research, and pharmacy to ensure all requirements for safety were in place.

Evaluation: The development of the protocol champion process and implementation of guidelines has contributed to the

professional development and autonomy of the clinical nurse. Increased knowledge of the protocol contributed to compliance, enhancing patient safety. Validation occurred by consistent documentation of all auditable regulatory requirements, and decreased nursing research queries.

Discussion: The process promotes coordination of care and collaboration between the research team and clinical nurses. The clinical nurse needs to have the research information to effectively manage clinical trial patients at the bedside. A decrease in errors and deviations are noted when the research knowledge is provided to the clinical nurse. As a result, there are better outcomes for the patient and the clinician.

128377 (Poster)

MEETING THE NEEDS OF THE METASTATIC COLORECTAL CANCER PATIENT: FACILITATING A COUPLES' RETREAT.

Maura Kadan, RN, MSN, OCN®, Johns Hopkins Hospital, Baltimore, Maryland; Eden Stotski-Himelfarb, RN, BSN, Johns Hopkins Hospital, Baltimore, Maryland; Luis Diaz, MD, Johns Hopkins Hospital, Baltimore, Maryland

Significance and Background: Survivorship initiatives for cancer patients continue to be at the forefront of cancer care. Much of the focus has been on patients who have completed active treatment for their cancer; however few programs exist for patients and their caregivers with terminal metastatic colorectal cancer. Herein, we describe an initiative to meet the needs of couples where one member has incurable metastatic colorectal cancer.

Purpose: A 3-day retreat was held at a local community center. A focus group of patients and providers identified the needs of metastatic colorectal patients. Once program goals were established, the group created an agenda including experts from various fields: nutrition, exercise, spirituality, coping, caregiver support, clinical trials, palliative care, intimacy, and symptom management. Time was also allotted for meditation, massage, reiki, and relaxation. Patients and their partners completed quality of life surveys. This format was based on retreats facilitated by our Breast Cancer Center and the data they gathered from these events.

Interventions: The retreat agenda encompassed the spiritual, psychosocial, physical, and intrapersonal needs of the attendees. The facilitators intended to encourage a sense of community among the attendees. By telling their stories, expressing emotions, asking difficult questions, these couples found hope and strength within themselves and from their new friendships. The couples reconvened for a social gathering 1 month after the retreat.

Evaluation: Six couples attended this retreat. All patients were actively being treated with chemotherapy, and with ECOG performance status within the range of 0-1. Pre-retreat surveys indicated patients and partners "want to make the most of their time, want to feel in control of their disease, and are concerned about their loved ones coping with this diagnosis." Responses to post-retreat surveys were limited. Informal feedback included the benefit of connecting with other couples and appreciation for the agenda.

Discussion: Oncology nurses are equipped to have difficult conversations with their patients. We need to initiate difficult conversations with our patients, outside of the daily treatment plans and symptom management. Determining what patients find important when faced with terminal cancer will help health care providers approach quality of life and goals of care with the individual's needs in mind.

129497 (Poster)

NO PASS ZONE: INCREASING PATIENT SATISFACTION ONE CALL LIGHT AT A TIME.

Yvette Ong, MS, BSN, RN, OCN®, NE-BC, UT MD Anderson Cancer Center, Houston, Texas; Uriel Tapia, BSN, RN, UT MD Anderson Cancer Cen-

ter, Houston, Texas; Andrea Mayfield, MSN, RN, OCN®, UT MD Anderson Cancer Center, Houston, Texas

Significance and Background: Once a patient hits the call button, every second that passes adds a sense of urgency and anxiety until someone, anyone responds to the call light. The patient satisfaction committee composed of clinical nurses, nursing assistants, patient service coordinators, and nursing leadership on a 32-bed medical oncology unit recognized this as an area of patient safety and satisfaction that needed improvement. The committee implemented a “No Pass Zone” creating the expectation that no team member will walk by a patient’s call light without responding.

Purpose: To describe the background and implementation of a “No Pass Zone”.

Interventions: Although not all team members may have the skill set required to address specific patient care needs, with the “No Pass Zone”, expectations were established to reinforce the message that answering call lights was a team responsibility and that communication to an appropriate caregiver who was best qualified to meet the request may be needed. Training was performed through the use of scripts and role modeling. Patient service coordinators were coached to be more proactive in obtaining information when patients called so nurses can expedite requests.

Evaluation: The initiative has improved patient satisfaction mean scores for the Press Ganey question related to promptness in response to call from 84.1 (2010) to 89.8 (2012); from 19% (2010) to 89% (2012) as compared with National Comprehensive Cancer Network benchmarks; and from 41% (2010) to 92% (2012) as compared with Academic Medical Centers. The shared ownership in meeting patient care needs has reinforced a culture of team accountability.

Discussion: Oncology nurses are key drivers of patient safety and satisfaction. This information can be shared with the interdisciplinary team to engage them in a collaborative effort in enforcing a “No Pass Zone” in their organizations.

129733 (Poster)

USING A SIX-STEP EVIDENCE-BASED PRACTICE CHANGE MODEL TO REDUCE THE RATE OF CENTRAL LINE-ASSOCIATED BLOOD STREAM INFECTIONS IN ONCOLOGY PATIENTS. Ikuko Komo, RN, MSN, AOCNS®, Banner Good Samaritan Medical Center, Phoenix, Arizona; Ann Earhart, MSN, ACNS-BC, CRNI, Banner Good Samaritan Medical Center, Phoenix, Arizona; Valarie Wolfe, RN, BSN, OCN®, CRNI, Banner Good Samaritan Medical Center, Phoenix, Arizona; Lori D’Ambrosio, MBA, BSN, RN, OCN®, Banner Good Samaritan Medical Center, Phoenix, Arizona

Significance and Background: Central line (CL) associated blood stream infection (CLABSI) is one of the most costly and deadly hospital associated infections, particularly in immunocompromised cancer patients who experience a higher mortality rate. Despite numerous interventions to decrease CLABSIs on an Oncology unit at one inner-city Magnet designated hospital, a high rate of CLABSIs persisted. Multiple factors may lead to developing CLABSIs, which can create difficulties in identifying specific potential causes.

Purpose: The purpose of this EBP project was to utilize a six-step EBP change model in a systematic process to reduce the rate of CLABSIs.

Interventions: The first step involved an Assessment of the need for change. We compared the Oncology unit’s CLABSI rate to other units and national rates in the National Database of Nursing Quality Indicators database. The nursing staff was observed one-on-one for technique related to CL maintenance. Second, problems, interventions, and outcomes were Linked be-

cause of discrepancies in the methods staff cared for CLs. Hospital policies related to CL care were Linked to clinical guidelines. The third step included an exhaustive Synthesis of evidence from literature. The fourth step included the practice change Design, to reduce discrepancies and produce an evidence-based policy that includes a hands-on checklist. We also designed a fishbone diagram to evaluate the causes and effects of each CLABSI to determine what measures to take to reduce infections. As a result, improper techniques with CL maintenance and the need for re-education were identified. Additionally, systematic analysis was conducted to address barriers and improve facilitation of change and leadership support garnered for the practice change. Implementation, the fifth step, included hands-on re-education of hand washing, blood culture collection, intravenous port accessing/de-accessing, and peripheral inserted central catheter dressing change stations on all of the nursing staff.

Evaluation: An approximately 75% reduction of CLABSIs was achieved.

Discussion: The sixth step is to Integrate and maintain the low CLABSI rate through continued monitoring for adherence with daily rounding by leadership using a checklist for CL compliance. This project demonstrates that using the six-step EBP change model can help the success of EBP project in infections in oncology patients.

129744 (Poster)

TRANSITIONS IN ONCOLOGY CARE. Nicole Ross, MSN, CRNP, AOCNP®, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania

Significance and Background: The majority of cancer patients have competing co-morbid conditions which make their management more complex. Often patients are undergoing multidisciplinary therapeutic treatment courses, which are not easy to tolerate. When these patients are admitted to the hospital with an acute crisis, their care can feel fragmented, and even more so when discharged. About one quarter to one third of older adults with multiple chronic conditions are re-hospitalized due to preventable complications. Re-admission rates are high and patients often feel lost in transition, unsure of which provider to contact with concerns, feel unhappy with their care, or experience adverse clinical events due to frequent handoffs.

Purpose: The purpose of this abstract is to review the challenges of frequent patient handoffs or transitions, identify a model for identification of oncology patients at risk for re-admission, and provide guidelines to facilitate a smooth transition

Interventions: Identify a model for identifying oncology patients at risk for re-admission and potential adverse effects secondary to handoffs in care. Some of the guidelines that will be discussed include: Provide a contact # to discharged patients to call with questions or concerns; Follow – up phone calls after discharge; Follow up appointment within 1 week of discharge; Detailed and easily understood discharge medication list; Standardized discharge assessments completed by discharge planners; Improved Communication between inpatient and outpatient providers; Active engagement of patients and families to participate in their discharge planning; Arrangement of outpatient continuity of care: dietitian, social work, speech therapy, etc.

Evaluation: Attendees will be able to comprehend the challenges of transitions in oncology care, describe a model for identification of patients at high risk for readmission, and be aware of suggested guidelines

Discussion: This information can be utilized by oncology nursing providers and applied at the time of admission for identification and for early implementation of guidelines to prevent readmissions. The identification and guidelines should be utilized again when discharge planning is in place to address any new problems.

130615 (Poster)

HIGH DOSE INTERLEUKIN 2 IMMUNOTHERAPY ELECTROLYTE REPLACEMENT PROTOCOL. Marie Asay, RN, BSN, OCN®, CCRN, Huntsman Cancer Hospital, Salt Lake City, Utah; Colleen Ford, RN, BSN, Huntsman Cancer Hospital, Salt Lake City, Utah; Rebecca Formosa, RN, BSN, Huntsman Cancer Hospital, Salt Lake City, Utah; Medalit Hambly, RN, BSN, Huntsman Cancer Hospital, Salt Lake City, Utah; Stephanie Sanders, PharmD, Huntsman Cancer Hospital, Salt Lake City, Utah; Joan Sanders, APRN, Huntsman Cancer Hospital, Salt Lake City, Utah

Underwriting or funding source: This retreat was funded by The Johns Hopkins Colon Cancer Center and Swim Across America.

Significance and Background: Patients with renal cell carcinoma and metastatic melanoma can be treated with high dose interleukin 2 (HD IL-2). This treatment is administered in the intermediate care unit (IMU) for monitoring therapy related toxicities. Toxicities include capillary leak syndrome and cardiopulmonary toxicities causing electrolyte abnormalities and cardiac arrhythmias. Appropriate management may require use of vasopressors and frequent electrolyte replacements. Electrolyte replacement often delays treatment. Adopting an electrolyte replacement protocol allows nurses to be proactive and timely to prevent life threatening toxicities.

Purpose: This project shows the value and importance of having an electrolyte replacement protocol for HD IL-2 patients. Having a protocol allows earlier electrolyte replacement, allowing timely IL-2 doses and preventing complications from therapy toxicities. The goal of the electrolyte replacement protocol is to enhance the patients care and safety during their hospitalization.

Interventions: A literature review revealed no evidence of HD IL-2 or oncology treatment standard electrolyte replacement. Electrolyte values were analyzed from 21 patients over a 20 month period, totaling 95 admissions. The electrolyte values analyzed included potassium (K+), magnesium (Mg), phosphorus (PO4), ionized serum calcium (Ca+), and carbon dioxide (CO2). The data collected consisted of the electrolyte order and correlated electrolyte lab value. Data analysis consisted of frequency, mode and median of electrolyte order for each lab value. After compilation and data analysis, the information was compared to existing electrolyte replacement protocols currently available in the institution. It was found the data matched that of an existing surgical intensive care unit protocol. The research was presented to providers for review and approval.

Evaluation: Staff education was provided. The protocol was placed in a bedside binder for quick reference. The nursing staff has expressed satisfaction with the protocol. Nurses report the protocol enables timely electrolyte replacement, decreasing treatment delays and therapy toxicities. Six months after implementation, the protocol will be reviewed for timeliness of electrolyte replacement and change in therapy toxicities.

Discussion: Collaborative nursing practice, implementing an electrolyte protocol, directly impacted patient safety with timely management of electrolytes and decreasing treatment delays. Further protocols may be developed for replacement of sodium bicarbonate and calcium.

131483 (Podium)

OBTAINING TACROLIMUS LEVELS THROUGH A CENTRAL LINE VS. PERIPHERAL BLOOD DRAW: AN EVIDENCE BASED REVIEW. Jessica Nickel, RN, OCN®, University of Maryland Medical Center, Baltimore, Maryland; Karen Kaiser, PhD, RN-BC, AOCN®, University of Maryland Medical Center, Baltimore, Maryland; Laura Hearson,

MSN, RN, OCN®, University of Maryland Medical Center, Baltimore, Maryland; GCC Clinical Practice Committee (all members), RN, University of Maryland Medical Center, Baltimore, Maryland

Underwriting or funding source: Bayer HealthCare Pharmaceuticals

Significance and Background: Practice variances existed in blood draw methods for obtaining tacrolimus levels between Inpatient Bone Marrow Transplant and Outpatient Bone Marrow Transplant clinic nurses in the Marlene and Stewart Greengarden Cancer Center. These variances may be responsible for discrepancies of tacrolimus levels between peripheral blood draw method and central line blood draw method. Accurate levels are critical to optimize patient outcomes. Variations resulted in verification of levels by repeat testing using peripheral blood.

Purpose: The purpose of this evidence based project was to determine and implement a standardized and optimum method for nurses to obtain accurate Tacrolimus levels in order to improve patient outcomes.

Interventions: The cancer center's Clinical Practice Committee members reviewed articles, contacted the manufacturer and performed benchmarking with other cancer centers. Articles found were limited to the solid organ transplant population, but were applicable to the BMT population. Information obtained indicated that tacrolimus levels vary based on administration times, seasons, drug interactions, and food interactions. According to the manufacturer, tacrolimus also undergoes extensive absorption to polyurethane IV catheters, hence it is not recommended to use central line catheter lumens for tacrolimus blood draws. Cancer centers across the nation have varying practices for obtaining tacrolimus levels. Based on the limited but compelling data, the GCC Clinical Practice Committee proposed a practice change to peripheral blood draws throughout the cancer center for tacrolimus. Due to the importance of consistent administration times and awareness of food and drug interactions, in conjunction with the Patient Education Committee, patient teaching instructions were revised to address food and drug interactions and timing of dosing of drug administration in relation to meals.

Evaluation: By standardizing our patient education and method for drawing Tacrolimus levels, we have reduced repeat blood draws to zero. In addition, we now have a consistent method of performing tacrolimus blood draws throughout the cancer center.

Discussion: The accuracy of tacrolimus levels results is pivotal to assuring reliable results. Nurses play a vital role in optimizing patient outcomes in a BMT population through implementation of standardized, evidenced based practices in blood draw procedures and educating patients about the important factors which they influence at home.

131692 (Poster)

BIOLOGICAL WARFARE: PREPARING THE NURSE TO CARE FOR PATIENTS RECEIVING MICROORGANISMS TO FIGHT CANCER. Cynthia Holt Bedell, MSN, RN, ANP-C, Mary Crowley Cancer Research Center, Dallas, Texas; Stephanie Walker, RN, Mary Crowley Cancer Research center, Dallas, Texas

Significance and Background: New technology is improving old paradigms of utilizing microorganisms to fight cancer. Dr. Coley in the late 1800's noticed that a sarcoma tumor disappeared after the patient developed a Streptococcus pyogenes infection. This started years of research using bacteria and bacterial based vaccines to treat cancer. At the turn of the century chicken pox virus was noted to remit a lymphoma and

rabies could shrink cervical cancer tumors. It was not until 1980 that modern medicine embraced the use of these agents to treat cancer. BCG (Bacillus Calmette–Guérin) an approved treatment for superficial bladder cancer involves the installation of live bacteria into the bladder.

Today many microorganisms including bacteria and viruses are being used to fight cancer. They may be used as a vector to deliver gene therapy or targeted therapy to the tumors; or they may actually replicate within the cancer cell causing direct cell lysis and/or death (oncolytic viruses); and they may induce a local or systemic immune response to fight the cancer. These agents may be given as an intra-tumoral injection, a vaccine or an intravenous infusion.

Purpose: With increased utilization of these agents nurses will need to become aware of and implement Biosafety Standards as outlined in the Biosafety in Microbiological and Biomedical Laboratories Manual.

Interventions: Procedures and care must be implemented to protect the patient from life threatening infections or complications from the agents. Personal protective equipment and isolation procedures should be established and utilized in order to protect the health care team. Processes should be developed to protect the general public from transmission of the organism and possible spread of infection.

Evaluation: All of these procedures need to be comprehensive but also sensitive to issues such as social isolation and secondary stigma of exposure to biological agent such as a herpes simplex virus.

Discussion: The oncology nurse will be crucial in establishing plans of care for this emerging patient population.

131720 (Poster)

IMPROVEMENT IN PATIENT PAIN SATISFACTION SCORES FOR AN ADULT INPATIENT ONCOLOGY UNIT: A PAIN MANAGEMENT INITIATIVE. Megan Zahnow, RN, MS, Anne Arundel Medical Center, Annapolis, Maryland; Tara Dubois, RN, Anne Arundel Medical Center, Annapolis, Maryland; Jan Clemons, RN, OCN®, Anne Arundel Medical Center, Annapolis, Maryland

Significance and Background: Cancer pain affects 25% of newly diagnosed patients, 33% in active treatment, 75% with advanced disease, and 33% of survivors who have completed treatment. Nursing interventions are a key component to the improvement of pain management for the adult patients with cancer pain.

Purpose: The purpose of this study is to determine if implementing a nursing Pain Management Initiative improves patient pain satisfaction resulting in improved unit HCAHPS pain benchmarks of 80% or better.

Interventions: Eight interventions were initiated in a nursing Pain Management Initiative.

1. Improvement in quality of initial and one hour post intervention pain assessments
2. Educate nurses in NCCN pain guidelines, adjuvant medications, pain types, symptoms, and mechanisms of pain
3. Offered pain medication for prn dosing prior to patient request
4. Educate patient on pain medications and when dosing is due
5. Request for pain consult for unsatisfactory pain sustained more than 24 hours
6. Nursing assistants to include pain as the 5th vital sign
7. Nurses read and sign Pain Management Initiative
8. Initiative reminders in shift huddles

Evaluation: HCAHPS oncology pain satisfaction benchmark is 80% as compared to the unit's January-March 2012 score of 78.6% and April-May 2012 score of 72.4% in regard to the question: H4AF "Staff doing everything they could to help with

pain". The nursing Pain Management Initiative was initiated. Unit based results for July-September 2012 was 88.9%.

Discussion: Nursing pain interventions may lead to improved cancer pain management and patient reported pain satisfaction. Recommendations for practice include: increase nursing knowledge on types, symptoms, and mechanisms of pain; use of NCCN pain guidelines; engagement of interdisciplinary teams; and awareness of appropriate adjuvant medications. A continuance of tracking HCAHPS pain satisfaction scores will be performed for a total of 12 months to evaluate sustainability of improvement in correlation to the unit's Pain Management Initiative. There will be consideration to include the results from question H4AE: "Pain well controlled", in order to obtain a stronger representation of true pain management scores.

131821 (Poster)

CANCER AND HIV: A DUAL NURSING CHALLENGE. Melanie Carrow, RN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York

Significance and Background: Advances in anti-retroviral therapies prolong survival for patients with HIV. The HIV infected has a higher incidence of some types of cancer compared with uninfected people of the same age. Specific cancers are known as "AIDS-defining malignancies": Kaposi's sarcoma, non-Hodgkin lymphoma, and cervical cancer. A diagnosis of these cancers in an HIV positive individual, confirms a diagnosis of AIDS. The introduction of Highly Active Anti-retroviral Therapy (HAART) reduced the incidence of AIDS associated cancers, prolonged survival and fostered partial restoration of immune function. Currently, more non-AIDS-related cancers, such as lung, anal, liver and Hodgkin's lymphoma are emerging. Today cancer patients with HIV are treated aggressively, challenging the health care team to balance HIV management and cancer treatment.

Purpose: To advance the expertise of the oncology nurse in current management strategies for the cancer patient with HIV.

Interventions: The cancer prognosis for people infected with HIV can be poorer, as malignancies appear to take a more aggressive clinical course. When the patient with HIV develops a malignancy, the treatment for both disease entities becomes complex. Management requires astute assessment, ongoing surveillance, care coordination, and continuing patient and caregiver education in order to achieve optimal outcomes.

Evaluation: The nursing challenges associated with cancer treatment in the HIV positive patient include the dynamic care requirements necessary to effectively balance HIV management and cancer treatment throughout the disease trajectory. At our cancer center, patients with HIV and cancer are managed through collaboration of a multidisciplinary team ensuring all aspects of care are addressed. This requires interventions from oncology, infectious disease, hematology and our bone marrow transplant team. These special patients are now experiencing prolonged survival of their duo-diagnoses.

Discussion: HIV infection is associated with an increased risk and opportunity for the development of cancer. The non AIDS diagnosing malignancies appear to occur regardless of HIV treatment and immune competence. At this time, the role of HIV infection, immune suppression and other viral infections, in the development of cancer is being actively investigated with new information emerging daily. It remains the responsibility of the entire healthcare team to maintain the knowledge of this information.

132469 (Poster)

RADIOIMMUNOTHERAPY: AN EMERGING THERAPY FOR NON-HODGKIN'S LYMPHOMA WITH IMPORTANT RADIATION SAFETY NURSING IMPLICATIONS FOR THE OUTPATIENT SETTING. Gloria Wood, BSN, RN, H. Lee

Moffitt Cancer Center and Research Institute at International Plaza, Tampa, Florida

Underwriting or funding source: Funding was provided by Myriad Genetic Laboratories, Inc.

Significance and Background: Most patients with indolent forms of non-Hodgkin's lymphoma (NHL) present with advanced disease and are generally considered incurable. Long-term remission may be obtained with chemotherapy combined with monoclonal antibody therapy directed against the CD20 antigen, but the disease eventually becomes fatal when drug-resistance develops. A new strategy called radioimmunotherapy (RIT) has been showing promise by selectively targeting the CD20 positive lymphoma cells with a monoclonal antibody that can be combined with a radioactive agent. RIT is a safe, effective and significantly under-utilized therapy for patients with NHL. Two approved agents (90Y-ibritumomab tiuxetan and 131I-tositumomab) are available in the United States.

Purpose: To present the similarities and differences in the two RITs and discuss the nursing implications for radiation safety.

Interventions: The radiation nursing safety procedures focus on the principles of time, distance, and shielding. Decreasing time spent with a patient receiving RIT will decrease radiation exposure. Increasing distance from a patient will decrease radiation exposure. Tositumomab, with a half-life of 8 days, emits beta and gamma radiation whereas ibritumomab has a half-life of 64.1 hours and is a beta emitter. Thus, radiation precautions are even more imperative for tositumomab. Safety precautions involve bodily fluids, washing hands often, avoiding deep kissing and using a condom for sexual intercourse during the first week after treatment. All staff must wear monitoring badges to monitor radiation exposure as well as lead aprons when coming into contact with tositumomab patients. Instruct the patient to shower daily, wash hands often, drink plenty liquids, take thyroid medication, maintain a 6-foot distance from others, use a separate bathroom, sit while urinating and flush toilet 3 times with lid down, and wash dishes/utensils separately for one week after treatment. Blood counts will be monitored weekly with a physician evaluation in 8 weeks post treatment.

Evaluation: The nurse is knowledgeable of the background and development of RIT which is essential for nurses to educate and manage the necessary safety precautions in caring for these patients to minimize the risk of radiation exposure to staff and others.

Discussion: Through teaching and education, nurses play a critical role in promoting radiation safety.

132532 (Poster)

USE OF A VALIDATED ASSESSMENT TOOL DEMONSTRATES THE FREQUENCY OF PATIENT-EXPERIENCED, REGIMEN-RELATED SIDE EFFECTS ASSOCIATED WITH THE TREATMENT OF COMMON SOLID TUMORS.

Christopher Jordan, RN, OCN®, ACORN CRO, Memphis, Tennessee; Susan Weidner, MS, Inform Genomics, Boston, Massachusetts; Stephen Sonis, DMD, DMSc, Inform Genomics, Boston, Massachusetts; Mark Walker, PhD, ACORN CRO, Memphis, Tennessee; Jason Chandler, MD, The West Clinic, Memphis, Tennessee

Underwriting or funding source: Derma Sciences

Significance and Background: Although side effects associated with chemotherapy-based regimens have been well described, a disconnect exists between the incidence and severity of side effects noted by professional caregivers and those noted by patients.

Purpose: The study enrolled 384 patients. PCM was used to prospectively assess symptom distress of 6 targeted side effects—nausea/vomiting (NV), oral mucositis (OM), diarrhea,

fatigue, peripheral neuropathy (PN), cognitive dysfunction (CD)—for each chemotherapy cycle on a scale of 0 to 10 (severe distress=10).

Interventions: Patients were considered to have moderate-to-severe side effects if the maximum score was ≥ 4 during the first 3 cycles of chemotherapy. Patients received their planned chemotherapy and supportive care deemed appropriate by their physicians.

Evaluation: The frequency of patient-described, moderate-to-severe side effects was substantial and varied by diagnosis and chemotherapy regimen. Among patients with breast cancer (n=187), fatigue (57%), chemotherapy-induced nausea and vomiting (CINV) (43%), and OM (31%) were most commonly reported, whereas fatigue (54%), CINV (36%), and PN (26%) were most often cited by patients with colorectal cancer (n=89). Patients with non-small cell lung cancer (NSCLC) (n=43) reported fatigue (65%), PN (38%), and OM/NV (30%) most frequently. CINV was a consistent finding among all regimens, ranging in frequency from 25% among NSCLC patients to 43% in patients with breast cancer, despite the ubiquitous use of standard anti-emetic protocols.

Discussion: The side-effect burden associated with chemotherapy remains, despite advances in supportive care. Notably, the self-reported incidence of studied side effects generally exceeds the rates typically cited in the literature. This underscores the need for oncology nurses to continue their important role in monitoring and assessing consequences of chemotherapy. The study results also point to a need for more effective supportive care strategies along with new tools to help predict individual risk for chemotherapy-related side effects which may allow for more tailored supportive care interventions in advance of treatment and, thus, a more optimized patient treatment plan.

132616 (Poster)

CODE BLUE: JOURNEY TO CONFIDENCE. Deborah Loric, MSN/MHA, OCN®, CMSRN, UCLA-Santa Monica Medical Center, Santa Monica, California; Mac Queyquep, RN, UCLA-Santa Monica Medical Center, Santa Monica, California; Patricia Jakel, RN, MN, AOCN®, UCLA-Santa Monica Medical Center, Santa Monica, California

Significance and Background: UCLA Santa Monica is a 266 Bed combination community /academic environment. The Oncology Unit is a high acuity 26 Bed Unit. The staff on the unit ranges from novice to expert. There is a high potential for emergency situations due to the acuity of patients on the unit. At all levels nurses experienced anxiety and a lack of confidence surrounding resuscitations.

Purpose: RN's improved in confidence/competence with regular simulation training. The training included classroom sessions and unit based simulated emergencies attended by all staff. A prior study utilized "surprise" CPR training with simulator to improve skills and reduce anxiety among staff. They completed 131 drills using the SIM 4000. A gradual and steady improvement was shown. The decision was to provide staff with surprise Mock Code situations in which real-time education and feedback was accomplished.

Interventions: Nurses on the Oncology Unit were given a pre-test, a surprise Mock Code Blue, and they were given a post-test.

- Prepared CPR Dummy and Crash Cart
- Paged Staff of Code Blue (without warning)
- Observe nurses responses
- Evaluation/Discussion
- Immediate Teaching

Evaluation: CPR education and simulation increased substantially their ability to be confident and efficient in code blue situations. The data demonstrated a 20% increase to a confident level and a 33% increase to a somewhat confident level. To improve patient safety and outcomes on our oncology unit we will continue monthly Mock Codes. All staff will be required to

attend one per quarter. We will continue to monitor skills and confidence of the staff.

Discussion: As chemotherapy regimens and protocols become more advanced the need for ongoing readiness during code blue situations is essential. The oncology patients are sicker with higher acuity levels. This trend calls for staff that are prepared to react quickly, efficiently and with confidence. This process can be easily replicated throughout any nursing unit to ensure confident staff.

132619 (Poster)

SAY AHH! MAKING SENSE OF ORAL ASSESSMENTS FOR MUCOSITIS. Joanne Growney, RN, ANP-BC, OCN®, MA, Hackensack University Medical Center, Hackensack, New Jersey

Significance and Background: Chemotherapy and radiation therapy, the mainstay of current cancer treatment often results in devastating side effects involving the oral cavity. Mucositis, an inflammatory and /or ulcerative lesion of the oral and/or gastrointestinal tract is a common therapy related toxicity affecting up to 100 % of bone marrow transplant patients, 80 % of patients receiving radiation therapy, and approximately 40 % of patients undergoing standard multi-cycle chemotherapy. Mucositis significantly impacts the patient's overall physical and functional well being as well as their quality of life. The consequences of mucositis include pain; malnutrition and dehydration, all which may lead to increased emergency room visits, hospitalization, and potential therapy interruption. Oral examination and routine oral hygiene performed by the patient or their caregiver is critical to recognizing early stages of mucositis, and controlling mucositis. However, these efforts alone are not sufficient to detect some of the subtle early signs and symptoms of mucositis. Both the patient and the nurse play key roles in recognizing early stages of mucositis and in performing oral care practices. A review of this organization's practices suggests that although oral assessment and grading are occurring in a policy compliant manner, there is a high degree of variability in the actual assessments performed. Literature suggests the lack of uniformity in practice for oral assessments associated with the use of multiple grading instruments for mucositis is problematic. Literature also supports the need for thorough, timely nursing oral assessments combined with standardized grading scales. This is coupled with strong evidence that suggests mucositis can be prevented or contained by good patient oral hygiene leading to lower occurrence and severity of the disease and symptoms. There is strong evidence suggesting the implementation of preventative strategy such as patient/family education on the importance of oral hygiene practices can lower the incidence and occurrence of mucositis. Literature supports the need for patients and caregivers to conduct thorough, daily, oral assessments combined with consistent oral hygiene practices to promote physical and functional quality of life. Study evidence suggests mucositis can be prevented or managed by performing rigorous oral hygiene leading to lower occurrence in the severity and progressive symptoms. Research suggests the implementation of preventative strategies such as the patient/family education can lower severity of mucositis symptoms and the nurse plays a unique role in performing this patient/caregiver education at every opportunity of point of care.

Purpose: Oral Mucositis is a complication of cancer therapy for many patients. Mucositis is defined as an erythema and ulceration of the mucosa. Oral mucositis plays a significant role in both the physical and psychosocial aspects of patients who experience cancer therapy. The purpose of this EBP project is to develop a patient-centered education program on the identification of signs and symptoms of mucositis and oral hygiene practices based on best practices to minimize the sequelae of oral mucositis. This will be accomplished by developing a trans-

disciplinary EBP team, inclusive of APNs, staff nurses, pharmacists, dietician, oncologists, dentist and patient/caregiver representation. This EBP team will identify best educational practices incorporating patient preferences for education content, and assure collaborative decision-making among team members. The focus of this project will be the implementation of a patient-centered cancer education program related to oral hygiene practices and the identification of signs and symptoms of mucositis. Comprehensive oral assessment conducted by the nurse will lead to earlier identification of the signs and symptoms of mucositis. Rapid detection of the onset of mucositis by the patient and nurse will lead to implementation of interventions that will promote improved patient outcomes. The project goals include: patient/caregiver early recognition of symptoms of mucositis, and improved quality of life patient outcomes in the areas of pain, dehydration, and weight loss. Therefore will the identification, selection, implementation of the OAG with oral hygiene practices it is believe it will result in earlier recognition of mucositis symptoms and early initiation of the appropriate treatment.

Interventions: The EBP project was initiated using the Johns Hopkins EBP Model form for the question development and project management. The EBP project will be carried out in phases. The first phase is to standardize an oral assessment tool for mucositis across population and settings and the development of a practice policy. The Mucositis EBP workgroup developed a pilot to gather data on the selected oral assessment tool in order to show evidence that the tool was endorsed by the staff nurses using it. In addition the workgroup brought the project through the appropriate hospital councils to incorporate the OAG into the daily shift assessment. Included in phase 1 the nurse educator completed the education of the all nursing staff on oral assessment, oral hygiene and chart documentation. Next came phase 2 which included the development of a standardized patient education and a nursing policy that governs when and how education and assessment is performed. We are now approaching phase 3 where the mucositis workgroup will be developing standards of treatment based on OAG score know as the Mucositis protocol.

Evaluation: At this point in time the EBP project has completed Phase 1. During this phase a pilot study was completed on 492 oral assessments. These assessments included 24 RN participants and 5 APN participants. The results of this pilot showed that 82% of users agreed on utilizing the Oral Assessment Guide (OAG) as the assessment tool because it was a thorough tool. In addition to that the 86% of the participants felt the tool was user-friendly. Next in Phase 2 the Mucositis EBP workgroup is standardizing the patient education booklet; nursing policy on performing oral assessment; and oral hygiene practices. Phase 2 included having the workgroup present to the hospital informatics council the new OAG to be place in the electronic medical record.

Discussion: At the conclusion of this EBP project patients and caregivers will be able to demonstrate and articulate an oral assessment, signs and symptoms of mucositis, and oral hygiene practices. The oncology nurses' role is intended to enhance cancer care for symptom management. So this EBP project of standardizing: oral assessment skills; oral hygiene practices; and intervening with a mucositis protocol will become part of the oncology nurses' armament to aid the patient through the treatment process which will result in enhanced cancer care.

132868 (Poster)

THE PAIN RESOURCE NURSE: BEDSIDE CHAMPIONS FOR EVIDENCE-BASED CHANGE: ONE HOSPITAL'S JOURNEY OF HELPING BEDSIDE NURSES FIND THEIR VOICE. Mary Eanniello, RN, MSN, OCN®, CHPN, Hartford Hospital, Hartford, Connecticut; Ann Russell, RN, MSN,

CCRN, Hartford Hospital, Hartford, Connecticut; Julie Michaelson, RN, Hartford Hospital, Hartford, Connecticut; Jennifer Dupuis, RN, OCN®, CHPN, Hartford Hospital, Hartford, Connecticut; Vanessa Silva, RN, Hartford Hospital, Hartford, Connecticut; Nancy Silva, RN, OCN®, Hartford Hospital, Hartford, Connecticut

Significance and Background: Pain and symptom management is a cornerstone of quality oncology and palliative nursing care. Bedside nurses need a way to identify opportunities for improved quality and safety at the patient bedside. They also require education for maintenance of competence and professional growth. The Pain Resource Nurse group was created to address hospital wide issues related to Pain Management. This multidisciplinary group is involved in all aspects of Pain Management and encourages the Pain Resource Nurses to participate in both general nursing issues related to pain as well as more specialty focused issues. Oncology Pain Resource Nurses have been uniquely involved in helping to create responses to a recent Joint Commission Alert related to Opioid Administration Safety and serve as clinical nursing experts for difficult clinical scenarios.

Purpose: The Pain Resource Nurse Group has worked closely with pharmacy and informatics to create safety initiatives, policy and procedures related to continuous opioid infusions as well as patient controlled pain management systems. Pain Resource Nurses actively participate in monthly Competency Day education as well as participating in per review/auditing of the electronic record for compliance to plan of care/interventions. This group uses monthly meetings as a forum to bring bedside initiatives and concerns to the group to create best practice strategies and solutions.

Interventions: The Pain Resource Nurse has become an integral part of the oncology/palliative team; Audits have demonstrated improved pain assessment and re-assessment as well as creating a forum for best practice and concerns for quality and safety. Monthly education and creation of a peer professional support group has corrected identified inconsistencies in care and documentation.

Evaluation: Pain Resource Nurses have worked collectively with nursing leadership and pharmacy to improve the pain experience and patient satisfaction scores. Regulatory documentation standards have been consistently reached and are a reflection of this team's efforts.

Discussion: The use of bedside "champions" has proven to be an effective model for creating best practice. This group will participate in creation of simulated education for pain management. Professional growth and identification of safety and quality issues will be the focus of monthly meetings.

133119 (Poster)

INCORPORATING PHARMACOVIGILANCE DATA INTO EVIDENCE-BASED PRACTICE: THE CASE OF ERYTHROPOIETIC STIMULATING AGENTS. Loretta Williams, PhD, RN, AOCN®, OCN®, The University of Texas MD Anderson Cancer Center, Houston, Texas; Chet Bohac, MD, PharmD, MSc, Amgen, Thousand Oaks, California

Significance and Background: Pharmacovigilance (PV) is the collection, monitoring, and evaluation of safety information to discover adverse events (AEs) associated with medications. Nurses need to be aware of PV data, assist in its collection, and include it in the evaluation and discussion of risks and benefits for evidence-based practice. The case of erythropoietic stimulating agents (ESAs) provides an exemplar for the use of PV data.

Purpose: Based on safety concerns related to decreased survival and tumor progression in patients with cancer, in May 2007, the US Food and Drug Administration (FDA) Oncology Drug Advisory Committee recommended ESA use in adult patients with cancer be restricted to anemia from myelosuppressive chemotherapy being

administered with non-curative intent. We are reviewing PV data related to ESA use in adults with cancer since 2007.

Interventions: A PubMed literature search utilizing the terms ESA, safety, cancer, and anemia was performed. Only English-language abstracts since 2007 were included. 394 references were identified. 98 of these studies reported outcomes in ESA use in adult patients with cancer treated with chemotherapy and were reviewed for incidence of AEs. Of these, 12 studies reported survival outcomes in randomized, controlled trials (RCTs).

Evaluation: Since 2007, data from 12 RCTs with outcomes related to patients with cancer treated with ESAs for chemotherapy-induced anemia have shown no statistically significant effect of ESA use on survival or tumor progression. In addition, a review of all 98 studies indicated no increased incidence in any known or new AEs related to ESAs. This information provides oncology nurses with current information on ESA safety since the FDA warning.

Discussion: The known benefit of ESAs in adults with cancer is the reduction in transfusion incidence by increasing hemoglobin levels. Oncology nurses should weigh the known benefit of ESAs with the risks of decreased survival, tumor progression, and other known AEs, such as thromboembolic events, in educating and counseling patients to effectively manage chemotherapy side effects such as anemia-related fatigue. Oncology nurses should continually evaluate current safety information, including PV data, and should be aware of the methods of reporting AEs that they observe.

133800 (Poster)

CAPS FOR CHAPS. Jacqueline Britton, RN, OCN®, Barnabas Health Community Medical Center, Toms River, New Jersey; Donna Reinbeck, RN, BSN, Barnabas Health Community Medical Center, Toms River, New Jersey

Significance and Background: The inspiration for this program came when a young man in his 40's appeared for his treatment wearing a shabby baseball cap to cover his balding head. This was the motivation for the Caps for Chaps program.

Purpose: Caps for Chaps focuses on the patients individual needs. It addresses issues relating to physical appearance and also helps to maintain a patients self esteem during a challenging time in their life.

Interventions: Local and professional sports teams and local businesses are asked to donate caps to the infusion center. The caps are offered to our patients when they visit our center to receive chemotherapy. This helps lift the spirits of our male patients and support them in their fight against cancer.

Evaluation: This program has been very successful. Patients are very grateful and appreciative. They feel a sense of caring from the staff of the infusion center. Patients leave the center feeling that someone recognizes that alopecia can be as devastating for them as it is for women.

Discussion: It is essential to get community support from local vendors and sports teams in order to obtain caps with logos. This was done with the assistance of the Barnabas Health System which provided letters to send out requesting caps. Many former patients also heard of our need through a newsletter and also donated caps. Alopecia is one of the most noticeable side effects of Chemotherapy and has a profound effect on the psychosocial adjustment of the patient undergoing treatment. It is important for the nurse to recognize the importance of the impact this has on the male patient and his acceptance of the treatment as some patients refuse chemotherapy because of the fear of hair loss.

134100 (Poster)

HOSPITAL-ACQUIRED PRESSURE ULCER PREVENTION IN THE HEMATOLOGY ONCOLOGY (HO) POPULATION. Kirsten Pedersen, RN, BS, OCN®, Smilow Cancer Hospital at Yale-New Haven, New Haven, Connecticut; Jill Williams,

RN, BS, Smilow Cancer Hospital at Yale-New Haven, New Haven, Connecticut; Lisa Truini-Pittman, RN, MPH, OCN®, Smilow Cancer Hospital at Yale-New Haven, New Haven, Connecticut

Significance and Background: Basic skin care is often delegated to unlicensed staff (PCAs) as the RN manages more specialized aspects of oncology care. This can lead to lack of ownership of aspects of care given to hospitalized HO patients. Although HO patients develop risk factors that lead to the development of PU, many of our patients were not assessed as 'at risk.'

Purpose: To develop an action plan to help staff recognize the risk of HAPU in the HO population and to decrease the incidence.

Interventions: Data from the prevalence survey was reviewed. A chart review was conducted of patients who developed HAPU in the prior 6 months and patients currently on the unit. A review of hospital policies regarding skin care, HAPU prevention and management, skin care products and equipment was undertaken and discussed with staff. Walking rounds were conducted with nursing staff. Education on the importance of correct documentation of the Braden Scale was emphasized with identification of at risk patients. RNs completed the National Database of Nursing Quality Indicators (NDNQI) pressure ulcer training. Resource nurses received advanced education and time to assess patients at risk for HAPU development. These nurses then provided real time staff education on care planning, use of equipment/products, and accurate documentation. Weekly audits were undertaken to assure thorough documentation. HAPU prevention was discussed at each staff meeting.

Evaluation: The prevalence of HAPU was reduced from 14.29% to 0% in one quarter and was sustained at below the hospital's rate for four quarters. Subsequent audits have shown improved accuracy in HAPU risk assessments.

Discussion: Our program has improved the RN's accountability for HAPU prevention. HAPU prevalence was decreased by accurately establishing risk, using standardized education, educating staff on quality assurance and metrics, supporting skin resource nurses, and auditing charts and patients with immediate remediation. These actions can be adopted by hematology oncology units as a proactive approach to prevent HAPU.

134513 (Poster)

ACCOMMODATION OF RELIGIOUS PRACTICES IN THE ACUTE PALLIATIVE CARE UNIT. Yu Hu, RN, BSN, OCN®, CHPN, MD Anderson Cancer Center, Houston, Texas; Ruben Rivera, RN, BSN, OCN®, CHPN, MD Anderson Cancer Center, Houston, Texas; Chanelle Clerc, RN, BSN, CHPN, MD Anderson Cancer Center, Houston, Texas; Julieta Fajardo, RN, BSN, CHPN, MD Anderson Cancer Center, Houston, Texas

Significance and Background: The majority of the patients admitted to the acute palliative care unit have a limited life expectancy of weeks to days. Many people believe that religious practices can promote physical and spiritual well-being. Because of the diversity among patient populations; it is imperative that the palliative nurses assess each patient on admission for their unique religious practices. Once the patient's religious practices have been identified, it is a nursing goal to address continually and assist the patient with meeting religious practices throughout the hospitalization. Research has reported that patients near the end of life can experience suffering on many levels such as physical, social, emotional, and spiritual.

Purpose: The purpose of this presentation is to identify and address the diverse religious practices of palliative care patients.

Interventions: A literature search was conducted on four religious groups' practices that are seen most frequently in an in-patient palliative care unit; Christianity, Islam, Judaism and

Buddhist The literature search revealed the religious practices specific to each group.

Evaluation: These practices provide staff education and direction for developing interventions for each group.

Discussion: Provision of comprehensive end-of-life care using a holistic approach can increase patients and nurses' comfort in addressing needs near the end of life. Accommodating the diverse religious practices of patients benefits not only the patient and family, but also provides nurses additional interventions that support a peaceful and dignified death. Rituals and traditions provide a sense of purpose and duty by guiding the caregivers during a time of crisis and perceived chaos. When patients and family needs and concerns are met, staff can feel confident that they have accomplished their goal, thus making the experience supportive for all.

134903 (Poster)

RETINOBLASTOMA: NAVIGATING COMPLEXITY. Allison Kimbro, PNP, Memorial Sloan-Kettering Cancer Center, New York, New York

Significance and Background: Retinoblastoma (RB) is a disease primarily of young children with approximately 300 cases diagnosed annually in the United States. Although RB can be fatal, 95% of children achieve cure with early diagnosis and prompt intervention. Because RB is of a genetic origin, when the disease is identified in a child, surveillance of the entire family becomes of paramount importance. The implications of carrying the retinoblastoma gene can be overwhelming. Treatment options for retinoblastoma include selective intra-arterial chemotherapy (SIAC), laser and cryotherapy, systemic chemotherapy, brachytherapy, and enucleation. The complex care coordination of the ophthalmology oncology nurse includes facilitating genetic testing for the child and family, scheduling visual and general health assessments, radiology testing, preparing the patient for ocular exams under anesthesia and recovery from anesthesia while providing therapeutic interventions and supportive care to patients and families.

Purpose: This presentation will provide an overview of the complex care coordination and unique needs of children with retinoblastoma and examine the role of the ambulatory care nurse navigating these patients and their families.

Interventions: The nurse/ family relationship begins at initial consultation, continues during the course of illness, and throughout the lifetime of the patient. Nursing interventions focus on continuous physical and psycho-social assessment and patient and family education. Prompt referral for genetic counseling is warranted to facilitate informed decision making about future family planning. Common emotional issues for the patient and family include potential alterations in body image, significant loss of vision, and enucleation. The nurse customizes education to pediatric patients and their families in preparation for planned therapies, acute and long term care measures, and life long follow up.

Evaluation: At our comprehensive cancer center significant cure rates for RB are achieved through the multidisciplinary care management and complex nursing navigation with patients and families facing this diagnosis.

Discussion: The ophthalmology oncology nurses are educators, patient and family care providers, advocates, and care coordinators. They are an essential part of the team in helping retinoblastoma patients and their families traverse the complexities of the disease and treatment.

135038 (Podium)

THE CRITICALLY ILL ONCOLOGY PATIENT: PROMOTING TIMELY TRANSFER TO INTENSIVE CARE. Mary Callaghan, RN, MN, AOCNS®, APN, Northwestern Memorial Hospital, Chicago, Illinois; Barb Gobel, RN, MSN, AOCN®, Northwest

ern Memorial Hospital, Chicago, Illinois; Terri Halvorsen, RN, MS, Northwestern Memorial Hospital, Chicago, Illinois

Significance and Background: Aggressiveness of cancer care continues to rise in parallel with scientific discoveries in the treatment of a variety of malignancies. Acute admission of cancer patients to an intensive care unit (ICU) is considered with increasing frequency due to a better life expectancy and more aggressive therapies. At our large urban academic center, there were frequent reports of patients staying on the inpatient oncology units from two to six hours while nurses monitored and delivered interventions that required a higher level of nursing care exceeding the nursing hours per patient day available on the general oncology units.

Purpose: In response to a concern regarding length of time critically ill patients remained on the general heme/onc unit, a multidisciplinary team including Oncology and MICU nursing staff, Rapid Response Nurses, MICU Chief and Chief Resident and Oncology Hospitalist Attending, was convened to improve identification of oncology patients requiring higher levels of nursing care and facilitate timely transfers to more acute units. Review of transfers to the intensive care unit was performed for 6 months. Key components of the review included prior 48 hour review of patient status, review of the nursing care provided prior to transfer, review of MEWS (modified early warning scores) trending, length of time to transfer from identification of need, Rapid Response Team intervention, and interviews of personnel involved in patient evaluation.

Interventions: Based upon a review of cases, key recommendations of the team were to incorporate nursing care needs into decisions to transfer patients to ICU; clarify the chain of command and method to resolve disagreements between health care providers; provide education to medical staff regarding nursing care hours and limitations to non-ICU monitoring and care; re-educate nursing staff regarding Rapid Response Team consultation and use of modified early warning scores (MEW); and identify a method to review transfers and escalation failures from general oncology units to ICU.

Evaluation: The multidisciplinary team addressed findings through education, process improvement and the development of the escalation pathway. The escalation pathway utilizes modified early warning scores (MEW scores), monitoring requirements, specific interventions and an algorithm for clinical intervention. Quarterly meetings of the multidisciplinary team were implemented to discuss escalation failures. Overall, delays in transfer to a higher level of nursing care decreased by 50% at 3 months and 100% at 6 months post-implementation of the pathway as measured by incident reporting. The pathway and quarterly meetings continue to be utilized to monitor the process.

Discussion: In evaluating critically ill oncology patients for escalation to a higher level of care, a multidisciplinary approach that addressed barriers through education, process improvement and development of an escalation pathway improved timely transfers at one large urban academic center. The escalation pathway utilizes modified early warning scores, monitoring requirements, specific interventions and an algorithm for clinical intervention. This requires consistent multidisciplinary review of failures and ongoing communication between disciplines. This multidisciplinary approach could be adapted in other academic centers where early and prompt transfer of critically ill oncology patients to the intensive care unit impacts nursing level of care.

135090 (Poster)

AN ERGONOMICALLY CORRECT WORK ENVIRONMENT BENEFITS AMBULATORY ONCOLOGY NURSES. Carrie Fijal, RN, BSN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Elizabeth Cruz, RN, BSN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York

Significance and Background: In 2010, the Bureau of Labor Statistics ranked registered nurses as the fifth most injured oc-

cupation in the U.S. And in the 2011 Health and Safety Survey, the American Nurses Association found that disabling musculoskeletal injuries were the second most common health concern amongst nurses. In the ambulatory setting, computer use is essential to completing most tasks. Nurses utilize the computer to perform several job responsibilities including documentation, review of patient's medical records, and communication with colleagues and multidisciplinary departments. Poorly designed computer workstations that require the employee to have repetitive awkward posturing are the leading cause of work related injuries.

Purpose: Our goal was to determine whether creating an ergonomically sound work environment would prevent physical discomfort to the oncology nurse, increase productivity, and increase job satisfaction. The ambulatory GI Medical Oncology nursing staff requested changes to the current work environment to attain this goal.

Interventions: Paul Zel, the Director of Safety at MSKCC, was asked by our group to conduct an ergonomic assessment of the ambulatory clinical area. Several areas were identified in needing improvement; these included the chairs, computer set up, counter space and leg area.

Evaluation: We plan to assess nursing satisfaction through the use of a satisfaction survey and plan to screen for physical discomfort by utilizing the extended Nordic Musculoskeletal Questionnaire (NMQ-E) pre- and post-implementation of the ergonomic changes to the current work environment.

Discussion: As evidence by supporting literature, a non-ergonomically sound work environment causes work related injuries. Currently in an ambulatory clinical area at MSKCC it was assessed that several areas of improvement were needed to create an ergonomically correct nursing work environment. We anticipate through this project that making ergonomic changes to the work environment will benefit the staff and the institution. We predict it will increase job satisfaction, increase productivity and decrease physical discomfort. The information obtained through this project could potentially be used by other institutions enabling them to create a clinical environment with proper ergonomic design.

135139 (Poster)

PREVENTION OF CEREBELLAR TOXICITY FROM CYTOSINE ARABINOSIDE: NURSE EDUCATIONAL TRAINING PROGRAM AND ASSESSMENT PROTOCOL. Kerry Nichols, BSN, OCN®, Billings Clinic Hospital, Billings, Montana; Kerry Nichols, RN, BSN, OCN®, Billings Clinic Hospital, Billings, Montana; Connie Anderson, RN, BSN, CMSRN, OCN®, Billings Clinic Hospital, Billings, Montana; Rhonda Gradwohl, RN, MSN, CMSRN, Billings Clinic Hospital, Billings, Montana; Delayne Gall, RN, OCN®, Billings Clinic Hospital, Billings, Montana

Significance and Background: Cytosine arabinoside (also known as Ara-C) is an antineoplastic agent primarily used in the management of acute myelogenous leukemia and aggressive lymphomas. When given in high doses (>3 Grams/m), patients may develop neurologic, cerebellar toxicity. The drug is usually administered intravenously every 12 hours for a total of six doses. The effect is cumulative with the risk of neurotoxicity increasing with subsequent doses. The toxicity is primarily exhibited by subtle changes such as unsteady gait or hand tremor. A lack of guidelines from the Oncology Nursing Society exists.

Purpose: The setting is a regional center for the treatment of acute leukemia and aggressive lymphomas. High dose Ara-C is administered at the cancer center to approximately 20 to 25 patients per year. One patient on the inpatient unit developed severe neurotoxicity with subsequent functional decline, and became functionally dependent. A team was convened to exam-

ine the practice. The team yielded several process outcomes. A neurologic assessment tool was designed with a variety of tests that more clearly measure cerebellar toxicity. Tests were broken into those for ambulatory patients and those for bedridden patients. An improvement of the neurologic assessment was taped and used in an educational electronic module that is now required by all chemotherapy certified RNs. A double check system by two chemotherapy certified RNs was put into place for the neurologic assessment. Computer screens were revised to account for the mandatory "double" neurologic assessment.

Interventions: The revised neurologic assessment resulted in holding dose of cytosine arabinoside on three separate patients. No significant neurologic, cerebellar toxicity has been observed on any patient since the initiation of the program.

Evaluation: The revised neurologic assessment resulted in holding dose of cytosine arabinoside on three separate patients.

Discussion: While rare, neurologic toxicity from cytosine arabinoside is a serious and potentially life-threatening complication. Nurses are on the frontline assessing patients prior to dosing, and can prevent this serious toxicity with diligent neurologic assessment.

135145 (Poster)

A NOVEL INTERPROFESSIONAL CLINIC DESIGN FOR PATIENT CENTERED CANCER CARE. Jennifer Lynn Smith, CNP, US Department of Veterans Affairs Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio; Sonya Curry, CNS, Department of VA Affairs, Cleveland, Ohio; Melanie Lynch, MD, Department of VA Affairs, Cleveland, Ohio; Lisa Arfons, MD, Department of VA Affairs, Cleveland, Ohio; Polly Mazanec, PhD, ACNP, FPCN, AOCN®, Department of VA Affairs, Case Western Reserve University, Cleveland, Ohio

Significance and Background: Specialty care practices at many medical centers operate in distinct silos, burdening patients and families with fragmented care and multiple appointments. Advanced practice oncology nurses play a key role in coordinating and managing care for patients within a complex cancer care system.

Purpose: A major purpose of this funded Center of Excellence (COE) ambulatory clinic project is to provide timely quality interdisciplinary cancer care for veterans who have a positive cancer screening test or a diagnosis of cancer.

Interventions: Patients are pre-screened by the advanced practice registered nurse (APRN) navigator and scheduled to see the appropriate disciplines during the one-hour appointment. The patient navigator coordinates with primary care providers and collaborates with other disciplines to organize multiple appointments within one visit. During the clinic, patients and family caregivers have the opportunity to be seen by the following specialties: APRN patient navigator, medical oncology, surgical oncology, radiology, behavioral health (psychologist), social work, palliative care and survivorship depending on need. The survivorship APRN follows all patients from the time of a cancer diagnosis through all stages of survivorship. Radiology is available for consultation and same day imaging and procedures if needed. Prior to the start of the clinic, patients are reviewed by all team members during a huddle discussion. The environment of care is designed to allow the team to work together in a large conference room, updating each other throughout the day. The team meets again at the end of the day to review goals of care and make adjustments to tailored patient-centered treatment plans.

Evaluation: Data including patient demographics, timeliness of consult and treatment planning, adherence to appointments, travel expenses, and patient satisfaction are in analysis. Nursing-sensitive outcomes including prevention of lymphedema and management of fatigue and distress will be reported on the first nine months of the project.

Discussion: Patient navigation and survivorship APRNs are essential team members for quality ambulatory cancer care. The nurse navigator improves adherence to appointments and coordinates care among multiple disciplines which decreases burden and out of pocket expenses. The survivorship APRN improves prevention and management of side effects and late effects of cancer and its treatment.

135257 (Poster)

DEVELOPMENT OF A PAIN ALGORITHM. Megan Fries, RN, BSN, OCN®, Mercy Medical Center, Des Moines, Iowa; Kim Schou, RN, BSN, Mercy Medical Center, Des Moines, Iowa

Significance and Background: Lack of pain assessment and pain management has led to decreased patient pain satisfaction at Mercy Medical Center. An interdisciplinary team developed an algorithm to provide all disciplines, with a focus on nursing, effective tools to better assess and treat patients in pain. This algorithm includes nursing interventions, pharmacological modalities and complementary therapies.

Purpose: Patient satisfaction scores on the unit were low, the interdisciplinary team wanted to create a tool to help nurses better assess and treat pain. The purpose of this initiative was to facilitate improvement of nursing assessment and management of patient's pain while including patient education during the process.

Interventions: The interdisciplinary team reviewed literature for different nursing interventions, pharmacological modalities and complementary therapies effective in pain control. Real case studies were reviewed on patients having uncontrolled pain to help understand how to appropriately treat different types of pain. Different forms of the algorithm were piloted to see what was best received among disciplines.

Evaluation: The goal is to create an effective algorithm to be used collaboratively by all disciplines to help improve patient pain satisfaction scores on 8-South (oncology unit) at Mercy Medical Center. Algorithm to be updated through information obtained from ongoing assessments and evaluation of its effectiveness.

Discussion: We all know that quality pain control in an oncology patient can be tough. Due to this, the interdisciplinary team felt that it was important to develop a tool to help all healthcare team members to more effectively treat pain. Currently, on the oncology floor, the algorithms are hanging inside of the nurse servers outside of each room. This enables not only the oncology staff but all members of the interdisciplinary team to effectively treat all types of pain.

135270 (Poster)

IMPLEMENTING BEDSIDE END-OF-SHIFT REPORT IN AN ONCOLOGY SETTING. Cynthia Carsten, RN, BSN, OCN®, Santa Monica UCLA Medical Center, Santa Monica, California; Pattie Jakel, RN, MN, AOCN®, Santa Monica UCLA Medical Center, Santa Monica, California; Ermina Cavcic, RN, BSN, OCN®, Santa Monica UCLA Medical Center, Santa Monica, California; Deborah Lorick, RN, MSN/MHA, CMSRN, OCN®, Santa Monica UCLA Medical Center, Santa Monica, California

Significance and Background: The end-of-shift report is crucial as nurses communicate critical patient information. Previously, report occurred at the main nursing station, was not standardized and lasted nearly an hour. Patients were at increased risk for falls, call bells weren't responded to, which decreased patient and RN satisfaction.

Purpose: This project was for our patients and their loved ones, and the evidence supports it. It improves patient safety and patient collaboration in their plan of care. A sense of pro-

professionalism is also demonstrated when there is a standardized report. It has been found to increase patient and nurse satisfaction, and reduces overtime hours. Thus the unit practice council decided to implement this project because it would really benefit our patients.

Interventions: Three-hour educational sessions were scheduled for each RN, to teach them how to give a systematic, as well as sensitive report at the bedside. We practiced role playing, with realistic scenarios of anxious and talkative patients. Nurses were coached on how to handle especially sensitive patient situations.

Evaluation: The outcome measured was satisfaction, using 5-point Likert scores, from both the patients' and RNs' perspective, before and after the implementation of bedside report.

Discussion: The new practice was in effect for one month, we did post-surveys, which demonstrated that we were heading in the right direction. From the patient survey, the greatest improvement not surprisingly been that "the RN keeps me informed of my care." From the RN survey, the greatest improvement has been that this style of report "fosters partnership between patients, nurses, and their families." Verbal feedback from patients said that they really appreciate it. RNs stated finding increased accountability from the previous shift. Some RNs were receptive to this change; it was inevitable that others were hesitant to embrace it. The major barrier to bedside report was feeling badly about disturbing sleeping patients. Length of report time was decreased with practice. Bedside report is a new practice that will take some time to perfect. Overall our results have proven increased nurse satisfaction, and most importantly patient satisfaction.

135360 (Poster)

"24" HOURS TO DISCHARGE AFTER ROBOTIC SURGERY FOR COMPLEX GYNECOLOGIC MALIGNANCIES (STANDARDS OF CARE EVEN JACK BAUER COULDN'T ACHIEVE). Nicole Reimer, RN, BSN, OCN®, Lehigh Valley Health Network, Allentown, Pennsylvania; Sarah Mason, RN, Lehigh Valley Health Network, Allentown, Pennsylvania

Significance and Background: Robotic assisted surgery is a leading edge technology fast becoming the standard of care. Because it is less invasive and does not require large incisions, minimally invasive robotic procedures are ideal for many gynecologic surgeries.

Purpose: This presentation explores minimally invasive robotic surgery in the gynecologic oncology population. A case study illustrates review of the evidence, criteria for patient selection, equipment and surgical procedure, pre- and post-operative care, and outcomes.

Interventions: Robotic surgery has been utilized for endometrial and cervical malignancies for three years within an academic, community Magnet™ hospital which serves as a referral center for patients with complex diagnoses and care issues. This surgical population, averaging 15 cases per week, is cared for on a 20 bed medical-surgical hematologic oncology unit. The case study describes a patient diagnosed with grade 1 endometrial adenocarcinoma. Her robotic procedure included a total hysterectomy, bilateral salpingo-oophorectomy, cystoscopy, placement of bilateral ureteral catheters, and extensive lysis of adhesions.

Evaluation: This patient's outcomes are illustrative of those routinely experienced by robotic surgery gynecologic patients. Within 24 hours of surgery, the following were achieved: absence of nausea; positive bowel sounds with flatus; diet advancement to regular; independent ambulation; successful voiding trial after catheter removal; pain control with oral medications; patient education; and, discharge to home. Overall outcomes for this population compared to traditional open and laparoscopic surgeries include: decreased length of stay with associated in-

creased hospital capacity and patient flow; increased patient satisfaction – both overall and specifically for pain control; decreased patient acuity with less nursing care hours per patient day; increased nurse satisfaction; and, increased 'standard work' through adherence to established practice guidelines.

Discussion: This presentation has implications for oncology nurses in acute care settings who currently or will care for patients undergoing robotic surgery for malignant gynecologic conditions. The robust experience of the nurses from the presenting organization will prove beneficial to learners, particularly related to standards of care that have demonstrated improved nurse sensitive patient outcomes and can be tied to defined questions in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

135369 (Poster)

THE INS AND OUTS OF FALL PREVENTION: IMPROVING AWARENESS, PROVIDING EDUCATION, AND PROMOTING EARLY FALL PREVENTION IN THE OUTPATIENT ONCOLOGY SETTING. Elizabeth Blasiak, RN, MSN, OCN®, Smilow Cancer Hospital at Yale New Haven Hospital, New Haven, Connecticut; Sara Lantowski, BSN, OCN®, CBCN®, Smilow Cancer Hospital at Yale New Haven Hospital, New Haven, Connecticut; Catherine Bursey, MSN, Yale New Haven Hospital, New Haven, Connecticut; Cindy Johnson, BSN, MBA, Yale New Haven Hospital, New Haven, Connecticut

Significance and Background: Falls are considered a preventable public health problem. Fall prevention is a national patient safety goal and patient falls are a nursing-sensitive indicator of quality. Research efforts have been focused primarily on inpatient fall prevention. Despite high volumes of patients treated in the outpatient setting, practice standards are limited. Oncology patients are at a higher risk for falls due to disease symptoms and treatment side effects in all settings. Early identification and education for high risk patients by nurses must be initiated in outpatient areas to in order to positively impact safety in both ambulatory and home settings.

Purpose: The purpose of this program was to recognize patients at risk for falls in ambulatory oncology settings, to implement a screening tool, and provide nurse-driven patient fall prevention education resulting in self-care and home safety.

Interventions: Ambulatory fall prevention begins with identification of patients who are at high risk. Ensuring that all ambulatory oncology patients are evaluated for fall risk is challenging due to high volume of patients and the fact that nurses are not always the first care provider with each patient encounter. Utilization of a screening tool versus nursing assessment at initial patient contact allows ancillary staff to contribute to the fall risk identification process. A brief four-question tool was implemented after education of nursing and ancillary staff. A positive patient response to any of the four questions triggers further nursing assessment and nurse-driven patient education. The four questions focus on fall history, need for physical assistance, equipment use, and confusion. The screening is conducted by the ancillary staff and any positive response is communicated to the nurse. Exam room flags, escorting the patient, and increasing visibility are interventions that are applied to patients considered high risk.

Evaluation: Falls occurring in ambulatory oncology are limited but any fall can result in patient injury. Evaluation of program efforts will focus on outpatient fall trends pre and post implementation.

Discussion: Patient falls are considered a nursing-sensitive indicator. Providing patients with early education on fall risk and prevention would be expected to minimize falls in ambulatory oncology, the home setting, and potentially translate into fewer inpatient falls.

135401 (Poster)

INCREASING TEAMWORK: DOES IT HAVE AN EFFECT ON PATIENT SATISFACTION? Melissa James, BSN, RN, Karmanos Cancer Center, Detroit, Michigan; Clara Beaver, MSN, RN, AOCNS®, ACNS, BC, Karmanos Cancer Center, Detroit, Michigan; Cindy Murray, BScN, RN, OCN®, Karmanos Cancer Center, Detroit, Michigan; Lindsay Bruggeman, BSN, RN, Karmanos Cancer Center, Detroit, Michigan; Taylor Griglak, BSN, RN, Karmanos Cancer Center, Detroit, Michigan; Megan Griglak, BSN, RN, Karmanos Cancer Center, Detroit, Michigan

Significance and Background: Surveys of staff and patients indicated low levels of satisfaction. Burdened with multiple changes in the work environment staff members were experiencing a decrease in teamwork and low morale on the unit. Literature supports that there is a positive relationship between teamwork and patient satisfaction. The decision was made to utilize the book “Who Moved My Cheese”, by Spencer Johnson to help the team become more ready for change and strengthen the cohesiveness of the team.

Purpose: To promote staff and patient satisfaction by implementing a team building program based on “Who Moved My Cheese”.

Interventions: Presentation of the “Who Moved My Cheese” philosophy to all staff members through in-services and copies of the book being available. Each shift was started with a positive quote that was posted on a board located at the nurses’ station. Each staff member was presented a “commitment of care” contract to review and sign. Once signed a teamwork pin was given to that staff member. Increased awareness of teamwork was made evident through a “pat on the back board” and awarding star coupons. These awards were used to promote staff to staff feedback of teamwork and recognition for going above and beyond their daily work.

Evaluation: Three months post intervention staff re-surveyed. Results of the survey showed a dramatic increase in teamwork, trust, work satisfaction, decreased projection for job turnover and respect for team members. In addition the results of the benchmark patient satisfaction survey showed substantial improvement.

Discussion: This project demonstrates the more the team worked together the more satisfied the patient. The result of this project invites us to rethink the meaning of competent care. Traditionally competence has been viewed as a characteristic of an individual, but this study suggests that it is also important to be competent as a team. Oncology nurses need to think carefully about the role of teambuilding in their day to day activities.

135437 (Poster)

PAUSE (PATIENT-AWARENESS-UNDERSTANDING-SITUATION-EXPLANATION): A PATIENT JOURNAL TO IMPROVE QUALITY OF LIFE FOR THE OLDER ADULT WITH CANCER. Maureen Rogers, RN, Roswell Park Cancer Institute, Buffalo, New York; Darryl Somayaji, PhD, RN, MSN, CCRC, Roswell Park Cancer Institute, Buffalo, New York; Teresa Brzozowicz, RN, Roswell Park Cancer Institute, Buffalo, New York; Megan Spoth, RN, Roswell Park Cancer Institute, Buffalo, New York; Abigail Killion, RN, Roswell Park Cancer Institute, Buffalo, New York; Leslie Killion, RN, Roswell Park Cancer Institute, Buffalo, New York; Erin Mouyeos, BSN, RN, OCN®, Roswell Park Cancer Institute, Buffalo, New York

Significance and Background: Older adults are defined as individuals that are 65 years of age and older and are at greater risk to develop cancer and have a higher mortality rate than the younger population. It is projected that by 2030, more than 20% of the population in the United States will be older than 65 years of age. Oncology nurses need to address cancer education, practice, and research issues faced by the aging population.

Purpose: The purpose of this project is to engage the older adult patient and their family in the decision-making process related to cancer care.

Interventions: The goal is to improve patient-centered cancer care by providing a mechanism to empower patients to reflect on their cancer experience at a comprehensive cancer center. The acronym for the cover is P-patient, A- awareness, U- understanding, S-situation, and E- explanation. The journal may be used to express feelings, ask questions, and note events that are meaningful to the patient. This deliberate “pause” for questions and discussion can occur at any time during the patient’s cancer journey. The journal contains pocket folders for specific instructions and information, as well as lined note paper to write down questions and requests. The journal is provided to the patient upon admission and will be a point of discussion between the patient and nurse every shift. Although this project is focused on the older adult, the journal can be used by any patient.

Evaluation: The project will be evaluated for utility by the patient with the unit nurse at the time of discharge. Understanding how the older adult patient view treatment options, survivorship, palliative and end of life care is critical in providing optimum oncology nursing care.

Discussion: PAUSE is a nursing initiative created by the AgeWISE nurse residents at our organization. AgeWISE is a geropalliative care program designed to improve care for the older adult by building geropalliative care capacity among our expert oncology nurses, who mentor our newer nurses. This initiative is part of a transformative learning process that supports innovative strategies aimed at bringing change in nursing practice to improve overall care for our cancer patients and families.

135647 (Podium)

CANCER TREATMENT AND FERTILITY PRESERVATION: THE RN ROLE IN PATIENT EDUCATION. Andrea Andres, BSN, RN, Queen’s Medical Center, Honolulu, Hawaii; Stephanie Guy, BSN, RN, OCN®, Queen’s Medical Center, Honolulu, Hawaii

Significance and Background: As survivorship for most types of cancers improves, there is increasing interest and attempts to preserve fertility among cancer patients. Many major cancer organizations acknowledge the importance of addressing quality of life as it relates to the long-term consequences of cancer treatment, such as infertility. Evidence shows that nurses do not discuss cancer-treatment infertility and fertility preservation options with patients with cancer despite the belief that it is part of their role.

Purpose: This project seeks to increase staff nurses’ and patients’ knowledge of cancer treatment effects on fertility and the option of fertility preservation and also address system issues.

Interventions: Staff education materials on “Cancer Treatment Infertility and Fertility Preservation” were created, in-services were conducted, and pre and post-tests were compared to evaluate knowledge. The following materials were also created: 1) nursing-focused “Cancer Treatment Infertility Education Screening Algorithm,” 2) patient brochures that include directory of fertility specialists in Hawaii, 3) QMC Practice Guideline for Fertility Preservation, and 4) Fertility Preservation Toolkit. A house-wide multi-disciplinary Fertility Preservation Group was created.

Evaluation: The overall feedback was positive. To evaluate the effectiveness of staff education in-services, pre and post-tests mean scores were compared. In 2011, the mean score of the pre-tests was 55% (n=53) compared to a mean post-test score of 91% (n=27). In 2012, pre and post-tests mean scores were 61% (n=27) and 95% (n=30), respectively. Since in-services began in Oct 2011, several patients have delayed treatment to pursue the possibility of fertility preservation as a result of nursing education.

Discussion: Nurses play a vital role in educating patients on how cancer treatment can affect their future ability to reproduce. It is also consistent with the additions made by ASCO/ONS in the Chemotherapy Administration Safety Standards (Draft) 2012: "Discussion regarding infertility risk occurs prior to chemotherapy with all patients capable of reproduction is documented in the medical record."

135650 (Podium)

VITAMIN D DEFICIENCY IN ADULT STEM CELL TRANSPLANT PATIENTS: THE RULE, NOT THE EXCEPTION.

Margaret Eren, RN, AOCNP®, MSN, Duke University Health System, Adult Stem Cell Transplant Program, Durham, North Carolina

Significance and Background: Vitamin D deficiency is increasingly recognized as a major health concern. Vitamin D has long been known to help bone health. It is also important for proper functioning of many tissues throughout the body. Vitamin D is important for calcium and phosphorus metabolism, the cardiovascular system, proper immune function, and many other organ functions. Bone marrow transplant patients have a number of risk factors for Vitamin D deficiency including malnutrition and sun avoidance.

Purpose: Vitamin D levels were checked in patients being treated at the Duke Adult Bone Marrow Transplant Program from July 2010 to August 2012. One hundred and eleven patients were evaluated for Vitamin D deficiency. The age range was 17 to 71 years of age. The subjects were 41% autologous transplant patients and 59% allogeneic transplants. Racial make up was 77% white, 16% African American, and 5% other races. There were 56 males and 55 females. Vitamin D deficiency was defined as 25 OH D level of below 30 ng/mL. The mean 25OHD level in this patient group was 20.5. Nonwhite patients had a mean level of 18.4. Only nineteen of the 111 patients, or 17%, had levels above 30. Of these 19 patients, 10 (53%) were taking an over the counter or prescription Vitamin D supplement (Vitamin D2, Vitamin D3, or Calcium + Vitamin D). This group of patients demonstrated a high rate of Vitamin D deficiency. Most of the patients who were not Vitamin D deficient were taking a Vitamin D supplement.

Interventions: Most of the patients evaluated in this retrospective study were Vitamin D deficient. Due to the overwhelming prevalence of Vitamin D deficiency in the adult bone marrow transplant population, our practice has been changed to screen all transplant patients for Vitamin D deficiency prior to transplant and supplement as indicated.

Evaluation: This project was done retrospectively from patient records. Data obtained lead to a change in our practice. Patients are now being screened for Vitamin D deficiency and supplemented to try to decrease their overall health risks. This information was shared with clinicians in our department to increase knowledge and, subsequently, improve our patient care.

Discussion: Oncology patients in general have some of the same risk factors as this stem cell transplant population and should, therefore, be screened for Vitamin D deficiency and supplemented as needed.

135673 (Poster)

THE IMPLEMENTATION OF AN ELECTRONIC COMMUNICATION BOARD.

Michelle Wild, RN, BSN, OCN®, Roswell Park Cancer Institute, Buffalo, New York; Dana DeLuke, AAS, RN, Roswell Park Cancer Institute, Buffalo, New York; Deanne Rozak, CSA, Roswell Park Cancer Institute, Buffalo, New York

Significance and Background: Increased traffic at the nurses' station and multiple interruptions for the charge nurse raised awareness for the need to implement an electronic communi-

cation board. The IMCU is a fast paced area where patient assignments need frequent adjustments based on acuity, transfers, admits and discharges. Often physicians, physical therapists, occupational therapists, respiratory and other staff need to identify pertinent employees working each shift. This includes the charge nurse, secretary (CSA), nurse manager, hospital clinical assistant (HCA) and nurse practitioner (NP). In addition it is imperative that they know which registered nurse (RN) is assigned to care for each patient.

Purpose: Efficient and effective nursing requires timely delivery of medications and care. The Joint Commission for the Accreditation Organization (JCAHO) acknowledges that interruptions contribute to medical errors. Interruptions to identify appropriate staff on the unit are cumbersome and disruptive.

Interventions: The implementation of an electronic communication board provided a resource to help healthcare team members and families effectively identify the nurse assigned to a specific patient. A computer was set up at the front nurses' station to continuously run a PowerPoint program. Rotating screens show a list of patients' room numbers, the RN assigned to the patient and a photo of the RN. The second screen displays the current NP, HCA, CSA, nurse manager and charge nurse on duty with a corresponding photo. This communication tool assists families and visitors arriving on the floor to know who to contact with questions or concerns. The board is updated daily by the unit secretary to reflect current assignments and changes as they occur.

Evaluation: This initiative has resulted in a strong and positive response from many members of the health care team. Family members have verbalized comfort by connecting a name and face to the patients' nurse. The charge nurse has reported fewer interruptions and nursing satisfaction has increased.

Discussion: Physicians and ancillary staff have noted an overall increase in communication. An oncology setting brings additional fears to the family member of the loved ones receiving care. This simple project decreases stress and anxiety for this vulnerable population by enhancing communication between everyone involved.

135682 (Podium)

EFFECTIVENESS OF THERAPEUTIC MASSAGE IN REDUCING CANCER PATIENTS' SYMPTOMS.

Jeanene Robison, MSN, RN, AOCN®, The Christ Hospital, Cincinnati, Ohio; Ann Fuhrman, BSN, RN, AOCN®, The Christ Hospital, Cincinnati, Ohio; Cheryl Smith, LMT, The Christ Hospital, Cincinnati, Ohio; Maria Foley, BSN, RN, OCN®, The Christ Hospital, Cincinnati, Ohio; Elaine Strong, BSN, RN, OCN®, The Christ Hospital, Cincinnati, Ohio

Significance and Background: Nurses provide holistic care to oncology patients during their cancer journey, including receiving their chemotherapy/biotherapy infusions and managing symptoms. To create a healing environment, oncology nurses assess patient symptoms and plan strategies to reduce adverse effects of aggressive medical therapies. Complementary therapies, such as Therapeutic Massage (TM), are being increasingly used to decrease cancer patient's symptoms.

Purpose: Based on literature review, many authors describe benefits of massage therapy in cancer patients, including decreased symptoms (pain, fatigue, anxiety, nausea). Authors stated that study limitations included small sample sizes, and additional research was needed. We designed three studies to evaluate the effectiveness of massage therapy in decreasing symptoms in oncology patients: Phase 1 (1/2010 – 12/2010): Prospective single convenience group, pre-post design; outpatient oncology. Phase 2 (1/2011 – ongoing): Randomized, 2 group, crossover, experimental trial. Each outpatient subject had four visits: two Quiet Rest (QR) and two Therapeutic Massage (TM). Phase 3 (6/2012 – ongoing): Prospective single convenience group, pre-post design; four populations of oncology/hematology inpatients.

Interventions: For each study, the nurse reviewed the chart for patient specific assessment data, used visual analogue scale for patients to rate their symptoms pre- and post-intervention, and completed a post-intervention Brief Patient Satisfaction Questionnaire. TM intervention consisted of gentle massage (20 minutes) to lower arm/hand and/or to lower leg/foot. TM was modified, as clinically indicated. QR intervention consisted of quiet/rest time (20 minutes).

Evaluation: In the Phase I study (N=58), results demonstrated a statistically significant reduction in pain, fatigue, and anxiety ($p < 0.002$) with 20 minutes of massage. Results demonstrated high patient satisfaction, with a mean score of 4.7/5.0. We applied for/received a \$5,000 grant from the Daisy Foundations's J. Patrick Barnes Grant for Nursing Research and EBP. In Phase 2 study (N=38), which is ongoing, preliminary results demonstrate statistically significant decrease in 4/5 symptoms. In phase 3 study (N=70), which is ongoing, preliminary results demonstrate significant decrease in most of the symptoms. Detailed statistical analysis will be presented.

Discussion: The implications for oncology nursing include initiating or expanding a massage therapy program for both inpatient and outpatient cancer patients. Nurses are encouraged to use massage therapy as a non-pharmacological method of decreasing patient's symptoms.

135709 (Poster)

PROTECTING OUR NURSES WITH SAFE PATIENT HANDLING. Sara Bosse, RN, BSN, Johns Hopkins Hospital, Baltimore, Maryland; Kathryn Mooney, RN, BSN, OCN®, Johns Hopkins Hospital, Baltimore, Maryland

Underwriting or funding source: Texas Woman's University, Houston, Texas

Significance and Background: Nursing personnel are among the most at risk population for musculoskeletal injuries. These injuries are debilitating, sometimes career ending, and almost always preventable. Maryland is one of ten states that has passed legislation for safe patient handling standards. This legislation is targeted to avoid needless disability and wasted financial resources. It also protects patients from unnecessary suffering. Oncology patients are at a high risk of pain, bleeding, and fractures. Bone marrow transplant patients suffer from graft versus host disease related skin breakdown. These patients should not be subjected to the pushing and pulling of manual lifting. The addition of critical care patients on this unit increases the risk for injury. With growing evidence to support safe patient handling and a revised hospital protocol, changes were made on the unit.

Purpose: To turn this legislation into practice, patient lifting should be seen as a specialized skill. Nurses need education, support, and equipment to implement a safe-handling policy.

Interventions: Hospital-wide Safe Patient Handling and Movement Protocol was used to guide implementation on the unit level. Barriers were identified and safe handling coaches were identified. Equipment was purchased, including transfer sheets, roll board, and a mechanical lift. Unit staff received training on safe handling practices. The safe patient handling needs of each patient were assessed daily and algorithms in place to guide staff how to effectively move a patient.

Evaluation: Prior to implementation we identified barriers to safe handling practices, including lift equipment that was not stored on the unit. By purchasing a lift dedicated to our 16-bed unit, staff members have quicker access to equipment. Success was demonstrated by a decrease in staff injuries, patient reports of feeling more secure with the lift, and staff reports of increased use.

Discussion: The average age of a nurse is on the rise and obesity is a national epidemic. A safe handling program is needed now, more than ever. Hospitals must foster a culture of safety that empowers nurses to create better work environments.

135720 (Poster)

OVERCOMING THE RESISTANCE OF STAFF NURSE PARTICIPATION IN RESEARCH. Clara Beaver, MSN, RN, AOCNS®, ACNS, BC, Karmanos Cancer Center, Detroit, Michigan; Brenda Fowler, BSN, OCN®, Karmanos Cancer Center, Detroit, Michigan; Sandra Randolph, RN, OCN®, Karmanos Cancer Center, Detroit, Michigan

Significance and Background: In a research intensive environment nurses often are called upon to participate in funded clinical research projects. Typically the decision to participate is made at a management level. Often staff experience dissonance between their accountability to the patient and their accountability to the profession. Nurse Managers need to be creative to resolve this issue in a way that facilitates the research and helps the nurse meet their clinical responsibility.

Purpose: To optimize staff participation, minimize staff resistance and maintain a high standard of patient care during the research project.

Interventions: Collaboration between the researcher and unit management (nurse manager and Clinical Nurse Specialist) in a meeting prior to research project lead to mutually agreed upon goals to enhance participation. A creative plan to incentivize the staff and reassure them that they were supported during the project was needed prior to starting the project. Some examples used to incentivize staff included monetary reward for completing research surveys, earning a pizza party for participation, and providing continuing nurses education credits for participating in presentations. Examples of supporting the staff included extra staffing available during presentations, unit management available on unit to help with patient care and regular encouragement from management.

Evaluation: Most of the unit staff chose to participate in the research study. The support of management to make this study successful was noticed by the staff. The incentives were also well received by the staff and who often stated that was part of the reason they participated.

Discussion: Oncology Nurse Researchers and managers need to be sensitive about the possible sources of resistance that may influence staff nurse participation in a research project. Offering creative solutions to help decrease the barriers will help increase staff participation.

135994 (Poster)

COLOR-CODED TOOLKIT PAVES THE WAY TO IMPROVING ORAL ADHERENCE IN CLINICAL TRIALS. Yuk Wong, RN, BSN, OCN®, MA, The Cancer Institute of New Jersey, New Brunswick, New Jersey; Heather Camisa, RN, BSN, OCN®, The Cancer Institute of New Jersey, New Brunswick, New Jersey; Pamela Scott, RN, The Cancer Institute of New Jersey, New Brunswick, New Jersey

Significance and Background: As more targeted therapies are designed to combat cancer, oral chemotherapy will continue to be the focus because of its ease in delivery as compared to other treatments. Oral cancer medications are often more convenient for patients, less costly than other delivery methods, and require less healthcare resources to administer. However, accountability to take the drugs as prescribed is shifted to the patient rather than the clinician. Nonadherence to oral treatment continues to be a problem and has been shown to reduce treatment success, may lead to repeat office visits and/or hospital admissions, and even death.

Purpose: The purpose of this project was to develop a patient friendly toolkit for nurses to help patients better adhere to oral cancer treatments. The toolkit was designed using evidence-based guidelines, adult learning principles, as well as patient recommendations and feedback. In addition, education regarding the patient's personalized instructions was included to help reinforce the treatment goal.

Interventions: Phase I research nurses assessed current practice and resources, developed, and implemented the toolkit for active oral clinical trials protocols. The toolkit contains a nurse-developed screening to identify barriers and specific strategies for oral therapy compliance; a color-coded pill diary with instructions; individualized patient calendars with detailed explanations specific to their oral regimens; a quick reference sheet with symptom management guidelines and study contact information; plus an education sheet about taking treatments by mouth, which reviews safe-handling. Each protocol was assigned a color-coded kit.

Evaluation: The oral adherence toolkit is set to roll out this January. Anecdotal feedback from the staff has been extremely positive. Evaluation methods include a pre and post implementation survey completed by the staff, charts audits regarding oral adherence, and a patient survey. Changes to the toolkit will then be made based on recommendations.

Discussion: Oncology research nurses have the ability to empower their patients during each interaction. The use of evidence-based practice guidelines combined with nursing expertise, and patient preferences can be incorporated to promote patients' adherence to oral cancer treatments. This toolkit is easily adaptable for all patients on clinical trials as well as standard treatment regimes.

135997 (Poster)

BEST PRACTICE MANAGEMENT OF DIFFICULT AIRWAY IN ADULT PATIENTS WITH CANCER. Brenda Shelton, MS, RN, CCRN, AOCN®, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, Maryland

Significance and Background: Difficulty establishing an invasive airway is the most common serious risk of emergency and surgical care. Difficult airway (DA) in adults with cancer occurs ten times more frequently than in other patients. Use of emergency airway resources for cancer patients within this institution is higher than any other inpatient area.

Purpose: Literature was reviewed to determine evidence-based practices for identification and management of DA in adults with cancer.

Interventions: A search of English language and human studies from 2000–2011 in MEDLINE, EMBASE, CINAHL, and Cochran Libraries yielded 1765 citations, supplemented with hand-searching. Key words included difficult and complex with intratracheal, endotracheal, intubation, and airway management. The evidence was narrowed to 53 articles. Evidence was classified and graded using the Johns Hopkins Nursing Evidence-Based Practice Model's criteria. Evidence included two systematic reviews, three randomized controlled trials, thirty-one observational studies, and seventeen review articles. Five articles were deemed high level of evidence, forty articles good evidence, and eight scored low strength of evidence.

Evaluation: Thirteen articles described incidence, risks, and outcomes associated with DA intubation. High level evidence supports the problem of difficult airway intubation in patients with acromegaly, obesity, pregnancy, or with head/neck pathology. Two systematic reviews of airway assessment scales provided guidance for performance of assessment, and seventeen studies described application of assessment methodologies. Prediction of difficult airway using eleven scoring systems demonstrated moderate sensitivity (49% [CI 41-57]), and high specificity (97% [CI 93-100]). Nine studies using computed tomography or ultrasound for airway assessment were inconclusive. Two research articles described difficult airway management protocols that were reinforced by national guidelines and expert opinion.

Discussion: Evidence translation supports implementation of systems to address communication and care for DA patients. A protocol for assessment, proactive airway planning, patient education, and supply modifications within a University-based NCI-designated Comprehensive Cancer Center is described and serves as a model for implementation in other oncology prac-

tices. The presentation describes the evidence-based strategies, and facilitators and barriers that have been encountered while implementing these recommendations.

136043 (Poster)

CHEMO CHECKPOINTS: A TEAM APPROACH TO SAFE ADMINISTRATION. Susan Zuk, RN, MSN, AOCN®, Paoli Hospital, Paoli, Pennsylvania; Sara Hollstein, RN, MSN, AOCNP®, Paoli Hospital, Paoli, Pennsylvania; Carol Matthias, RN, BSN, OCN®, Paoli Hospital, Paoli, Pennsylvania; Michael Dabrow, DO, FACOI, Paoli Hospital, Paoli, Pennsylvania; Joseph Stuccio, RPh, Paoli Hospital, Paoli, Pennsylvania; Deborah Stuccio, RN, MSN, CMSRN, Paoli Hospital, Paoli, Pennsylvania; Jennifer Forster, RN, BSN, Paoli Hospital, Paoli, Pennsylvania

Significance and Background: The oncology staff and physicians identified chemotherapy administration as a high risk, high volume procedure that could benefit from a systematic and comprehensive analysis. The nursing staff completed a knowledge assessment which defined learning needs and competency focus. Our clinical team flow-mapped the entire chemotherapy process from obtaining consent to delivery at the chair-side. Mapping of each unique chemotherapy setting highlighted safety checkpoints and common themes. The systematic review of the institution's policy and procedures compared to evidence based literature was the foundation to base improvement opportunities.

Purpose: The multidisciplinary team identified chemotherapy order verification as the key safety priority. Consistent procedures to ensure safety related to ordering, preparation and administration was critical. Review of the literature, objective observation of current practice and site visits to examine best practices provided the PI evidence. Also, safety catches for dosing, calculations, and regimen clarification were episodic and not based on systematic review.

Interventions: Finding a standard format to verify the chemotherapy order led to the creation of our chemotherapy checklist that both pharmacy and nursing utilized. The checklist ensured that all aspects of the chemotherapy order were double-checked by pharmacy and nursing. Education of staff and the implementation of the chemotherapy checklist coincided with the growing expertise of the oncology staff encouraged a culture of safe communication with our physicians. Adoption of NCCN evidence based order templates and standardized reference materials ensured double check processes using identical methods.

Evaluation: The Chemotherapy Safety Process Improvement Initiative has become hard wired within our practice. Tracking near misses with the chemotherapy process have inspired confidence and knowledge in our staff. Creating competencies within nursing for the verification process and calculation proficiency was essential. Adopting an additional safety check at the infusion pump was an evaluation finding.

Discussion: Oncology nursing has an integral role in the chemotherapy administration process and the verification of regimens, dosing, and preparation has critical significance with patient safety. Providing methods to identify the high risk procedures in an oncology setting, provide tools for the verification process and offer education and competency examples will promote safe and competent care in any setting.

136085 (Poster)

REDUCING CATHETER ASSOCIATED URINARY TRACT INFECTIONS: A NURSE-DRIVEN URINARY CATHETER REMOVAL PROTOCOL. Jennifer Devine, RN, BSN, Lehigh Valley Health Network, Allentown, Pennsylvania; Tiffany Lopez, RN, BSN, Lehigh Valley Health Network, Allen-

town, Pennsylvania; Shannon Lichty, RN, BSN, Lehigh Valley Health Network, Allentown, Pennsylvania

Significance and Background: The utilization of indwelling urinary catheters in acute care settings is often inappropriate, prompted by such things as staff convenience, lack of knowledge of alternative incontinence treatments, and unawareness of risks associated with prolonged use. Urinary catheter use contributes to negative outcomes, including urinary tract infections, patient discomfort, mobility issues, increased health care costs, morbidity, and mortality.

Purpose: This presentation describes a nurse-driven urinary catheter removal protocol, and a variety of other interventions to decrease indwelling urinary catheter utilization and associated infections.

Interventions: A goal was set by staff on a 30 bed medical-surgical/oncology unit in an academic, community Magnet™ hospital to decrease the use of urinary catheters. A nurse driven urinary catheter removal protocol based on evidence was developed. Nursing staff were educated on acceptable uses of urinary catheters, risks of prolonged use, alternative incontinence options, intermittent urinary catheterization, and bladder scan protocols. All staff, including non-licensed assistive personnel, were educated on infection control issues, inclusive of maintaining a closed catheter system. Physicians received education on the benefits of early catheter removal, medical necessity documentation, and treatment alternatives.

Evaluation: Data collection consisted of tracking the number of urinary catheter days and rates of catheter associated urinary tract infections (CA-UTIs). Comparison data analysis demonstrated a decrease in the catheter utilization rate and the rate of CA-UTIs over a three year period (2010–2012). Specifically, the catheter utilization rate decreased from 20.6% (2010) to 16.3% (2012) and the CA-UTI rate decreased from 2.31 (2010) to 0.71 (2012) with a sustained 243 day period in which there were no identified CA-UTIs.

Discussion: The unit's leadership team fostered an atmosphere of trust in which nurses were empowered to hold one another accountable for timely removal or avoidance of indwelling catheters. Through positive reinforcement, transparency of data, and a unified desire for best practice, the unit staff worked together to affect positive change in the quality of patient care.

136123 (Poster)

IS ORAL ELECTROLYTE REPLACEMENT MORE EFFECTIVE THAN IV REPLACEMENT IN THE ADULT ONCOLOGY POPULATION? Rebecca Martin, RN, BSN, OCN®, Hackensack University Medical Center, Hackensack, New Jersey; Joanne Growney, RN, ANP-BC, MA, OCN®, Hackensack University Medical Center, Hackensack, New Jersey; Keri Bicking, PharmD, Hackensack University Medical Center, Hackensack, New Jersey; Maribel Pereiras, PharmD, Hackensack University Medical Center, Hackensack, New Jersey; Christina Howlett, PharmD, Hackensack University Medical Center, Hackensack, New Jersey; Kimberly Howlett, RN, MSN, OCN®, Hackensack University Medical Center, Hackensack, New Jersey

Significance and Background: Electrolyte abnormalities are the most common laboratory findings in patients with malignancies. Clinical manifestations of several electrolyte deficiencies occur with frequency in malignancy. Patients who are admitted for chemotherapy regimens as well as for complications post chemo receive electrolyte replacements on a daily basis. Experience has shown consistent patient and staff nurse dissatisfaction with the current replacement protocol. From their skilled nursing judgment, oncology nurses have found that patients can receive up to 500ml of excess fluid from IV electrolyte

replacement, causing unnecessary fluid overload. Another issue that has been identified by oncology nurses with IV replacement is the potential for phlebitis and pain due to administration of IV potassium. Both of these occurrences can lead to increased costs and admission stays.

Purpose: The purpose this EBP project was to see if oral electrolyte replacement is just as effective as IV replacement in the adult oncology population. Safest way to treat mild to moderate hypokalemia is with oral replacement and that IV potassium replacement is indicated for severe hypokalemia or those who cannot take oral. For hypomagnesemia and hypophosphatemia, oral repletion is preferred in asymptomatic patients.

Interventions: With a multidisciplinary team devised of an oncology physician, PharmD, APN, nurse educator, and staff RN, the original IV electrolyte protocol was revised to include oral options. The revised order set was presented to the hospital Pharmacy Review Committee for physician approval. Upon approval, a pilot study was initiated. Education of the nursing staff was key to the success of the pilot. Once the staff RN identified a decrease in the serum electrolyte value, they assessed the patient for the presence of nausea, vomiting, diarrhea, or mucositis. If all was negative, the nurse was able to proceed with the oral electrolyte replacement (OER) protocol. Data was gathered on a total of 73 instances of OER use regarding nurse compliance as well as the lab values following the replacement.

Evaluation: Overall nurse compliance for using the OER protocol was 95.9%. For potassium, 65.4% of the occurrences using the OER met the target range for the serum level after repletion. For magnesium, 58% of the occurrences using the OER met the target range. For phosphorus, 100% of the occurrences using the OER met the target range. When discussing the results with the project team, it was felt that this initial pilot was a success and that the OER protocol will eventually be used for all in-patient adult oncology patients, further enhancing cancer care.

Discussion: The overall staff nurse compliance was extremely high. The reason for this is that the staff nurses were ready for the change in protocol. They identified the issues originally and the project team came together because of their requests. It was a smooth transition from using the IV protocol to the OER. Through staff nurse feedback, it was found that a potassium phosphate oral replacement does not exist on the hospital's formulary, so only sodium phosphate replacement was used. This was vital information because it identified an unanticipated finding and a need to change the OER protocol. In addition to this, data showed that PO magnesium did not work as effectively for moderately low serum levels, however mildly low serum magnesium levels was successful. Therefore, the parameters on the OER protocol were changed to reflect this finding and will be re-piloted.

136170 (Poster)

STREAMLINING PATIENT EDUCATION IN THE CORRECTIONAL CARE SETTING. Gail Kwarciany, MSN, RN-BC, OCN®, AOCNS®, University of Texas Medical Branch, Galveston, Texas; Malaine Moore, RN, University of Texas Medical Branch, Galveston, Texas; Stormy Stevenson, RN, University of Texas Medical Branch, Galveston, Texas

Significance and Background: Patient education has been shown to improve patient compliance and achieve optimal care outcomes. For the oncology patient in the correctional care setting achieving patient understanding of the treatment plan, potential side effects, and discharge information for ongoing self care, effective, efficient patient education is critical. The ASCO/ONS Chemotherapy Administration Safety Standards describe the minimum components for patient education. Providing effective, efficient education to offender patients returning to a secure environment, while adhering to security considerations is a challenge.

Purpose: The purpose of this presentation is to describe the development of a patient education packet for oncology patients in a correctional care setting that met patient needs as well as security criteria.

Interventions: Staff nurses on the inpatient unit of a maximum security prison hospital identified the components of education related to chemotherapy administration to improve outcomes such as patient satisfaction, symptom management, length of stay, preventable readmissions, and staff satisfaction. Utilizing ONS and ASCO recommendations critical topics were identified. A search located appropriate print materials that adhered to institutional requirement such as the National Cancer Institute. Materials were reviewed and selected based on various factors such as readability, cost, and acceptance by patients. A packet was constructed that all patients would be given with optional additions such as individual drug regimens and low literacy materials. The packets are easy to assemble, store, and access by the nurse. Documentation of patient education is facilitated by electronic entry of a data point rather than each individual item. Security approval was required from the prison system to allow offenders to be permitted to carry the packet to their home prison unit.

Evaluation: The packets have provided a consistent level of patient education. Retrospective medical record review and patient and staff satisfaction scores indicate improvement. Packets will be reviewed annually to ensure current material and any improvement in the process as needed.

Discussion: Meeting the needs of patients for effective oncology education has been facilitated by this project. Although this took place in a correctional care setting, it could be used in any setting.

136250 (Poster)

2% CHLORHEXIDINE GLUCONATE BATHING TO REDUCE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTIONS (CLABSI) IN HEMATOPOIETIC STEM CELL TRANSPLANT AND HEMATOLOGIC MALIGNANCY PATIENTS. Kelly Bailey, RN, BSN, OCN®, University Hospitals Seidman Cancer Center, Cleveland, Ohio; Christina Reeber, RN, BSN, OCN®, University Hospitals Seidman Cancer Center, Cleveland, Ohio

Significance and Background: Patients with hematologic malignancies and those undergoing hematopoietic stem cell transplant require a central venous catheter nearly 100% of the time. This population of patients are immunocompromised, which makes them more susceptible to central line associated blood stream infections. Nurses play a significant role in helping to reduce the risks of patients obtaining CLABSI.

Purpose: The project was a prospective descriptive quality improvement initiative. The project took place at a large urban academic cancer center, 26 bed bonemarrow transplant unit. The objectives were to evaluate the effects of using daily CHG bathing wipes on the four month aggregate infection rate of patinetes on the bone marrow transplant unit as compared to the four months prior. To also monitor adverse skin effects related to using CHG bath wipes. Unit based staff and patients were educated on the proper use of CHG bathing wipes. A data collection tool was used to collect patient demographic information and CLABSI data.

Interventions: CLABSI lead to increased morbidity, mortality, length of hospital stay and cost. Persons with hematologic malignancies and those undergoing a hematopoietic stem cell transplant have a higher rate of central line infections as compared to other patient populations. Site specific rates for central line infections were twice the National Healthcare Safety Network benchmark, and intervention was in need to help reduce this rate of CLABSI.

Evaluation: Data collection tool was utilized and a formula was used to determine CLABSI rate. Data showed a 50% re-

duction rate in CLABSI during the four month initiative. No research studies on the use of CHG wipes on hematology/oncology patients were found. The findings of this quality improvement project is applicable to oncology nursing to help decrease CLABSI in this patient population.

Discussion: The immunocompromised oncology population have a higher risk of CLABSI. Our project has shown that CHG bathing appears to be an effective, well tolerated and a non-invasive intervention in preventing CLABSI in immunocompromised cancer patients. This new data, that we have obtained, can help assist oncology nurses in using CHG bathing wipes in their cancer patients, specifically hematopoietic stem cell transplant patinetes.

136257 (Poster)

TO CATHETERIZE OR NOT TO CATHETERIZE? THAT IS THE QUESTION. CAUTI PREVENTION IN THE ONCOLOGY POPULATION. AN EVIDENCE-BASED APPROACH.

Debra Rodrigue, RN, CNS, MA, Memorial Sloan-Kettering Cancer Center, New York, New York; Nora Love, RN, MS, CURN, CNS, Memorial Sloan-Kettering Cancer Center, New York, New York; Ellen Dougherty, RN, MA, CNOR, CIC, Memorial Sloan-Kettering Cancer Center, New York, New York; Ji Yon Chang, RN, BSN, Memorial Sloan-Kettering Cancer Center, New York, New York

Significance and Background: There is a direct relationship between length of catheterization and the risk of developing a urinary tract infection (UTI). In 2008, The Centers for Medicare and Medicaid Services (CMS) listed Catheter Associated Urinary Tract Infections (CAUTI) as a preventable hospital-acquired complication. Additionally, The Joint Commission included CAUTI prevention as part of the 2012 National Patient Safety Goals. In 2011, at this national comprehensive cancer center, it was found that 80% of catheters were placed in the operating room while the remaining 20% were placed on the inpatient units. Within a 7 month period in 2012, we reported a CAUTI rate of 16% thus making CAUTI prevention a priority.

Purpose: A multidisciplinary working group of inpatient nursing and infection control practitioners convened to address the concerns brought forth by these alerts, while tailoring it to the specific needs of the oncology population. This group developed a comprehensive evidence-based policy reflecting best practice guidelines and conducted a nursing wide education program focusing on CAUTI prevention.

Interventions: Education included the implementation of criteria for appropriate catheter insertion and alternatives to indwelling catheters, with an emphasis placed on the routine maintenance bundles. This included; keeping the drainage bag off the floor and below the level of the bladder, keeping the catheter secured, daily personal hygiene, performing hand hygiene before and after manipulating the catheter, maintaining a sterile closed drainage system, and ensuring measuring gradients are properly labeled. Subsequently, an evidenced-based patient care plan, patient education documentation form, urinary catheter insertion order set, handoff notification and a CAUTI prevention sticker for drainage bag placement were developed to enhance these guidelines. Supplies were updated to reflect current standards.

Evaluation: Measurement of the process outcome will include the monthly compliance monitoring of the maintenance bundle with a goal of 100% compliance. Additionally, the outcome measurement of CAUTI rates will be monitored monthly with a goal of zero detected.

Discussion: This CAUTI prevention initiative provided the nursing staff with the best evidence for the care of the oncology patient with an indwelling urinary catheter. A decrease in CAUTI rates and compliance to the maintenance bundle will be the markers of our success.

136314 (Poster)

MANAGEMENT OF STOMATITIS ASSOCIATED WITH MTOR INHIBITORS IN HORMONE RECEPTOR-POSITIVE/HER2-NEGATIVE ADVANCED BREAST CANCER: CLINICAL EXPERIENCES FROM A SINGLE CENTER. Josephine Divers, RN, BSN, Texas Oncology–Baylor Charles A. Sammons Cancer Center, Dallas, Texas

Significance and Background: The mTOR inhibitor everolimus has recently been FDA-approved to manage hormone receptor-positive (HR+), HER2-negative advanced breast cancer (BC) after failure of letrozole or anastrozole. Although everolimus is effective, stomatitis is a frequent adverse event (AE) that significantly affects patient quality of life. Because nurses interact with patients and work to manage AEs, knowledge of effective strategies to manage stomatitis may help to improve tolerability and patient outcomes.

Purpose: To describe the experiences and techniques from a single center to manage mTOR-related stomatitis in patients with HR+, HER2-negative advanced BC.

Interventions: Use of a prophylactic measure to prevent stomatitis is essential. A baseline oral assessment must be performed to ensure no gum irritation or mouth sores are noted before initiating treatment. 1. Use 15-ml baking soda/salt mouth rinse QID (swish and spit) (mix 1/3-tsp baking soda and 1/3-tsp salt in 1-qt water. Refrigeration is not needed. Do not eat or drink anything for 10 min after rinsing. 2. Use 10-ml prescribed mouth rinse QID (swish and spit) (16-oz recipe: 320-ml Benadryl solution, 2-g tetracycline powder, 80-mg hydrocortisone, and 40-ml nystatin suspension, QS with water). Wait 10-15 minutes after using baking soda/salt rinse. Combination of mouth rinses strongly recommended, and should be used as directed. If mouth sores develop, stop medication and call nurse immediately. Communication between nurse and patient is important, so continued reinforcement of symptom prevention and management is imperative. If there are no changes from baseline oral assessment, medication is continued. Using triamcinolone oral paste can assist in healing mouth ulcers.

Evaluation: Patient will have office visits every 2 weeks with oral assessment. If there are no changes from baseline oral assessment, medication is continued. If changes develop, patient is instructed to hold dose of medication until grade of stomatitis is determined by clinical team.

Discussion: Prevention is key to managing stomatitis associated with mTOR inhibitors. By teaching the patient to recognize any changes in the mouth, communicate those changes to nursing staff, and be compliant with oral rinses, our center has been successful in minimizing stomatitis.

136325 (Poster)

ESSENTIAL COMPONENTS FOR SKILLED ONCOLOGY NURSING CARE: MEETING THE STANDARDS AND MORE. Gail Kwarciany, MSN, RN-BC, OCN®, AOCNS®, University of Texas Medical Branch, Galveston, Texas; Pamela Davis, MBA, BSN, RN, OCN®, University of Texas Medical Branch, Galveston, Texas

Significance and Background: Providing effective quality specialized oncology nursing care is a challenge in any setting, but more so on a non-dedicated oncology unit. Competing priorities may relegate the oncology nursing focus to the background. Adhering to oncology nursing standards such as ONS and ACOS requires not only staff education but a support system that provides motivation and ongoing surveillance for continued adherence for both nurse competence and optimum outcomes.

Purpose: The purpose of this presentation is to describe the integration of oncology nursing standards, knowledge, and practice in the environment of a non-dedicated inpatient and

outpatient oncology unit. Nurses who view this poster will become aware of one institution's effort to promote high level expert oncology nursing in a non-specialty environment. They may increase their knowledge of standards and recommendations for practice that are evidence-based to improve patient outcomes.

Interventions: Previously, oncology nursing care was supported through the successful completion of the ONS Chemotherapy and Biotherapy course and intermittent educational programs. Orientation for new employees to this mixed Medical-Surgical/Oncology and Day Procedure/Infusion Therapy unit did not include an oncology-specific component. The Oncology Patient Care Facilitator and the Oncology Clinical Nurse Specialist identified critical components to ensure both an elevated oncology nursing knowledge base and validated clinical competency of the nurses providing care for oncology patients. These components include a structured, 6 week Oncology Nursing Internship Program for all new nurses, both novice and experienced, monthly and quarterly professional development programs specific to oncology with continuing nursing education credits, hands on "skills fairs", and nurse clinician involvement in policy revisions, patient education packets, competency tools, and product reviews.

Evaluation: The program is dynamic and continues to evolve with input from leadership and nurse clinicians. Since the implementation, ongoing medical record review and analysis of outcome indicators demonstrate increased staff satisfaction and retention, improved patient outcomes with reduction in length of stay and readmissions for complications such as neutropenic fever. Preceptors express satisfaction in the structured program with consistent information provided to all nurses.

Discussion: This integrated program has shown improved patient and staff outcomes and could be used as a model for other programs in any oncology nursing environment.

136343 (Poster)

THE ONCOLOGY NURSE'S ROLE IN ASSESSING AND MANAGING HAND FOOT SYNDROME WITH A NOVEL THERAPY: "A PILOT STUDY: TREATMENT OF PALMAR PLANTAR ERYTHRODYSESTHESIA WITH TOPICAL SILDENAFIL." Wanda Honeycutt, RN, BSN, CCRP, Duke Cancer Institute, Durham, North Carolina; Kellen Meadows, PhD, Duke Cancer Institute, Durham, North Carolina; Leigh Howard, RN, MSN, NP-C, Duke Cancer Institute, Durham, North Carolina; Herbert Hurwitz, MD, Duke Cancer Institute, Durham, North Carolina; Christy Arrowood, RN, BSN, Duke Cancer Institute, Durham, North Carolina; Neal Arrowood, MSCRC, Duke Cancer Institute, Durham, North Carolina

Significance and Background: Hand foot syndrome (HFS), is a common adverse event of many anticancer agents. Although HFS is rarely life-threatening, the skin changes are often painful and debilitating and can impair activities of daily function. As a result, HFS-related symptoms can frequently lead to dose reduction and/or discontinuation of otherwise effective anticancer treatment.

There is no current treatment for HFS other than dose reduction or stopping treatment. However, recent anecdotal evidence suggests use of topical sildenafil may improve HFS-related symptoms. To further evaluate these findings, we conducted a randomized, double-blind, placebo-controlled pilot study to evaluate the safety, efficacy and feasibility of topical sildenafil cream for the treatment of HFS. In this study, oncology nursing was instrumental in developing methods used to educate and measure patient compliance, assess symptom improvement and treatment effect on patient activities of daily living.

Purpose: The primary clinical endpoint was improvement in HFS grade.

Interventions: Once patients met eligibility, they were randomized to apply active 1% sildenafil cream to either the right or left hand and/or foot and placebo cream to the opposite hand and/or foot. Subjects were instructed to apply 0.5 ml of cream to each affected hand/foot twice daily via metered dispensers. Non-latex waterproof gloves were supplied to minimize the contamination of the creams. Use of emollients was encouraged as part of standard care. Oncology nursing tools such as comprehensive diary cards were developed to record the study cream application, pain and anti-cancer treatment. Detailed patient instructions were given on cream application and diary card completion. Clinical assessments were evaluated by NCI-CTC version 4.0 grading and patient reported pain at rest and weight-bearing.

Evaluation: Ten subjects were enrolled; 9 were evaluable for safety and efficacy. Although there was no improvement in HFS CTC grading, a trend was noted for relative improvement for pain and skin changes. No treatment-related toxicities were observed. Subject compliance was high throughout study participation indicated by robust diary card completion.

Discussion: Topical 1% sildenafil cream is well-tolerated, feasible to administer and may help mitigate PPE-related symptoms. Oncology nursing instruments are critical to successfully characterizing patient enthusiasm and compliance for investigational therapies.

136365 (Podium)

NURSE NAVIGATION: A CASE STUDY AT THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER REGIONAL CARE CENTERS. Diana Vasquez, RN, MSN, CPHON®, The University of Texas MD Anderson Cancer Center Regional Care Centers, Houston, Texas; Laurie Hughes, MSN, RN, FNP-C, The University of Texas MD Anderson Cancer Center, Houston, Texas; Z. Nicole Luckett, MSN, RN, CPON®, The University of Texas MD Anderson Cancer Center, Houston, Texas; Monica Cerda-Juarez, MSN, RN, CPON®, The University of Texas MD Anderson Cancer Center, Houston, Texas

Significance and Background: Currently, a woman living in the United States has a 1:8 lifetime risk of being diagnosed with breast cancer. The shock of diagnosis combined with fear of the unknown can make the process unbearable. Dr. Harold Freedman, founder of Navigation, developed a process for improving access for medically underserved patients. At conception, Navigation started in the rural setting with lay people educating the community about breast awareness. Ever evolving, today it exists at specific levels of the healthcare continuum. From the time of diagnosis, the Nurse Navigator facilitates access to care and works with patients, physicians, multidisciplinary team members and the community to assist in coordination of care. The Navigator supports the educational and psychological needs patients and families have through the continuum of care. In addition, the Navigator helps identify and overcome barriers to care; overall, impacting access and quality of care through the cancer journey.

Purpose: The University of Texas MD Anderson Cancer Center Regional Care Centers have incorporated the Nurse Navigator role into the multidisciplinary team to expedite access and provide quality care for patients and families.

Interventions: Incorporating a Nurse Navigator as a direct point of contact for new patients facilitates access to care. The Nurse Navigator reviews imaging and biopsy results with the patient to help ease anxiety prior to the first appointment. At the first appointment, the Nurse Navigator meets the patient and a needs assessment is conducted; needs are addressed and appropriate resources are linked. Throughout the treatment, the Nurse Navigator continues to meet with the patient periodically and address concerns as they arise

Evaluation: As a result of adding Nurse Navigation to an ambulatory oncology center, breast cancer patients are connected with the appropriate physician in a timely manner and they more equipped with knowledge and resources to guide them through treatment and beyond

Discussion: At diagnosis, breast cancer patients are faced with the daunting challenge of traversing the complicated medical system. With the addition of Nurse Navigation, patients have same day contact with a clinical expert to guide them to the appropriate appointment.

136411 (Poster)

ESTABLISHING A SURVIVORSHIP PROGRAM IN A COMMUNITY BASED ONCOLOGY PROGRAM. Debra Ross, BSN, RN, OCN®, Mercy Cancer Centers, Toledo, Ohio

Significance and Background: "When am I a survivor?" Patients may ask this question or just be thinking it. This was the driving philosophy of our community-based oncology program to operationalize survivorship as a continuum requiring interventions at various points from the day of diagnosis to the follow-up phase. During the initial treatment whether it is chemotherapy, surgery and/or radiation therapy, patients are continually assessed for new or continuing issues that might arise as a result of the therapy. Once this acute phase is complete and the frequency of visits decreases, many patients feel anxious or unsure of what to expect or how to resume a normal life.

Purpose: Survivorship visits are an avenue our oncology program uses to fill in the gap perceived by the patient. Our goal is to provide the tools and support the patient and family need to recover as fully as possible.

Interventions: In April of 2011 our first Survivorship Visit was completed. These individual visits are facilitated by selected nursing staff and are approximately one hour in length. Key components of this visit include: a brief interview in which general questions are asked allowing the patient to direct the conversation toward personally relevant and significant issues; Facing Forward, a National Cancer Institute booklet is given; a written treatment summary is provided and reviewed; a needs assessment is conducted with referrals to community agencies made as indicated; following review of the treatment summary, a computerized care plan is completed through the Livestrong website.

Evaluation: Patient evaluations to date show top scores. Based on performance evaluations of this program from patients and healthcare professionals in our oncology program, future plans will be outlined. These include incorporating the STAR (Survivorship Training and Rehab) program into our care.

Discussion: This presentation will share the planning and preparatory work that was done including reviewing numerous treatment summaries and exploring the possibility of creating our own summary before deciding to use the ASCO Treatment Summary. The Livestrong website allows the patient to enter specific treatments and using directed questions about side effects, it then generates a plan that looks at long-term side effects and health management planning.

136415 (Poster)

MANAGING THE NUTRITION CHALLENGES OF THE HEAD AND NECK CANCER PATIENT. Anzonette Pittet, Registered Dietitian, Kaiser Permanente, Santa Clara, California

Significance and Background: Head and Neck Cancer (HNC) is defined as malignancies that originate in the squamous cells or glandular tissues of the head and neck region (nasal cavity, oral cavity, oropharynx, larynx and esophagus). Treatment options for HNC include surgery, chemotherapy and radiation or a combination of these modalities. An estimated 40% of patients with HNC is malnourished at diagnosis. Treatment related side effects result

in increased treatment related toxicities, therapy interruptions, increased health care cost and lasting life altering side effects. When a cancer care team does not have access to an Oncology Nutrition Specialist, the RN is responsible for the assessment and management of nutrition related side effects of this complicated cancer population which may result in further decline in nutrition status. When RN's can identify the nutrition stages during therapy they can better manage nutrition related side effects of HNC patients, improve tolerance to therapy, reduce therapy interruptions and improve recovery and rehabilitation.

Purpose: Activity: Powerpoint presentation

1. Discuss incidence of HNC
2. Discuss treatment modalities for HNC
3. Discuss nutritional stages experienced by patients undergoing chemoradiation for HNC
4. Discuss trends in the management of nutrition impact symptoms
5. Discuss outcomes related to nutrition management of HNC patients

Interventions: 1. Review current literature and up to date scientific evidence related to the management of HNC treatment acute sequelae (Mucositis, Xerostomia, Dysgeusia, Odynophagia, nausea and vomiting). 2. Present guidelines to optimize nutrition intake and minimize weight loss

Evaluation: Effective management of the HNC patient through assessment, education and follow up can improve the management of HNC related acute sequelae with reduction in treatment interruptions, increased QOL and faster recovery after completion of therapy.

Discussion: When a cancer care team does not have access to an Oncology Nutrition Specialist, the RN is responsible for the assessment and management of nutrition related side effects of this complicated cancer population. Oncology RN's working in clinics with minimal RD support will be able to identify patients at risk of nutritional decline, recommend interventions to minimize the impact of decline and support HNC patients in their journey through treatment and recovery.

136421 (Poster)

SURVIVORSHIP NURSING CARE IN COMMUNITY ONCOLOGY. Michele O'Brien, RN, MSN, ACNS-BC, BA, Minnesota Oncology, Edina, Minnesota; Kimberly Ness, RN, MSN, ACN-BC, AOCN®, Minnesota Oncology, Edina, Minnesota; Jackie Foster, RN, OCN®, MPH, Minnesota Oncology, Edina, Minnesota

Significance and Background: Cancer survivorship encompasses physical, functional, emotional, spiritual, and social well-being. Without a defined role, nurses tend to be less involved in survivorship concerns and more involved in acute care. Nurses have a holistic approach to care and are ideally suited to address survivorship needs through an individual's cancer journey.

Purpose: Provide patient-centered, nursing guided survivorship care.

Interventions: Inspired by the article Season's of Survivorship, survivorship care at a community based outpatient oncology clinic is initiated at diagnosis. Patients are offered a one hour survivorship visit with an advanced practice registered nurse (APRN) after the treatment plan is defined. This visit is dedicated to patient concerns and quality of life (QOL). Additional visits are scheduled at times of transition: treatment completion, 3-6 months after treatment, and as needed. Prior to the visit, patients complete an electronic assessment. An individualized report of patient concerns and QOL is generated for the APRN to guide the visit and coordinate additional referrals for care. The APRN delegates follow up to nursing staff. Patient satisfaction is measured at each visit and via a follow up survey.

Evaluation: A total of 259 patients (296 visits) have taken the assessment from January 1 – September 30, 2012. Median

patient age was 60 (range 21-90). Breast cancer (n= 61) was the most common diagnosis seen. For all diagnoses, initial visit disease status was: stage I (n=44), II (n=62), III (n=71), IV (n=69). The most commonly selected patient concerns for all patients were physical/functional, fatigue, emotional and food/nutrition. Patients with stage IV disease more frequently selected health care directives while patients with early stage disease more frequently selected body image as a concern. As a result of the survivorship visit patients were referred to social work, nutrition, rehabilitation, community services and counseling.

Discussion: Attention to survivorship issues is essential to provide comprehensive care to those affected by cancer. A nursing led survivorship program can fill a gap in care with a holistic approach to cancer survivorship. Benefits of adopting a survivorship program include improvement in quality of care and patient satisfaction.

136472 (Poster)

REDUCING DISTRACTIONS PRIOR TO AND DURING DRUG ADMINISTRATION—RED MEANS STOP. Gertrude Cooke, RN, OCN®, UPMC, Pittsburgh, Pennsylvania; Leslie Stewart, RN, OCN®, UPMC, Pittsburgh, Pennsylvania

Significance and Background: Chemotherapy use is a high risk situation with many points of potential for errors. Where these agents are verified, prepared and administered are very busy areas with a high risk for distraction. The interruptions that occur when nurses are engaged in this process create an even higher risk for errors. Our team was able to identify a potential correlation between the number of errors and the amount of distractions in the proximity of the work area. Any interruption, drawing away or diverting attention, puts the process at risk for error.

Purpose: To develop processes that would improve and create an atmosphere conducive to drug administration. Observation and quantifiable data collection would be expected to prove that distractions contribute to errors. These processes and enhancements would be simple and sustainable

Interventions: Errors are identified and reported the nurse manager initiates a multidisciplinary review of the process breakdown, determining if the cause is an interruption or distraction or some other identifiable cause. It was determined that a need for some type of warning that the nurse was calculating or preparing to administer a drug was needed. Red warning lights were given to all nurses to place in a visible area at their desk or on their person.

Evaluation: Nurses collect data pre and post red light utilization. They will note if they are interrupted with the light on. The Nurse Manager would investigate any medication errors or near misses during all data collection periods. The initial collection period would be for two weeks prior. Post red light implementation data collection would occur over two weeks also.

Discussion: The process changes, through initial data collection and observation, showed significant improvement in employee job satisfaction and decrease medication errors caused by distractions/interruptions. At this point the process is being trialed at a single site in our 26-site network. Data collection and trials will precede at all other sites. Data for the initial site has not yet been compiled, but data for multiple sites will be obtained and reviewed over the next several months.

136517 (Poster)

THE ONCOLOGY NURSING ROLE IN DISTRESS SCREENING AND INTERVENTION. Jennifer Lynn Smith, CNP, US Department of Veterans Affairs, Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio; Sonya Curry, CNS, Department of VA Affairs, Cleveland, Ohio; Melanie Lynch, MD, Department of VA Affairs, Cleveland, Ohio; Susan Berman, PhD, Psy-

chologist, Department of VA Affairs, Cleveland, Ohio; Jennifer Dimick, LISW, OSW/C, Department of VA Affairs, Cleveland, Ohio; Robert Dimick, RN, RNFA, Department of VA Affairs, Cleveland, Ohio; Polly Mazanec, PhD, ACNP, FPCN, AOCN®, Department of VA Affairs, Case Western Reserve University, Cleveland, Ohio

Significance and Background: A diagnosis of cancer, its treatment, and surveillance are fraught with distress. Ambulatory cancer care centers are working towards improving distress screening and management across the disease trajectory. According to the National Comprehensive Cancer Center Network (NCCN) guidelines all patients should be screened for distress at their initial visit, at appropriate intervals, and as clinically indicated. Despite strong recommendations from NCCN and professional organizations, many cancer centers are struggling to implement routine screening. In addition, the time line for what constitutes longitudinal screening of “appropriate intervals” has not been well established.

Purpose: A large Midwestern academic Veteran’s Affairs Medical Center has a federally funded project focusing on patient-centered cancer care. Patients coming to their cancer center of excellence are being screened at every visit to 1) determine the incidence and sources of distress across the disease trajectory, and 2) to identify appropriate parameters for longitudinal screening.

Interventions: All veterans coming to the Center of Excellence (COE) clinic are given the Distress Thermometer (DT) at the beginning of every visit. Those with distress scores > 4 are offered same-day intervention in the clinic with the appropriate provider (social worker, psychologist, and/or advanced practice nurse) depending on patient response to the source of the distress (practical, family, emotional, spiritual, and physical).

Evaluation: More than 300 patients have been screened. Many have reported practical and emotional distress; however, most of the patients have reported that the source of distress is related to their physical symptom experience. Frequency and severity of distress and patient-identified sources of distress are being analyzed for the first year of the clinic program. VA clinic standards for longitudinal distress screening will be developed by January 2013.

Discussion: Distress management is a nursing-sensitive outcome for quality cancer care. Although distress may be related to the psychological, social, or spiritual domains of quality of life, patients in this clinic frequently reported distress related to physical symptoms associated with cancer or its treatment. Oncology nurses can decrease distress and effectively utilize limited psychosocial resources by identifying the source of the distress and intervening with the appropriate management.

136629 (Poster)

PATIENT-SPECIFIC VACCINE THERAPY: THE TIME IS NOW.

Cynthia Holt Bedell, MSN, RN, ANP-C, Mary Crowley Cancer Research Center, Dallas, Texas; Trish McCord, RN, Baylor Plano, Plano, Texas; Janet Weidenbach, BSN, RN, OCN®, Mary Crowley Cancer Research Center, Dallas, Texas

Significance and Background: Enhancing the immune system through vaccine therapy has challenged scientists for the last fifty years. Only recently have vaccines successfully prevented cancer or improved the survival of individuals with cancer. Currently two vaccines are approved by the FDA for cancer prevention: hepatitis B and human papillomavirus types 16 and 18. Only one vaccine has FDA approval for the treatment of cancer; sipuleucel-T in the treatment of prostate cancer. A new cancer treatment approach under clinical investigation is the use of an autologous vaccine incorporating the patient’s own tumor antigens to enhance the immune system. These patient

specific tumor antigens are then used to re-educate the patient’s immune system to target the cancer for destruction. Except for sipuleucel-T which uses a patient’s dendritic cells, there are no FDA approved autologous tumor vaccines.

Purpose: However with multiple such clinical research trials underway, nurses need to be prepared for this new approach to cancer treatment.

Interventions: The first step in autologous vaccine production is the harvesting of the tumor. Tumor may be harvested at the time of definitive diagnosis and tumor debulking, during metastasectomy or during palliative surgery to diminish tumor burden. Challenges include patient education during a high stress pre-operative period, coordination of multiple departments including, surgeon’s office, operating room, pathologist, transport systems and the laboratory where vaccine will be produced. Education and coordination should include the patient consent, handling and processing of the tumor, and transporting the tumor to the lab. Once the vaccine has been manufactured, timing of its’ administration is critical. Patients will need to have adequate immune cells to enable the immune system education.

Evaluation: The techniques for giving the vaccine have to be understood and demonstrated. Methods for assessing injection site reactions need to be consistent and well documented, possibly using photographs or other measuring tools. Staff and patient education should include potential short term and long term complications such as injection site reactions, flu-like symptoms and stimulation of autoimmune diseases.

Discussion: Vaccine therapies hold promise for new long term control of cancer. Are you ready to provide this new treatment for patients?

136685 (Poster)

LANGUAGE BARRIERS AND CULTURALLY SENSITIVE CARE: TRANSLATING MENUS FOR NON-ENGLISH SPEAKING PATIENTS.

Minimol Xavier, RN, BSN, MD Anderson Cancer Center, Houston, Texas; Vlasta Aubrecht, RN, BSN, MD Anderson Cancer Center, Houston, Texas; Vivian Perkins, RN, BSN, OCN®, MD Anderson Cancer Center, Houston, Texas; Decoteau Silvestina, RN, MSN, NEA-BC, MD Anderson Cancer Center, Houston, Texas; DeCoteau Silvestina, RN, MSN, NEA-BC, MD Anderson Cancer Center, Houston, Texas

Significance and Background: Current research shows that proper nutrition can reduce a patient’s hospital stay and hasten healing and recovery. A major barrier to proper nutrition is a patient’s inability to understand hospital menus that are primarily in English. Our oncology institution provides care for a culturally diverse population with patients from different countries and cultures who are unfamiliar with the English language. Interpreting the menu and being able to order meals, and lack of readily available interpreters is challenging for non-English speaking patients. Failure of healthcare professional to address the cultural needs of patients can lead to poor clinical outcomes.

Purpose: To provide better service to meet the nutritional needs of non-English speaking patients by providing menus in languages representative of the diverse patients admitted to the institution.

Interventions: A professional action coordinating team (PACT) consisting of representatives from language assistance, clinical nutrition, and nurse representatives from various oncology specialty units was convened to provide solutions to better accommodate the needs of non-English speaking patients. Translational service was instrumental in creating and completing menus for soft, regular, clear liquid, diabetic, and neutropenic diets in five languages: Spanish, Turkish, Chinese, Vietnamese, and Arabic. Additionally, changes have been implemented to identify and educate non-English speaking patient. This ini-

tative has been adopted for full implementation institution wide.

Evaluation: The institutional PACT identified a need to provide menus in a variety of languages to improve nutritional service and meet the cultural needs of our diverse patient population. Nurses and nutritional services will obtain patient feedback from Press Ganey patient satisfaction scores on food / nutrition, and randomized survey of patients.

Discussion: Healthcare professional must be cognizant of the importance of effectively communicating with non-English speaking patients and effects on patient outcomes. To meet the needs of the patient and maintain regulatory compliance, healthcare institutions must implement processes that address language and cultural differences.

136728 (Poster)

PROACTIVE ADVERSE EVENT MANAGEMENT IN REGORAFENIB-TREATED PATIENTS WITH METASTATIC COLORECTAL CANCER. Taline Khoukaz, MSN, ACNP-C, Keck Hospital of USC, USC Norris Cancer Center, Los Angeles, California; Jessica Mitchell, RN, CNP, Mayo Clinic, Rochester, Minnesota

Significance and Background: Adherence and persistence of oral anti-cancer medications can be challenging for many patients. Patients with metastatic colorectal cancer (mCRC) frequently experience treatment-related adverse events (AEs), which may lead to non-adherence or discontinuation from their treatment regimen.

Purpose: Regorafenib (Stivarga®) is an oral multi-kinase inhibitor approved by the US-Food and Drug Administration in September 2012 for patients with mCRC who have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if KRAS wild-type, an anti-EGFR therapy. Approval was based on a multi-center, double-blind, placebo-controlled phase III study with 2:1 randomization (CORRECT), that showed superior overall survival and progression-free survival of regorafenib compared to placebo. While regorafenib showed an acceptable safety profile, patients experienced AEs such as hand-foot skin reaction, hypertension, fatigue, diarrhea and oral mucositis, and some patients showed an elevation of liver enzymes (AST and ALT) and hyperbilirubinemia. However, the overall discontinuation rate of regorafenib randomized patients (from treatment-related AEs) was low (8.3%, N=505 versus 2.7%, N=255 placebo), suggesting many AEs can be managed.

Interventions: Here we describe a strategic proactive approach to AE management in mCRC patients treated with regorafenib to maximize patient adherence that emphasizes patient AE education and reinforcement, as well as frequent clinic visits early in the initiation of therapy. For example, a common AE that occurred in patients treated with regorafenib was hand-foot skin reaction (47%, N=500 versus 7.5%, N=253 placebo), a dermatological toxicity characterized by hyperkeratotic lesions and erythema near joints and pressure points.

Evaluation: Hand-foot skin reaction occurs early during treatment and can be prevented or managed by prophylactic strategies including the use of emollient or keratolytic creams, removal of calluses, and proper protection of joints and pressure points. In addition, serious liver abnormalities, which were observed in a small proportion of patients, should be monitored frequently in the first two cycles of treatment so that dosing can be adjusted if necessary.

Discussion: Overall, AEs associated with regorafenib are manageable if a proactive strategy is applied including prophylaxis treatment as well as patient, caregiver and healthcare provider education. Proactive management allows patients to be treated with regorafenib without compromising its clinical benefit.

136729 (Poster)

READ BETWEEN THE LINES: A FRONT-LINE STRATEGY FOR REDUCING CENTRAL LINE ACQUIRED BLOOD STREAM INFECTIONS. Richard Miller, RN, BSN, OCN®, UHCCM Seidman Cancer Center, Cleveland, Ohio

Significance and Background: Central lines are an integral component of oncology treatments. Unfortunately, Central Line Acquired Blood Stream Infections (CLABSI) remain the most life-threatening, yet preventable, complication of intravenous therapy. The Centers for Disease Control identify possible causes of CLABSI as poor hand hygiene, contaminated IV fluids, non-sterile technique during dressing changes, and improper flushing. Furthermore, hospital costs of managing CLABSI are no longer reimbursed by Medicare. Estimated costs from a single episode are as high as \$56,000. CLABSI rates were above the national benchmark at our academic medical center.

Purpose: The purpose of this project was to implement a practice change based on current evidence to decrease the CLABSI rate.

Interventions: Review of evidence-based literature on CLABSI revealed that several new products were available for dressing changes. Chlorhexidine Gluconate gel pad data was quite promising with its broad antimicrobial effect against a variety of gram-positive and gram-negative bacteria, including organisms most commonly associated with CLABSI. The hospital's Comprehensive Unit-based Safety Program was the appropriate mechanism to suggest this practice change. With the committee's support and multiple steps, the practice change was made not just at the unit level, but throughout the entire medical center.

Evaluation: After four months, the CLABSI rate on the hematological malignancy unit was reduced by 42%. The CLABSI rate was below the national benchmark for 3 out of 4 months. These results cannot be totally attributed to our dressing change procedure, as several changes were made at the same time, but the positive results have increased our commitment to continuing this new practice. Evaluation and monitoring is ongoing.

Discussion: Front-line oncology nurses have a unique understanding of the challenges that encompass providing patient care and the specific needs of this patient population. This evidence-based practice project demonstrated how one bedside nurse was able to change a practice throughout an entire academic medical center. This change may contribute to lower CLABSI rates, hospital cost savings, and improved patient outcomes. All oncology nurses should feel empowered to consider daily practice, discover small changes that can make big differences, and be inspired to work with their organizations to influence positive patient outcomes.

136771 (Poster)

THE JOURNEY AND CONTINUED PROCESS TOWARD ACHIEVING CHEMOTHERAPY SAFETY. Karen Roesser, RN, MSN, AOCNS®, Thomas Johns Cancer Hospital, Richmond, Virginia; Susanne Colligon, MS, FNP, OCN®, Thomas Johns Cancer Hospital, Richmond, Virginia; Kelly Anchell, RN, OCN®, Thomas Johns Cancer Hospital, Richmond, Virginia; Brian Adkins, RN, OCN®, Thomas Johns Cancer Hospital, Richmond, Virginia; Tarshae Robinson-Coker, RN, OCN®, Thomas Johns Cancer Hospital, Richmond, Virginia; Jessica Robinson-Coker, RN, Thomas Johns Cancer Hospital, Richmond, Virginia; Darlene Johnson, RN, BSN, OCN®, Thomas Johns Cancer Hospital, Richmond, Virginia

Significance and Background: Both the Joint Commission and the Occupational Safety and Health Administration (OSHA) consider the administration of chemotherapy to be a high risk procedure. This is because should errors occur, they can result

in severe adverse effects and may even result in a sentinel event. Each institution should strive for a proactive approach which focuses on improved processes, documentation, and education all with patient safety in mind.

Purpose: The purpose of this is to describe the measures established which together have resulted in a remarkable patient safety record related to the administration of chemotherapy.

Interventions: The following measures have been instituted over a period of years to provide continued chemotherapy safety:

1. Development of a chemotherapy ordering form which includes all necessary supportive measures (hydration, antiemetics, etc.). This form has been amended three times.
2. Development of a Failure, Mode, and Effects Analysis (FMEA) to review this form and our chemotherapy processes which resulted in form changes and education.
3. Establishment of a specific safety process when both intrathecal and intravenous chemotherapy are ordered on a patient.
4. Development of individual chemotherapy ordering forms for specific regimens and for hypersensitivity reactions.
5. Provision of a tabbed section of the medical record which includes all chemotherapy related information (orders, compatibility, consent, dosage calculations, etc.)
6. Development of a Chemotherapy Advisory Council to review all policies, order forms, errors/near misses.
7. Development of a Chemotherapy Independent Verification Checklist for initial RN review and at the bedside.

Evaluation: Our chemotherapy errors has been very low with 0-7/year for 2008-2011. With 2,500 dosages/year, this represents a 0-29% error rate. An increase in errors to 1.3% in 2012 has resulted in the development of the Chemotherapy Independent Verification Checklist. Since its institution, no chemotherapy errors have occurred.

Discussion: The importance of chemotherapy safety cannot be overestimated. Policies, processes, forms, documentation, and education need to be continually reviewed to ensure that everything that can be done to ensure safety is occurring. ASCO and ONS have established continued standards for safe administration which each institution should review and incorporate into practice. It is only through continued attentiveness that safety occurs.

136804 (Poster)

NURSING CONSIDERATIONS FOR HEMIPLECTOMY: EVIDENCE-BASED NURSING PRACTICE. Rachel Chandu, RN, BSN, CMSRN, MD Anderson Cancer Center, Houston, Texas; Moly Cheriyan, RN, BSN, CMSRN, MD Anderson Cancer Center, Houston, Texas; Sarah Joy, RN, BSN, OCN®, MD Anderson Cancer Center, Houston, Texas; Silvestina DeCoteau, RN, MSN, NEA-BC, MD Anderson Cancer Center, Houston, Texas

Significance and Background: Hemipelvectomy (HP), a surgical amputation of the pelvis, the innominate bone and the leg, is considered the best form of treatment for high grade sarcoma. This surgery involves a lot of physical, psychological and emotional stress involving the loss of a limb and extensive rehabilitation necessary post-surgery. Management of these stressors are prolonged preoperatively, postoperatively and even after discharge from hospital. To assure that HP patients receive standard of care throughout the unit, a group of nurses developed evidence-based care recommendations and presented to all the nurses on the unit.

Purpose: To determine the best evidence for nursing care of patients after hemipelvectomy that would be used by all nurses on our unit. These care recommendations would be utilized to appropriately assess patients, establish an up-to date plan of care for interventions to prevent complications, and provide optimal teaching for the patients and the caregiver throughout the continuum of care and return to the community.

Interventions: A review of literature was conducted by a group of clinical nurses to determine the best evidence for post-operative care and management of hemipelvectomy patients. Plan of care was developed along with recommendations after surgery. This evidence was presented to all the nurses throughout the unit. These care recommendations will be applicable to all new nurses on orientation as well as to all nurses in the unit.

Evaluation: The nursing staff found the information beneficial to the care of hemipelvectomy patients. The new knowledge has improvised new knowledge and improved clinical practice. Nurses found the evidence-based presentation relevant, updated and beneficial in managing post-operative care of hemipelvectomy patients.

Discussion: Nurses play a significant role in ensuring optimal patient outcome for our oncology patients. It is important for all nurses to be equipped with the knowledge for prompt interventions and support for the patients and their families. This evidence-based care recommendation presentation will be helpful to all oncology nurses for future research.

136806 (Poster)

IMPLEMENTING A NURSE DRIVEN TOBACCO CESSATION PROGRAM FOR NEWLY DIAGNOSED ONCOLOGY PATIENTS. Bruce Grant, RN, BSN, OCN®, Spartanburg Regional Healthcare System, Spartanburg, South Carolina; Judy Drake, RN, CHPN, Spartanburg Regional Healthcare System, Spartanburg, South Carolina; Lucy Gansauer, RN, MSN, OCN®, Spartanburg Regional Healthcare System, Spartanburg, South Carolina; Patricia Hegedus, RN, OCN®, MBA, Spartanburg Regional Healthcare System, Spartanburg, South Carolina

Significance and Background: SRHS is a tobacco-free campus. Cancer patients receive the majority of their care in the GCC, which includes medical, radiation, and surgical oncologies, oncology support services, and the oncology inpatient unit. Before the implementation of the TCP the GCC had no personalized smoking cessation program, no designated smoking cessation counselor, and no organized referral process for the physicians to use.

Purpose: The purpose of this program is to minimize the impact of tobacco use among newly diagnosed cancer patients, family members and caregivers within the Gibbs Cancer Center (GCC).

Interventions: The program development process involved an extensive literature review and identification of evidence based interventions for tobacco cessation programs. The Quit Smart® program was selected because of its multiple intervention strategies, including counseling combined with pharmacotherapy, using the "fading" method, and brand switching. A registered nurse (RN) was chosen as the tobacco cessation counselor and obtained certification as a Quit Smart® leader. The certified counselor marketed the program to the various physicians' offices.

Following a referral, the initial assessment is done in the tobacco cessation counselor's office and requires one hour. Four counseling visits, averaging 15 to 30 minutes, are provided; then, either phone or follow up visits are made at 1 month and 3 months. For patients who reduced their tobacco use at the end of their counseling sessions, the follow up calls/visits are an excellent way to measure patient progress, and assess for relapse and need for further counseling. A Midas program was created as a working database to record initial assessments, subsequent visits, and satisfaction survey results. Lastly, patients are mailed a one page satisfaction survey after their completion of the TCP.

Evaluation: Before the implementation of the TCP the GCC had no personalized smoking cessation program, no designated smoking cessation counselor, and no organized referral process

for the physicians to use. Now, with the full integration of TCP into the patient referral process, the current program is operating at "best practice" levels. Due to the successful first two years of the TCP, the smoking cessation counselor position has been incorporated into the Cancer Survivorship Program and the TCP now benefits all cancer patients, family members and caregivers. From August, 2010, through March, 2012, 278 cancer patients, family members and caregivers were enrolled in the TCP. An impressive 20% of patients completing the TCP eliminated tobacco use, and of the 79% of patients who reduced their tobacco use, 95% maintained their tobacco reduction for one year.

Discussion: Through the use of Quit Smart certified nurse tobacco cessation counselor the tobacco use of most of the 278 cancer patients, family members, and caregivers has been decreased or stopped. To insure continued funding of the tobacco cessation counselor's position that job has been strategically assigned to the Cancer Survivorship Program at GCC, enabling all cancer patients to benefit from this support service.

136889 (Poster)

ONE SIMPLE CALL: THE DEVELOPMENT OF A TELEPHONE TRIAGE SCRIPT FOR PATIENTS ENROLLED IN HOME HOSPICE. Ann Culkun, RN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York

Significance and Background: Discussing end-of-life care can be challenging for even the most experienced oncology nurse. Care for patients with lung cancers is often coordinated in an outpatient setting with the nurse developing a therapeutic relationship with the patient and family. As a result, transitioning patients to end-of-life care is facilitated by the physician and nurse, and can be difficult when this relationship transitions to another care team. How does the nurse maintain a connection to patients while in home hospice?

Purpose: Transitioning end-of-life care from the treatment site to home, often located far away, requires effective communication. Challenges were noted when oncology nurses in a collaborative office practice for people diagnosed with lung cancers transitioned patients and caregivers to a home hospice program. A weekly telephone call to the patient and /or caregiver was implemented to provide coordination of care.

Interventions: In 2012, 44 lung cancer patients enrolled in a home hospice program received a weekly call from the primary oncology nurse. Initial education with the patient and the family included a description of home hospice services, what to expect and details of the intake process. This information was relayed verbally and with written information. In addition, information was shared informing the patient of a planned weekly phone call as a "check in" from the primary oncology team. The phone conversation focused on the patient and coordination of home care services. The nurse also assessed the health and well-being of the caregiver for coping and support.

Evaluation: Length of time for each call was less than 15 minutes. Of the 44 patients enrolled, the average length of stay in hospice was 19.8 days, with only one patient returning to the hospital for admission.

Discussion: Improving end-of-life discussion and coordination of care is a goal for all oncology nurses. This project took the initial steps to address the coordination of care from the treatment site to hospice. The implications for nursing practice include the development of a "script" to support this practice change. A review of the script, its development, and length of nursing time involved will be discussed.

136945 (Poster)

SAFE HANDLING OF CHEMOTHERAPY: IMPACT OF IMPLEMENTING A "CHEMO TIME OUT" PROCESS. Ann

Fuhrman, BSN, RN, OCN®, The Christ Hospital, Cincinnati, Ohio; Andrea Cline, BSN, RN, OCN®, The Christ Hospital, Cincinnati, Ohio; Jeanene Robison, MSN, RN, AOCN®, The Christ Hospital, Cincinnati, Ohio

Significance and Background: Oncology nurses at a Midwestern community hospital recognized two opportunities for improvement: (1) oncology staff's inconsistent compliance with appropriate use of chemotherapy safety personal protective equipment (PPE) in inpatient and outpatient oncology settings; and (2) patient/family "chatter" and phone use as sources of distractions when administering oncology drugs.

Purpose: The "Chemo Time Out" process was implemented for two purposes: (1) to increase the use of PPE by inpatient and outpatient oncology nursing staff, which follow the ONS Guidelines for Safe Handling; and (2) to decrease interruptions and distractions while administering chemotherapy / biotherapy, which is congruent with National Patient Safety Goals to limit distractions during medication administration. Surveys to measure compliance of using PPE appropriately and to measure level of distractions were distributed to outpatient and inpatient oncology staff during Fall, 2011. These surveys were repeated several months after the Chemo Time Out process was implemented.

Interventions: Interventions included:

- Staff/patient/family education on steps for implementing the specific "Chemo Time Out" process/ signage.
- "Chemo Time Out" signage described the process (e.g., patients and significant others were asked to refrain from discussions while the RN is wearing the blue chemo safety gown and administering the drugs) and was posted in patient rooms.
- Improvements in availability of chemotherapy safety PPE were implemented, including new chemotherapy gloves and disposable gowns; hooks placed in patient rooms and work areas to hang chemo gowns, and specified PPE storage areas.

Evaluation: The interventions were successful for increasing use of chemotherapy safety PPE, and decreasing the barriers to using PPE, by both inpatient and outpatient oncology nurses.

Interventions were successful for decreasing the distractions experienced by inpatient and outpatient oncology nurses. Outpatient nurses perceived phone calls during their shift to be more distracting than inpatient nurses.

Discussion: Minimal time and cost were required to implement "Chemo Time Out" process and outcomes were positive. Implications for oncology nursing practice include:

1. need to provide structure in patient rooms/patient care areas for PPE;
2. need to educate patients/family regarding importance of quiet during chemotherapy/biotherapy administration;
3. need to create process to minimize phone calls to oncology staff nurse during chemotherapy/biotherapy medication administration.

136987 (Poster)

MANAGEMENT OF NAUSEA AND VOMITING: RELATIONSHIP OF MODEL OF CARE, EMETOGENIC POTENTIAL AND ANTIEMETIC GUIDELINE USE ON PATIENT REPORT OF CHEMOTHERAPY INDUCED NAUSEA AND VOMITING. Deborah Selm-Orr, RN, MS, AOCN®, CRNP, Cancer Treatment Centers of America, Eastern Regional Medical Center, Philadelphia, Pennsylvania

Significance and Background: Oncology organizations including Oncology Nursing Society, National Comprehensive Cancer Network, and American Society of Clinical Oncology have published guidelines based on current evidence, yet patients continue to experience and express fears regarding CINV. This presentation/poster will discuss a recent pilot study that measured

variables of method of outpatient care, emetogenic potential of chemotherapy, antiemetics used, supplement and complementary medicine use, as well as nausea and vomiting. Evaluation of the effectiveness of implementing evidence based practice provides knowledge regarding effective interventions to control distressing symptoms that impact on patient quality of life.

Purpose: The major goal of this pilot study was to evaluate the impact of model of cancer care, comparing traditional care to Patient Empowered care. Other objectives included measuring patient assessment of chronic illness care, CINV, and quality of life. Other correlational factors such as use of supplements, massage and acupuncture were evaluated.

Interventions: The descriptive correlational pilot study was designed to evaluate the impact of model of care on CINV, but other outcome measures included emetogenic potential and antiemetic treatments utilized as well as complementary services utilized at the study facility. Patients with a diagnosis of cancer for at least 6 months, who had normal renal and liver function without recent radiation, not receiving adjuvant therapy; were approached to participate in the study. This was a onetime collection of data using descriptive information, the patient assessment of chronic illness care, the Rhodes nausea vomiting and retching scale and the European Organization for Research and Treatment of Cancer, Quality of Life Questionnaire-30(EORTC) were utilized to collect data.

Data collection occurred over a 4 month period. Patients were asked by infusion room nurses to participate and screening criteria were reviewed. Of 744 individual patients seen in the infusion room over that time period, 172 patients completed the questionnaires.

Evaluation: Currently, data is being analyzed. Of 172 patients, 40 patients were new to study site, with most patients receiving complementary treatments including massage, acupuncture and use of supplements. Reports of nausea and vomiting will be correlated and evaluated looking for relationship between Rhodes NVR scale and EORTC quality of life. This will assist in managing side effects of chemotherapy and improving quality of life for chemotherapy patients.

Discussion: Implications for oncology nursing practice include the validation of the need to perform ongoing reassessment of CINV. Utilization of complementary and alternative medicine can add to managing and controlling these symptoms. Actual measurement of emetogenic potential to determine antiemetic use would be important information. Providing evidence to support use of alternative treatments as well as standard antiemetic therapies will assist oncology nurses in providing up to date management of CINV.

137023 (Poster)

LOOK WHO IS BEING COOLED NOW: THERAPEUTIC HYPOTHERMIA POST CARDIAC ARREST IN THE ONCOLOGY PATIENT. Patricia Spellman-Foley, RN, MSN, MSKCC, New York, New York; Tara Caltabiano, RN, MSN, CCRN, MSKCC, New York, New York; Joyce Kane, RN, MSN, CCRN, OCN®, MSKCC, New York, New York

Significance and Background: Death from brain injury and/or poor neurologic outcome is common after cardiac arrest. The 2010 American Heart Association guidelines and ILCOR Consensus Statement of 2008 recommend considering an induced hypothermia protocol be administered to adult comatose patients with return of spontaneous circulation after in-hospital cardiac arrest of any initial rhythm. The goal is to decrease the body's core temperature thus protecting the brain from neurologic injury and improving neurological outcomes. Strict inclusion and exclusion criteria are usually included in hypothermia policies, many of which exclude our oncology ICU population. The process of cooling a patient followed by rewarming to normothermia carries many risks including life threatening electrolyte and fluid shifts. Despite the fact that this protocol would be

“high risk and low volume” in our unit, nursing still decided to embark on implementation knowing it would be worth it to our patients, even if only a few would benefit.

Purpose: Due to “high risk, low volume” status of this protocol, a user friendly device was purchased and an intensive training program was created. Additionally an in-depth evidence based policy was written, an order set developed, and current electronic documentation amended.

Interventions: Due to complexity of caring for patients post cardiac arrest, a multidisciplinary team was formed to develop a plan of care. Group of eight nurses formed a “superuser” group. The group wrote an evidence based nursing policy and worked with members of the multidisciplinary team to develop an electronic order set. They also trained the entire nursing staff after a “train the trainer” session approved by the company.

Evaluation: Project is currently ongoing. Quarterly inservicing provided by the super-users along with competency checklists. We are hoping the introduction of this product will encourage staff members to start thinking “hypothermia” the minute anyone has a cardiac arrest.

Discussion: Providing the nursing team with the tools, resources and involvement in the development and implementation of this current practice were the keys to its success. This promotes a stronger practice by staying current with ongoing research, providing up to date care focused on research findings before they become standard practice, and promoting recognition in nursing excellence.

137073 (Poster)

A MULTIDISCIPLINARY APPROACH TO INCREASE DISCHARGES BEFORE NOON ON THE INPATIENT ONCOLOGY SETTING. Mai-Fung Ho-Law, RN, MSN, OCN®, New York University Langone Medical Center, New York, New York; Michael Wuckovich, RN, BSN, New York University Langone Medical Center, New York, New York; Klara Culmone, RN, MSN, OCN®, New York University Langone Medical Center, New York, New York; Roseanne DeRiso, RN, MA, OCN®, New York University Langone Medical Center, New York, New York; Frances Cartwright, RN, PhD, AOCN®, New York University Langone Medical Center, New York, New York

Significance and Background: Discharges before noon (DBN) is an important initiative to ensure that patients arrive home or to a facility early in the day when needs and concerns can be addressed with the hospital's health care team, community pharmacy, and support services. DBN is associated with decreased length of stay (LOS), decreased readmission rate (RAR), and improved throughput from ED to hospital bed. Late discharges can negatively impact patient satisfaction.

Purpose: The DBN initiative is a nursing led process using a transdisciplinary model to ensure that the multidisciplinary team addresses all aspects of discharge planning for patients who are clinically ready.

Interventions: Staff meetings were held to discuss the benefits of DBN and to introduce the hospital-wide goal of 30% DBN. The daily multidisciplinary team rounds incorporated the identification of patients eligible for DBN. Each team member focused on their role in DBN which included organizing transportation, ordering and drawing labs at 4am, discharge teaching prior to discharge date, confirming discharge time with family or receiving facility. Around the clock updates were provided. Nursing, unit medical director, social work, case management and nurse practitioners provided ongoing education to the rotating house staff, fellows, and service attendings. Signs were posted in patient rooms noting discharge time of 10am. Team huddles were initiated to identify missed opportunities so that the processes could be improved.

Evaluation: In April 2012, the inpatient oncology unit achieved a DBN rate of 31%, a significant increase from the prior 12 months average DBN rate of 8%. The DBN rate continues to fluctuate but ranges between 30% and 52%. During this time, the readmission rate either remained steady or decreased indicating that the DBN patients were ready for discharge. The length of stay remained the same.

Discussion: The DBN initiative ensured that the multidisciplinary team shared a common goal. Nursing and the team reported that working together on this initiative improved overall collaboration and team spirit. Having a DBN goal for discharge helps patients and families to better plan for the day and facilitates more timely admissions and transfers.

137107 (Poster)

PATIENT EDUCATION PATHWAY FOR VAGINAL DILATION AFTER PELVIC RADIOTHERAPY. Larissa Day, BScN, MSc, CONC, Sunnybrook Odette Cancer Centre, Toronto, Ontario

Significance and Background: Pelvic radiation is a commonly used adjuvant treatment for cervical and endometrial cancers and women can experience a number of side effects, including vaginal stenosis, thinning of the vaginal mucosa, loss of lubrication, and loss of elasticity of the vagina. The use of a vaginal dilator facilitates medical examination of the vaginal vault, reduces sexual difficulties, improves psychological well being and facilitates resumption of sexual relations. Despite the potential benefits of dilator therapy, a qualitative study conducted at our centre revealed women found purchasing, owning and using a dilator embarrassing, they felt as though using the dilator was relieving the invasion of treatment, they were fearful of using it, and that it was simply not at the forefront of their recovery. Providing appropriate counseling, standardized patient education and addressing these barriers is crucial to these women's sexual health and ability to have comfortable follow up exams. Oncology nurses are uniquely positioned to address these issues and improve the patient experience.

Purpose: In this presentation newly developed tools and strategies to improve the patient experience and adherence to vaginal dilation therapy will be shared. These resources and this approach enable the specialized oncology nurse to feel prepared and comfortable facilitating crucial conversations and playing a vital role in patient education and counseling.

Interventions: The practice change consisted of a number of items, including interprofessional education sessions, updating our patient education material, producing a standardized vaginal dilator education pathway, making automatic referrals to our sexual health and rehabilitation clinic, developing our sexuality patient education class, and creating patient adherence diaries.

Evaluation: A formal evaluation examines the practice changes from both the patients' and the health care providers' perspectives. Patients and interprofessional team members were surveyed to capture their experiences. Patient self-report diaries measured a change in patient adherence to vaginal dilation therapy.

Discussion: The barriers to adherence are clear and it is the specialized oncology nurse who has the greatest opportunity to make a difference in the patient experience and ultimately the sexual health outcomes. It is vitally important more oncology nurses become comfortable with vaginal dilator education and that our recommendations are evidence based.

137137 (Podium)

THE BREAST CANCER SURVIVORSHIP QUALITY MEASURES: RESULTS OF A NATIONAL PILOT TEST OF EVIDENCE-BASED, PATIENT-CENTERED PERFORMANCE MEASURES FOR THE FIRST YEAR OF POST-TREATMENT

SURVIVORSHIP. Kristen Fessele, RN, MSN, AOCN®, Oncology Nursing Society, Pittsburgh, Pennsylvania

Significance and Background: Though several national oncology quality reporting programs exist, few focus on patient needs during the post-treatment survivorship period, which are distinct from those in the diagnostic and treatment phases. There is a need to objectively measure how consistently evidence-based care practices are implemented through development of quality measures (QM) for topics valued by nurses, patients and caregivers.

Purpose: To describe the design, process and results of the ONS Foundation-sponsored, national pilot test of the Breast Cancer Survivorship Quality Measures (BCSQM) project.

Interventions: The BCSQM set was developed by an ONS project team after extensive review of current evidence to guide the care of the patient after completing treatment for early stage breast cancer. From January through May 2012, 42 diverse national clinical practice sites contributed over 1700 patient cases examining the 12 month post-treatment period for Stages 0-III breast cancer. Measure topics include multi-symptom assessment, intervention for clinically significant problems, education specific to post-therapy concerns, evidence of patient engagement in health related goal setting and attainment, follow up care targeted to therapy administered, and the percentage of patients with improvement in fatigue and psychosocial distress one year post treatment. Focus groups, surveys and site visits for project staff re-abstractation were conducted to evaluate measure validity and reliability for use across all practice settings.

Evaluation: BCSQM results indicate opportunities to enhance the consistency in providing high quality care to this population. National rates were reported as: recommended symptom assessments (5.2%), interventions for clinically significant problems (1.81%), recommended elements of post-treatment education (3.87%), follow up care (70.2%), and a patient-engaged goal setting rate of 18.64%, with 75.4% of those patients demonstrating progress towards goal attainment. Fatigue and psychosocial distress improvement rates one year post-treatment were 6.08% and 3.86%, respectively.

Discussion: Development of QM allows objective evaluation of how consistently clinical practice recommendations are implemented. Testing indicates the need to educate broadly on the persistence of symptoms in the post-treatment population and effective symptom management, and for future research on the optimal dose and timing of nursing interventions to improve outcomes.

137155 (Poster)

FOLLOW-UP TO DELIVERING THE SAFEST AND QUICKEST CARE IN THE IN-PATIENT ONCOLOGY UNIT: MAKING THE CASE FOR THE "CHEMOTHERAPY READY" ADMISSION. Klara Culmone, RN, MSN, OCN®, New York University Langone Medical Center, New York, New York; Mai Ho-Law, RN, MSN, OCN®, New York University Langone Medical Center, New York, New York; German Rodriguez, RN, MS, New York University Langone Medical Center, New York, New York; Roseanne DeRiso, RN, MA, OCN®, New York University Langone Medical Center, New York, New York; Frances Cartwright, RN, PhD, AOCN®, New York University Langone Medical Center, New York, New York; Shannon Cartwright, MS, FNP-BC, AOCNP®, New York University Langone Medical Center, New York, New York

Underwriting or funding source: Amgen

Significance and Background: Inpatient chemotherapy regimens have become increasingly complex. Upon admission, patients wait long periods of time to receive their chemotherapy treatments for many reasons. A new process was initiated in November 2011. Following implementation, the average

turnaround time (TAT) from admission to administration of chemotherapy infusion began to decrease.

Purpose: Multidisciplinary team members share the common goal of decreasing the average chemotherapy infusion TAT by 50% while maintaining patient safety. The process was modified by developing an additional auditing tool that would serve as daily communication between inpatient and outpatient team members and identify opportunities for improvement within the process.

Interventions: Prior to implementing the new process, diagnostic imaging, lab work, and chemotherapy orders were initiated at the time of patient's arrival to the unit, resulting in a wait time of 9 hours 42 minutes for chemotherapy administration. Upon review of this workflow, it was recognized that all of this could be completed as an outpatient. In the new process, pre-admission criteria were standardized. Outpatient clinicians utilizing standardized chemotherapy treatment plans entered orders in advance. A pre-existing "Pre-admission Form for Elective Chemotherapy Admissions" checklist was revised to facilitate handoff from outpatient to inpatient. The admitting department reserved beds for chemotherapy admissions. An auditing form was created to further analyze time points in the process e.g., lab work done prior to admission, placement of venous access device as outpatient, chemotherapy mixed by pharmacy prior to patient's arrival, time of chemotherapy delivery to nursing unit, time RN initiated chemotherapy administration, etc..

Evaluation: From November 2011 to October 2012, the data from 231 chemotherapy admissions was collected and analyzed. As of October 2012, data showed that the TAT has been reduced to 5 hours and 59 minutes which is a decrease of approximately 38% from the original TAT.

Discussion: With the addition of the newly developed auditing form, the multidisciplinary clinical team improved communication by providing transparency about patient care expectations. We will continue to educate the oncology nursing staff on the process and build this into the culture of our nursing practice. This project remains as one of the quality improvement initiatives for the oncology service.

137194 (Poster)

MANAGEMENT OF NAUSEA AND VOMITING: RELATIONSHIP OF MODEL OF CARE, EMETOGENIC POTENTIAL AND ANTIEMETIC GUIDELINE USE ON PATIENT REPORT OF CHEMOTHERAPY INDUCED NAUSEA AND VOMITING. Deborah Selm-Orr, RN, MS, AOCN®, CRNP, Cancer Treatment Centers of America, Philadelphia, Pennsylvania

Significance and Background: Oncology organizations including Oncology Nursing Society, National Comprehensive Cancer Network, and American Society of Clinical Oncology have published guidelines based on current evidence, yet patients continue to experience and express fears regarding CINV. Action of the effectiveness of implementing evidence based practice provides knowledge regarding effective interventions to control distressing symptoms that impact on patient quality of life.

Purpose: The major goal of the study was to evaluate the impact of model of cancer care, comparing traditional care to Patient Empowered care. Other objectives included measuring patient assessment of chronic illness care, CINV, and quality of life. Other correlational factors such as use of supplements, massage and acupuncture were evaluated.

Interventions: The descriptive correlational pilot study was designed to evaluate the impact of model of care on CINV. Outcome measures included emetogenic potential, antiemetic treatments, as well as complementary services utilized. Patients with a diagnosis of cancer for at least 6 months, normal renal, liver function without recent radiation, not receiving adjuvant therapy; were approached to participate in the study. Data collection occurred over a 4 month period. Patients were asked by infusion room nurses to participate and then screened. Of 744 patients, 172 patients participated.

Evaluation: Currently, data is being analyzed. Of 172 patients, 40 patients were new to study site, with most patients receiving complementary treatments including massage, acupuncture and use of supplements. Reports of nausea and vomiting will be correlated and evaluated looking for relationship between Rhodes NVR scale and EORTC quality of life. This will assist in managing side effects of chemotherapy and improving quality of life for chemotherapy patients.

Discussion: Implications for oncology nursing practice include the validation of the need to perform ongoing reassessment of CINV. Utilization of complementary and alternative medicine can add to managing and controlling these symptoms. Actual measurement of emetogenic potential to determine antiemetic use would be important information. Providing evidence to support use of alternative treatments as well as standard antiemetic therapies will assist oncology nurses in providing up to date management of CINV.

137202 (Poster)

SUPPORTIVE ONCO-DERMATOLOGY AND ONCOLOGY NURSING: A PARTNERSHIP IN CARING FOR PATIENTS WITH DERMATOLOGIC TOXICITIES. Kathleen Madden, RN, MSN, BSN, FNP-BC, AOCNP®, NYU Langone Cancer Institute, New York, New York; Rajni Kannan, MS, BS, ANP-BC, OCN®, NYU Langone Medical Center, New York, New York; Caroline Muren, RN, BSN, OCN®, NYU Langone Cancer Institute, New York, New York; Crystal Escano, RN, BSN, NYU Langone Cancer Institute, New York, New York; Claire Stein, RN, BSN, OCN®, NYU Langone Cancer Institute, New York, New York

Significance and Background: Dermatologic toxicities have become more prevalent with the expanded use of immune and targeted therapies in oncology care. Cutaneous manifestations such as rash, pruritis, skin growths, fissures, exfoliation and pigmentation changes are some of the toxicities noted by patients to be physically distressing and potentially psychologically isolating. Cancer Care conducted a survey of 345 patients receiving oncologic therapies, revealing that two in five patients were not concerned with the possibility of skin toxicity. However 80% of patients who experienced dermatologic toxicities were actually very concerned about their symptoms and the impact on their daily function. Additionally, 63% of patients admitted, having underestimated the severity and impact that the dermatologic toxicities had on the quality of their lives. Recognition of this growing need has led to the development of Supportive Onco-Dermatology (SOD), an emerging specialty field focused on preventing dermatologic adverse events as a result of oncologic therapies. This dermatologic specialty encompasses and provides support to both patient and oncology care provider. Oncology nurses have a pivotal role in the dermatologic care of oncology patients from education to identification of toxicity during therapy, and symptom management.

Purpose: A collaborative initiative has been made between an SOD physician and several oncology nurses to develop and implement unbranded educational materials. The content, designed to be presented by oncology nurses to patients will encompass symptom identification and management strategies specific to cancer therapy induced skin toxicities.

Interventions: Educational materials will be utilized for teaching and supporting patients regarding the potential impact on quality of life in relation to cutaneous toxicities. Educational sessions will be held for oncology nurses to properly prepare them in patient instruction.

Evaluation: Patient's knowledge will be evaluated by conducting a brief question and answer session. Key points regarding self-assessment and care will be reviewed at the conclusion of the teaching session and then at each follow up encounter.

Discussion: Oncology nurses play a vital role in the education, assessment, management and supportive care of patients experiencing dermatologic toxicity. The use of teaching materials, prompt recognition and reporting of toxicities will enhance timely interventions thereby, minimizing potential treatment interruptions and hospitalizations.

137493 (Poster)

THE HALLWAY OF HOPE: A COMMUNITY EMBRACES HEALING, COPING, AND HAPPINESS THROUGH CHILDREN'S ART. Margaret Helsley, MSN RN AOCNS®, Henrico Doctors' Hospital, Richmond, Virginia; Tracy Lynch, MA, Self-Employed, Richmond, Virginia

Significance and Background: One patient's breast cancer experience and idea shared with her oncology nurse navigator became a community-wide project to create the Hallway of Hope, a collaboration between the patient, the oncology nurse, and administrative leaders of the hospital and the school system (art directors, art teachers, and students K-12). The power of a single relationship between the oncology nurse and her patient cannot be underestimated, as it can provide a broader opportunity for a concept of healing that involves and benefits an entire community.

Purpose: The purpose was to assist one patient in finding meaning in her own recovery, which developed into a larger

project. The project empowered children to help those in need and to offer patients, even for just a few moments at a time, with positive visuals and messages.

Interventions: The nine-month program development involved administrative approval by the hospital and school system, and then a series of planning and communication meetings between these two groups. Guidelines for the artwork with age-appropriate explanations along with a description of how the artwork would impact the patients was presented to the 70 school-specific art teachers. Over 700 voluntary pieces of K-12 artwork under the theme "What Makes Me the Happiest" were submitted to the newly created permanent art gallery within the hospital.

Evaluation: Evaluative measures included the overwhelming response from the school system, the children, and their parents, in addition to the hospital physician, staff, and visitors. The magnitude of the response has resulted in a continuation of art rotations. Success in helping the patient find meaning is reflected in the fact that this project became a vehicle to assist the community - teachers, children, parents, health care professionals in their altruistic desires.

Discussion: The implications of this project is an example of how the oncology nurse relationship with a patient can evolve into a more powerful and extensive support program. Other implications include the endless opportunities to connect with the community through their school systems whether for psychosocial support or educational programs.