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4036

STRATEGIES TO REDUCE MENTAL FATIGUE IN CAREGIVERS.

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Mental fatigue of the caregiver can lead to significantly impaired mood and function. This impairment is not only of consequence to the caregiver but to the care recipient. The caregiver's capacity to respond effectively to many demands of daily caregiving lessens with prolonged use of mental resources. Mental fatigue manifestations are irritability, lack of concentration, impaired memory, and frequent errors. Nursing is in a prime position to reduce mental fatigue in caregivers.

The purpose of this paper is to identify interventions to prevent and reduce mental fatigue in caregivers of cancer patients utilizing the framework of attention restoration theory (ART).

Conservation and restoration of energy are two main strategies to prevent and reduce mental fatigue. Conservation involves teaching the caregiver to reduce the demands of caregiving by seeking the help of others. It also involves prioritizing activities and saving energy for the most important caregiving tasks.

Restoring the capacity to direct attention is a growing interest to the research community. Studies have shown that the restorative effect of nature enhances mental capacity and therefore reduces mental fatigue. Being outdoors creates a natural human response in the brain that allows mental rest and relief from the demands at hand. Simply being outdoors in surroundings with trees and plants provides the resource needed for counteracting mental fatigue. Incorporating the natural environment into the caregiver's daily regimen for a minimum of 30 minutes three times a week will allow the caregiver to restore the effort needed to provide safe care and a decreased level of perceived burden.

The Attentional Function Index will be used to measure the capacity of the caregiver to exert mental effort in common activities of daily living. This instrument was based on ART and is designed to capture perceived effectiveness in directing attention for planning, decision making, following a train of thought, and concentration.

It is important for the oncology advanced practice nurse to assess and help caregivers decrease mental fatigue by using strategies to conserve and restore mental energy. The use of nature is a simple yet overlooked intervention that may reduce care recipient and caregiver sequela.

4037

INNOVATIONS IN LUNG CANCER MANAGEMENT.

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In 2008, 215,000 new cases of lung cancer were diagnosed. Study has shown that diagnosis is delayed to up to four months due to patients undergoing consecutive procedures before a diagnosis of cancer is made. It was noted by physicians in Pomona Valley Hospital Medical Center (PVHMC) that some patients' suspicious chest x-rays from ER visits, pre-op testing and other routine tests are often not followed up on a timely manner. Our aim is to expedite lung cancer diagnosis and treatment. The Lung Cancer Program (LCP) at PVHMC was introduced and an advanced practice nurse (APN) was hired to lead this program. The APN has created a process to obtain outpatient chest x-ray and chest CAT scan reports that may be suspicious for lung cancer.

To streamline the process from suspicious chest x-ray findings to a definitive lung cancer diagnosis to less than 25 days and to expedite actual treatment time from diagnosis to less than 25 days.

A report of abnormal CXR and CT scan of the chest from outpatient departments and ER are generated daily. Keywords were identified by LCP physicians including key radiologists. Key words are "nodul" (to include nodule and nodular), "malignan" (to include malignant and malignancy), "suggest", "recommend", "follow-up", "mass", "neoplas" (to include neoplasm and neoplastic), "fullness", and "lesion". The APN determines if the patient requires further work-up based on LCP's protocol or ordering physician's preferences. The APN monitors the results of follow up studies until a diagnosis of lung cancer is ruled in or out.

A tool was developed to measure the time of suspicious finding (CXR or CT scan) to diagnosis. The goal is less than 25 days. Another indicator is a measure of the time from diagnosis to actual treatment (e.g. chemo, surgery) and the goal is also less than 25 days.

Since the start of APN in August of 2008, both measures have been below 20 days.

It is evident that APN has the knowledge and expertise not just in coordinating care but keen clinical decision making, collaboration, education and continuous process improvement. This is a new concept that shows positive results. The concept of this program can definitely be adopted by other institutions.

4044

ENHANCING END OF LIFE CARE WITH DIGNITY: HOSPICE NURSING IN ROMANIA.

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Hospices of Hope (HOH) is the leading palliative care charity in South East Europe and is dedicated to improving the lives of the terminally ill in Romania and surrounding countries by increasing access to hospice care and training. The nurses at HOH significantly contribute to the ongoing care of patients at the end of life in Romania through support and training of palliative care nurses. The New England Alliance of HOH is composed of a collaborative team of nursing scholars from Simmons College in Boston, Massachusetts, the University of Rhode Island, and nursing professionals from the hospice in Romania. On a quarterly basis, the Alliance organizes a teleconference to address clinical, multidisciplinary and socio-cultural

issues related to end of life care in Romania. This team has also visited the country to provide education and clinical support to our hospice nursing colleagues.

The purpose of this project is to identify and define the nursing interventions currently utilized by the Romanian nurses affiliated with Hospices of Hope that promote patient dignity and enable a peaceful death. The project will validate and endorse expert end of life nursing practice that contributes to dignity at the time of death in Romania and advance international end of life nursing collaboration.

The Dignity-Conserving Care Model will then be used to develop programmatic changes in nursing practice to help the nurses implement quality improvement measures and education based on needs identified by the Survey.

An assessment of the Romanian nurses' understanding of dignified dying and interventions they currently use to promote this concept will be identified using the International Classification for Nursing Practice (ICNP) Nursing Language Survey. Results of the ICNP Survey will be used to correlate the nursing interventions utilized by the Romanian nurses affiliated with HOH with dignified dying practices and to identify interventions that could assist them in their end of life work. The Survey results will be analyzed using descriptive correlative statistics.

Teleconferencing technology will be used to disseminate the results and facilitate continued collaboration with the Romanian nurses as they work to integrate recommendations into their daily practice.

4045

IT'S SO MUCH MORE THAN BODY IMAGE: DESIGN AND IMPLEMENTATION OF A SEXUAL WELLNESS CLINIC.

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Body image, sexuality and intimacy have been explored in the breast cancer literature for many years. More recently those same treatment-related side effects have been appearing in the literature of other malignancies. The quality of life that we promise our patients must include discussions often perceived as uncomfortable. Patient's experiences with these complex issues are as unique as their underlying malignancy. It is the role of the APN to acknowledge all of our patient's needs and concerns, and help patients navigate the healthcare system to find the resources they need to enhance their quality of life on all levels.

The purpose of this poster is to describe the design and implementation of a multidisciplinary sexual wellness clinic for a diverse adult cancer population in an academic setting. This scholarly undertaking is the Capstone project of a DNP candidate at the University of Miami School of Nursing and Health Studies.

This multidisciplinary, advance practice nurse-driven clinic will provide individual and couples counseling, communication, education, and awareness activities to support patients and couples coping with the challenges that cancer diagnoses and treatments bring to relationships and intimacy.

Sexuality and intimacy are an important part of normal life for most individuals, but with chronic illnesses like cancer, quality of life often has a deeper and more complex meaning. Advance practice nurses, along with other experts on a multidisciplinary team, should be comfortable with addressing sexuality issues with patients, and at the same time provide patients and their partners with skilled interventions to manage and resolve these treatment related problems and help maintain their relationships and quality of life.

APN's and other cancer professionals must normalize discussions about sexual health and intimacy to all adult cancer patients. The concerns are not just for and about female patients, but men will have the same or similar need to discuss intimacy, relationship, and sexuality concerns with their healthcare provider. As APN's personalize cancer and survivorship care for our patients, there are increasing opportunities for evaluation, education, and explanations regarding sexuality and intimacy. As experts, APN's must do all we can to improve communication regarding these sensitive and personal issues.

4046

REMS: AN IMPORTANT ACRONYM FOR NURSE PRACTITIONERS.

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The FDA has begun identifying drugs and biological products approved or licensed that are deemed to have a Risk Evaluation and Mitigation Strategy (REMS). REMS is a strategy to manage a potential/known serious risk/side effect of a drug or biological product. Pharmaceutical companies were required to submit their plan to the FDA by September 2008, outlining their medication guide, patient package insert, a communication plan, elements to assure safe use, and an implementation system for healthcare practitioners participation. On February 6, 2009, the FDA sent letters to pharmaceutical companies manufacturing certain opioid products requiring companies to have developed a REMS program.

The purpose of this project is to help advance practice nurses (APNs) gain an understanding of REMS and the implications to their practice.

Opioids containing fentanyl, hydromorphone, methadone, morphine, oxycodone, and oxymorphone will be under the Food and Drug Administration Amendments Act (FDAAA). The FDA hopes to balance access for adequate pain control for patients, yet reduce the abuse/misuse of opioids. Therefore a risk management program will need to be developed and prescribers adhere to the plans approved by the FDA. Description of the six elements to assure safety will be described. Ultimately, practitioners will be required to have certification to demonstrate that they can diagnose the condition requiring opioids, understand the risks/benefits, and treat potential adverse reactions.

The implications for APNs who want to continue prescribing these opioids will be required to obtain training certifications from pharmaceutical companies (i.e. enrolling in REMS), will need to be prepared for recertification and reenrollment, and to have systems in place (including order sets, protocols, and evaluation procedures) to ensure drugs are dispensed only to patients with evidence of safe use.

Examples of REMS programs for those prescribing opioids will be presented.

4048

COST EFFECTIVENESS ANALYSIS OF ANTIFUNGAL PROPHYLAXIS IN HEMATOPOIETIC STEM CELL TRANSPLANT RECIPIENTS.

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Invasive fungal infections, if contracted, can cause significant morbidity and mortality in recipients of hematopoietic stem cell transplants. Because of the associated morbidity and mortality, prophylactic interventions have been employed to prevent or minimize the risk of invasive fungal infections. Besides fluconazole, which has been the standard of care, newer pharmaceuti-

cal agents have become available. Minimal research has been conducted on the incremental cost effectiveness of the various pharmaceutical treatment options.

To estimate the cost effectiveness of antifungal prophylaxis of two newer antifungal agents, itraconazole and voriconazole, compared to fluconazole for the prevention of invasive fungal infections (IFI) in hematopoietic stem cell transplant recipients in the immediate post-transplant period.

A decision-analytic Markov model was developed to compare the clinical benefits and costs associated with 2 antifungal prophylaxis strategies. Itraconazole and voriconazole were compared to fluconazole. The base case analysis was consistent with the Panel Recommendations for a Reference Case, using the societal perspective. Results are reported in 2008 US dollars, life years (LY), and quality-adjusted life years (QALY). The willingness-to-pay (WTP) threshold was $100,000/QALY. Sensitivity analyses included one-way analyses for each variable and probabilistic analyses (including cost effectiveness acceptability curves (CEAC)).

Itraconazole was found to be the cost effective option with a willingness to pay threshold of $100,000 per quality adjusted life year. Voriconazole did not meet the willingness to pay threshold to be considered cost effective when compared to fluconazole in the base case analysis. Additionally, voriconazole never had a greater probability of being cost effective when compared to itraconazole and fluconazole in the probabilistic sensitivity analyses.

This economic evaluation suggests that itraconazole is most the cost effective treatment option at a WTP thresholdof $100,000/QALY. Although itraconazole appears more expensive at face value, its health benefits make it an attractive prophylaxis option. Cost effectiveness analysis has emerged as a valuable methodology for nursing research. It is essential that nurses, key decision makers who influence health policy, understand cost effectiveness research and incorporate the methodology into studies.

4054

HOSPITAL ONCOLOGY ADVANCED PRACTICE NURSE (APN) AS ADJUNCT FACULTY: INNOVATIVE CLINICAL EDUCATION FOR BSN STUDENTS ACROSS THE PERIOPERATIVE CONTINUUM.

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Current nursing workforce challenges include increasing undergraduate student enrollment while ensuring quality classroom and clinical resources. In spite of increasing applications to nursing programs, schools are faced with faculty shortages and limited sites for clinical placements. Educational institutions have tried various approaches to expand the pool of qualified faculty and accommodate the increasing numbers of students needed to counter the nationwide nursing shortage. Advanced practice nurses in the service setting represent a valuable and often underutilized group of potential faculty members. When APN's organize and supervise student experiences, they have the advantage of knowing the hospital's policies and procedures, technology and optimal learning experiences in the organization.

This project describes an informal academic-service partnership between an urban academic university and a comprehensive cancer center. The service based APN supervises final semester senior students in a clinical rotation organized around the care of surgical oncology patients. The oncology perioperative patient care continuum serves as the structural framework for the students' clinical experience, encompassing the pre-surgical, operating room and postanesthesia care clinical areas.

The overall course goal is to foster the transition from student to graduate nurse. Within the perioperative environment, students are paired with a preceptor prioritizing and delivering nursing care to patients. Students focus on concepts relevant to bedside patient management including patient safety, communication, time management, evidence based practice, delegation and the role and responsibilities of the charge nurse. Presentations by expert nurses during clinical conferences assist the students in completing evidence based practice and case management assignments. This clinical rotation exposes the students to the reality of specialty focused care in a professional oncology environment.

The academic-service partnership highlights the pivotal role of the oncology APN in coordinating and supervising quality undergraduate clinical experiences. The university places the students in an optimal nursing practice setting; the student has a positive learning experience with patients across the surgical care continuum and the hospital has the opportunity to evaluate students for possible recruitment.

Future recommendations include expanding the model to other oncology areas, adding APN's as faculty and designing strategies to systematically evaluate cost and benefit outcomes.

4055

ENDOCRINE SENSITIVE EARLY STAGE BREAST CANCER: PRELIMINARY FINDINGS OF PATIENT EXPERIENCE OF ADHERENCE TO ENDOCRINE-BASED ORAL CHEMOTHERAPY.

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Adjuvant endocrine-based oral chemotherapy (EBOC) is used in the treatment of early stage breast cancer and can extend over the course of 5–10 years, during which time there is less frequent communication with the care team. To date, little is known about women's experience of adherence on EBOC.

APNs caring for women with early-stage breast cancer have an important role in patients' adherence on EBOC. Planned treatment breaks of days to weeks have been used by physicians and APNs to promote adherence with some oral chemotherapies. Recent literature shows taking treatment less often than prescribed may impact treatment efficacy. However, little is known about the patient experience of adherence. The purpose of this study is to describe the experience of women who are taking EBOC including an exploration of the relationship between planned breaks and adherence.

Rogers Science of Unitary Beings provides a nursing framework that has methodological congruence with a phenomenological approach. According to Rogers, people are greater than the sum of their parts. This implies that an event such as breast cancer cannot be separated from the whole person. People are historical beings with many life experiences, which add to the complexity of who they are as person. In choosing this theoretical lens, the researcher does not assume knowledge of the experience and is open to what may be unearthed through the process of mutual dialogue.

A qualitative phenomenological design guided data collection and analysis. All female patients diagnosed with early stage breast cancer on EBOC and have taken a treatment break for any reason were eligible to participate in nurse led focus groups. Data analysis is underway.

Early findings suggest women on EBOC need more communication with their care team. Participants experienced distress and difficulty managing side effects of treatment. Through the focus groups, an opportunity to share experiences and receive support from one another emerged.

The results from this study will provide valuable information to APNs who care for this population. Findings will help guide further nursing research and interventions to promote adherence, and improve the care of women with breast cancer.

4056

MANAGING THE GROWTH OF A TRANSPLANT CENTER WITH REGARDS TO NURSE PRACTITIONER STAFFING. Heather Brom, CNP, James Cancer Hospital and Solove Research Institute, Columbus, OH

Nurse practitioners (NPs) play a vital and expanding role within our transplant program. In recent years, our program has experienced significant growth. As such, our NP staff has tripled as we work to provide coverage for an inpatient service and clinic while maintaining continuity of care.

The role of the NP has replaced a house-staffed inpatient service to one that is solely NP staffed. In the clinic, NPs have taken on an expanded role as the clinic population now includes all acute leukemia patients. With this growth has come the challenge of maintaining continuity of care throughout the transplant process.

Over the last few years, several models have been used to provide optimal coverage to the BMT inpatient service and clinic while maintaining the NP's satisfaction with their role. Each model presented its own unique problems. We are currently using a rotating model. NP's are assigned to clinic for three months and then assigned to the inpatient service for six months. The NP rotation is staggered so that there is only one newly assigned NP each month. When in the clinic the NP is assigned to follow two physicians' clinic patients. For example, when a patient has their physician clinic appointment on Monday and needs to be seen later in the week, the same NP follows the patient. NPs in the clinic are responsible for completing History and Physicals for recipient and donor workups and performing procedures. While inpatient, NPs are assigned "primary" patients to ensure continuity.

We meet monthly with our administrative and program directors to evaluate the NP role and our program growth. We rely heavily on verbal feedback from the staff; we are also considering a more formal survey. Patient satisfaction scores have been fairly stable with 92.7% of responders rating NP satisfaction 9/10 or higher (10 being the highest sore) in 2009 (90.4% in 2008).

Our NP staffing model is a constant work in progress. We are considering permanent inpatient and outpatient NP roles. Hopefully as our growth stabilizes we will be able to find balance between inpatient and outpatient NP coverage while maintaining patient continuity.

4058

EXPLORING THE GAP BETWEEN ONCOLOGY NURSE PRACTITIONER EDUCATION AND ENTRY TO PRACTICE. Margaret Rosenzweig, PhD, APN-BC, AOCNP®, University of Pittsburgh School of Nursing, Pittsburgh, PA; Joan Giblin, FNP-C, AOCN®, Emory Healthcare, Atlanta, GA; Marcia Mickle, ACNP, AOCN®, Northwestern Medical Faculty Foundation, Chicago, IL; Allison Morse, ScM, MSN, ANP-BC, WHNP, OCN®, St. Elizabeth's Medical Center, Boston, MA; Patricia Sheehy, ANP-BC, OCN®, Dana Farber Cancer Institute, Boston, MA; Valerie Sommer, FNP-C, AOCNP®, US Oncology, Kansas City, MO

Nurse practitioners have established evidence of cost-effectiveness, patient satisfaction and quality care outcomes in multiple care settings, prompting the rapid growth of these professionals in cancer care. There is strong anecdotal evidence that a "gap" exists between necessary nurse practitioner knowledge and skills for the cancer care setting and the academic preparation of NPs entering cancer care. The actual incidence, specific clinical and professional knowledge deficits and patient and professional outcomes from this "gap "are unknown.

A project team of experienced oncology nurse practitioners (ONP) "Bridging the Gap" Project Team, formulated through the Oncology Nursing Society developed a questionnaire to assess educational needs of ONPs as they entered cancer care. The purpose of this study was to:

1) Identify the specific skills and knowledge needed by the ONP on entry to cancer care.
2) Describe any gap between academic preparation and needed skills and knowledge on entry to cancer care.
3) Identify the source of education for the ONP on entry to cancer care.
4) Describe impact of ONP knowledge deficits on patient care outcomes.
5) Describe impact of ONP knowledge deficits on first position retention.

The work is guided by the Theory of Adult Learning. This theory orients adult educators to helping adults learn, utilizing the concept of self motivation and need for applicability.

Cross sectional, descriptive study. An electronic survey was developed among the "Bridging the Gap" project team at a weekend retreat. Questionnaire consists of 28 items, 17 demographic, 7 items assessing clinical and professional educational preparedness and 4 items assessing patient and professional outcomes of identified educational deficits. The questionnaire, was randomly distributed via electronic survey to 610 self described oncology nurse practitioners in the Oncology Nursing Society's data base. Results expected by July 31, 2009.

Results will be tabulated and analyzed in SPSS, V. 17 according to descriptive and correlational statistics. Identified learning needs and patient and professional outcomes from educational deficits at entry to oncology practice will inform nurse practitioner curriculum, cancer care orientation programs and continuing education offerings.

4060

CANCER PATIENT'S PERCEPTIONS OF ONCOLOGY NURSE PRACTITIONER ROLE IN CANCER MANAGEMENT: FUTURE IMPLICATIONS. Catherine Bishop, DNP, MSN, NP, AOCNP®, Oncology/Hematology of Loudoun and Reston, Lansdowne, VA

There is growing evidence that the nation is facing a physician shortage, largely driven by the aging of the population and a physician workforce that has not grown to meet the needs of the nation. A multifaceted strategy will be needed to ensure cancer patients have access to oncology services in the future. Many options under consideration are being addressed by the American Society of Clinical Oncology. One consideration is to increase the numbers of advanced Oncology Nurse Practitioners (ONP) who care for the oncology population. Increasing the number of advanced ONPs may minimize interruptions in care and decrease the problem of

unequal access for the cancer patient that would occur with the projected shortages.

The purpose of this study is to assess patients' understanding of the role of the Oncology Nurse Practitioner in their cancer management.

The present study used a modified version of grounded theory based on Glaser and Strauss's classic work and Glaser's updates. The method is appropriate for the topic because grounded theory is a process that seeks to discover theoretical explanations when little information is available on a topic.

Qualitative study of 30 oncology patients within two community oncology settings. Data collection instrument will be questionnaire.

Study is in progress and will be completed in August 2009.

4063

THE USE OF DIASTOLIC BLOOD PRESSURE AS AN EFFICACY BIOMARKER IN PATIENTS TREATED WITH AXITINIB.

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Vascular endothelial growth factor (VEGF)-targeted agents have emerged as successful cancer treatments. Predicting individual treatment benefit is critical for clinical decision-making but remains challenging. The identification of a valid, predictive biomarker of treatment outcomes is important to APNs, particularly if it is easily measurable and doesn't significantly burden patients.

To evaluate diastolic blood pressure (dBP) as a biomarker of axitinib efficacy

This study is based on the physiologic/pharmacologic mechanisms of axitinib, an inhibitor of VEGF receptors 1,2,3 currently in clinical development. It is hypothesized that axitinib's inhibitory effects on VEGFR2 and the endothelial nitric oxide synthase/Akt pathway decrease nitric oxide in arteriole walls and resistance vessels, resulting in vasoconstriction and increased BP. Thus, BP elevations associated with axitinib may indicate drug activity at the desired molecular target and be a predictor of treatment outcome.

We explored the relationship between dBP and clinical outcomes in this retrospective analysis of five Phase II axitinib trials in various solid tumors. Baseline BP 140/90mmHg was necessary for participation, and BP was measured at each clinic visit. Patients received axitinib 5 mg BID; dose reductions/interruptions and use of antihypertensives were permitted. Patients were retrospectively categorized into two groups: those with at least one dBP≥90mmHg (≥90 group) or without dBP≥90mmHg (<90 group) during treatment. We evaluated overall survival (OS), progression-free survival (PFS), objective response rate (ORR), and adverse events (AEs).

230/238 (96%) patients with dBP measurements comprised the two groups: <90 group (n=100) and ≥90 group (n=130). Demographic characteristics were similar between groups. The ≥90 group had significantly better clinical outcomes for OS (30.1 vs 10.2 months; HR=0.546; p<0.001), PFS (13.1 vs 5.8 months; HR=0.42; p<0.001) and ORR (43.9% vs 12.0 %; p<0.001). Grade 3/4 AEs were largely similar between groups.

dBP≥90mmHg **w**as significantly associated with favorable clinical outcomes, suggesting utility as an early biomarker of axitinib efficacy. These findings have clinical implications with respect to drug dosing, treatment monitoring, patient education, and future research. Prospective evaluation of the utility of BP response as a guide to drug dosing and correlation with subsequent clinical outcomes is ongoing.

4064

DEVELOPING A TELEPHONE TRIAGE ALGORITHM TO PROVIDE CONTINUITY OF CARE AND WRITTEN PRACTICE GUIDELINES.

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An existing telephone triage process was fragmented and in need of cohesion and structure for nurses covering the phone for two of the disease based teams. There were multiple calls, trips to clinic, and emails being exchanged between the nurse and the medical team for the patient. There is an average of 50 calls per practice per day for symptom management, for prescription refills, test results, reassurance, and appointment changes. The NPs and PAs in these settings were frustrated with the lack of cohesiveness and variation in timely follow through with the rotating staff covering telephone triage.

The need for development of telephone standards became a priority for this group in the clinic. A group including clinic managers, clinic staff, NPS, PAs, and the CNS was developed to review existing guidelines and review the process.

First a review of the most common calls received via triage and focusing on frequent complaints, basically treatment related side effects and pain management. The group met weekly for 6 weeks and determined "decision pathways" which included the appropriate gathering of information from the patient and how to convey symptoms to the providers for intervention in a timely manner. Also addressed was the appropriate response from the Triage nurse back to the patient. We utilized the Oncology Telephone Triage Guidelines, AAACN guidelines, and PEP cards for background and decision support criteria. A literature review was also completed.

By utilizing the EBP standards and discussion, we developed a set of algorithms for eleven different symptom scenarios. Each included the exact information for the nurse on the telephone to consistently obtain, how to prioritize reporting to medical team, and how to convey a response message to the patient or caregiver.

The continuing role of the APN is identified as educating nursing staff on how to use the algorithms, conferring with medical teams as to need for improvement in communication, and to next assist the medical teams in developing a set of standing orders for non emergent interventions; while allowing Triage Nurses to function within their scope of practice. The process will be evaluated at regular intervals.

4066

USING BEST PRACTICES IN A CLINICAL GUIDELINE FOR SICKLE CELL ANEMIA.

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Concerns regarding the care of sickle cell patients hospitalized for pain episode were the impetus to develop a clinical guideline. Prior to the guideline, care was not consistent among providers resulting in inadequate pain control, care provider and patient frustration, as well as increasing length of stay. The clinical nurse specialist (CNS) proposed to the interdisciplinary sickle cell group that a clinical guideline be developed.

The purpose in developing the clinical guideline was to provide evidenced based treatments for patients with sickle cell

pain episode and demonstrate positive outcomes. The interdisciplinary sickle cell group agreed that pain management was a key component. Therefore, American Pain Society guidelines for the treatment of sickle cell pain episode were incorporated into the guideline as well as the National Heart Lung Blood Institute guidelines for managing sickle cell disease. Outcomes defined prior to implementing the guideline included the amount of time to first opioid dose following admission, length of stay, determination of frequency of transfusion and guideline (and associated order set) usage.

Broad interventions were educating patient care providers regarding the guideline content and monitoring outcomes. The primary specific interventions included pain and breakthrough pain management; frequent (hourly) monitoring of pain and relief, and, consulting the pain and palliative medicine service when pain is unrelieved.

The guideline facilitates rapid implementation of pain management and maximizes timely expert consultation. Data reflecting time to first opioid treatment, frequency of transfusion, frequency of guideline usage and length of stay will be shared. Comparisons to other cancer hospitals as well as patients admitted to other medical surgical units will also be included.

The advanced practice nurse can utilize clinical guidelines in the management of patient populations, healthcare provider education and to define outcome measures. While this type of project generally falls under quality improvement, outcomes from guidelines can be used to refine guidelines that can then evolve into research topics.

4068

TRANSITIONING AN ONCOLOGY NURSE PRACTITIONER PROGRAM IN THE ERA OF THE CONSENSUS MODEL. Suzanne Walker, CRNP, MSN, AOCN®, BC, University of Pennsylvania School of Nursing, Philadelphia, PA; Barbara Boland, MSN, CRNP, University of Pennsylvania School of Nursing, Philadelphia, PA; Elizabeth Prechtel Dunphy, MSN, CRNP, AOCN®, BC, University of Pennsylvania School of Nursing, Philadelphia, PA; Ann L. O'Sullivan, PhD, FAAN, CRNP, University of Pennsylvania School of Nursing, Philadelphia, PA; Victoria Sherry, MSN, CRNP, AOCNP®, University of Pennsylvania School of Nursing, Philadelphia, PA

Over the past few decades, the number of advanced practice registered nurses (APRNs) and specifically certified nurse practitioners (CNPs) has increased dramatically. Despite this fact, there has been a lack of consistency in the education and regulation of the APRN. A multitude of educational programs produce practitioners with varying skill levels and knowledge. Additionally, individual state licensing boards determine who can practice in their jurisdiction.

Nursing leaders therefore convened in an effort to standardize APRN education, practice, and regulation. In July 2008, the "Consensus Model for APRN regulation: licensure, accreditation, certification, and education" was completed. The Consensus Model, which represents the combined work of the APRN Consensus Work Group and the APRN Committee of the National Council of State Boards of Nursing (NCSBN), states that APRNs will be educated in one of four roles and six population foci. In this model, oncology is recognized as a specialty rather than a population. Implications of this designation may include the inability of APRN students who graduate from specialty programs to become licensed and certified to practice.

The University of Pennsylvania School of Nursing (UPSON) has one of the oldest and most highly regarded oncology nurse practitioner programs in the United States. In order to maintain this level of excellence, ensure compliance with Consensus Model recommendations, and increase accessibility of oncology coursework to all APRN students, UPSON proactively decided to change its Oncology Nurse Practitioner program from a stand-alone program to a minor.

Students who desire specialization in oncology have the option of transferring into either the Adult Health Primary Care or Adult Acute Care nurse practitioner programs. Each of these programs incorporates the oncology minor, thus broadening students' options upon graduation.

Since initiating this process, interest in the new oncology minor, which is open to all students in APRN programs at UPSON, has more than doubled.

This transition from program to minor will ensure compliance with Consensus Model recommendations and ensure that graduates of these programs have the necessary educational preparation for national certification examinations and job mobility nationwide.

4073

SURVIVORSHIP FOR BONE MARROW TRANSPLANT PATIENTS. Jill Beavers, RN, MS, NP, Ohio State University Comprehensive Cancer Center/James Cancer Hospital, Columbus, OH

There are over 900,000 pediatric and adult survivors of hematological malignancies. Survivors are at increased risk for secondary cancers, diabetes, cardiovascular disease, osteoporosis, and functional decline. Nurse practitioners can have a direct effect on survivorship by developing survivorship care plans for transplant patients.

As treatment advances have considerably changed the course of hematological malignancies, the needs of people with leukemia and lymphoma has changed as well. The success of a bone marrow transplant is good news, but it is also accompanied by new fears of secondary cancers or other physical side effects. A survivorship care plan would implement a standard screening schedule and long-term follow up would provide preventative recommendations, testing, and comfort to survivors of hematological malignancies.

A cancer survivorship plan for bone marrow transplant patients would include six month, 12 month, and annual assessments of physical and psychosocial well-being with special emphasis placed on preventative screenings unique to the bone marrow transplant patient. A concise cancer survivorship plan would monitor for prevention of recurrent and secondary cancers, assessment of late medical and psychosocial effects, and coordinate care between primary care providers and specialist care providers.

Clinical patient outcomes will be monitored at six month intervals. The goals of the project have not yet been evaluated as this is a proposed project.

There is currently minimal information about long term follow up for bone marrow transplant patients. These patients are living longer and their risk of unique complications is only now becoming evident.

4074

A NAUSEA SCALE (0–5): A PRACTICAL TOOL TO GUIDE NURSING ASSESSMENT AND INTERVENTIONS. Angela Halpin, RN, MN, CNS, Hoag Memorial Hospital Presbyterian, Newport Beach, CA; Jessica Lynn Kozuki, MSN, NP/CNS, OCN®, Hoag Memorial Hospital Presbyterian, Newport Beach, CA

There are differences between clinician and patient perception of nausea. Effective communication about nausea is necessary to promote effective treatment. The APN's role in

studying the 0–5 nausea scale is effective in both modeling practice changes and in impacting patient outcomes. The background of the problem is rooted in facts that nausea is a common oncology symptom. In cancer patients, it is usually caused by cytoxic chemotherapy agents. Seventy to eighty percent of all patients who undergo chemotherapy are estimated to experience nausea and or vomiting. Kirkova et al. compared 21 nausea instruments. Therefore, the oncology nurses applied an adapted nausea tool while practicing at the bedside.

Purposes: to develop a nausea scale (NS) that facilitates communication among patients, nurses, and physicians and to measure nurse satisfaction. The aim was for nurses to report the 0–5 NS significantly easier to use in assessment & communication.

Two instruments: The NS ranges from 0 indicating none or no nausea, to 5 indicating severe nausea with dry heaves. Over a 90 day period, 89 nausea events were rated post application of the 0–5 NS on n= 55 patients by 25 nurses. 25 nurses' satisfaction was measured.

The preference for the 0–5 nausea scale is evident based on patient's ability to communicate their level of nausea, as well as the ease with which the nurse can communicate to the doctor. Data was categorized in terms of nurses' preferences, (1) preference with the old scale 0–10, (2) no difference, or (3) prefer 0–5 NS. The results demonstrated significantly the 0–5 point scale over the 0–10 point scale in the following four areas: (a) nurses understanding ($t = 3.61$, $p = .001$), (b) nurse's communication with the patient ($t=4.23$, $p=.0003$), (c) ability for patients to communicate ($t=5.4$, $p=.0001$) & (d) communication with physician ($t= 5.7$, $p =.0001$).

The scale is integrated into practice, with nurses documenting patients rating of their nausea using specific descriptors. A policy exists & a report is available daily to evaluate for improved patient outcomes. Future research is to begin to further explore 0–5 NS psychometrics.

4080

INFLAMMATORY BREAST CANCER: IDENTIFYING, DIAGNOSING, AND MANAGEMENT. Pamela Vranas, RN, ONP, MS, AOCN®, CBCN, UT M.D. Anderson Cancer Center, Houston, TX

Inflammatory breast cancer (IBC) is a rare form of breast cancer which accounts for only about 1% to 5% of all cases of breast cancers, but it is a highly aggressive disease with a poor prognosis (5 year survival rate of 40%). Symptoms progress in only a few weeks, lymph nodes are usually involved, and all too frequently patients are metastatic on presentation. Unfortunately patients are frequently misdiagnosed in a situation where prompt diagnosing and treatment is key to increasing survival- delaying lifesaving therapy. Oncology nurse practitioners serve as the front line to the care for patients. It is important that they be able to recognize IBC, understand the urgency of this disease and know how they best assist their patients.

The purpose of this activity is to familiarize the attendees with how IBC clinically presents, how it is diagnosed, overview of treatment options, and learn how they can effectively assist their patients.

This activity will review the signs/symptoms of how IBC presents, what tests are used to diagnose it, and review treatment options. Several case studies will be used to further solidify the information.

The goal of this activity is for nurse practitioners to be become familiarized with how IBC presents, how it is diagnosed, treatment options, and how they can support their patients emotionally and physically throughout the therapy. The attendees will learn how to effectively intervene with the patients through the continuum of care appropriately.

Patients with IBC are generally younger, frequently misdiagnosed, and are very worried upon presenting to the oncologist. The challenges to nurse practitioners are unique in this population. The patients are seeking accurate information, treatment and hope, but all they find is misinformation and dismal statistics. Nurse practitioners are the key to providing patients with accurate education, emotional support, directing them to appropriate resources, and providing them with the hope and support needed to fight this deadly disease. With better understanding of the aggressiveness of IBC and treatments, they can provide better support services to the patient and their families.

4094

LONG TERM CARE AFTER ORAL, HEAD AND NECK CANCER. Cheryl Huang, RN, MS, AOCN®, Arthur G. James and Richard J. Solove Cancer Hospital and Research Institute, Columbus, OH; Vicki Heinke, MSW, LISW, Arthur G. James and Richard J. Solove Cancer Hospital and Research Institute, Columbus, OH; Erica Reimer, MSW, LISW, Arthur G. James and Richard J. Solove Cancer Hospital and Research Institute, Columbus, OH; Joyce Hendershott, MSW, LISW-S, ACSW, Arthur G. James and Richard J. Solove Cancer Hospital and Research Institute, Columbus, OH; Patricia Schmitt, MA, CRC, Arthur G. James and Richard J. Solove Cancer Hospital and Research Institute, Columbus, OH; Karen Hock, MSPT, CLT-LANA, Arthur G. James and Richard J. Solove Cancer Hospital and Research Institute, Columbus, OH

Head and neck cancer is the sixth most common cancer globally and represents 3% of new cancers diagnosed. The survival rate for this devastating cancer is slowly on the increase, but quality of life studies for many survivors indicate that their survivorship is not without issues both acute and long-term. The clinical nurse specialist and survivors had presented multiple times to physicians, nurses and dentists regarding these issues. A need for education for head and neck survivors was identified by support group facilitators and members.

The support group facilitators met with additional social work and physical therapy staff to plan a free survivor focused educational event. The goal of the conference was to provide education, assistance and resources for head and neck cancer survivors and their caregivers across the state of Ohio that addressed the greatest challenges as identified by the members of the head and neck cancer support group at the Comprehensive Cancer Center.

Financial support was sought from local companies while the majority funding was provided by a grant from James Care for Life. Survey results from the support group determined the topics of nutrition, dental care, mental health, and speech. A leading head and neck oncologist gave the keynote address. Topics were presented in small group settings and repeated so all participants could attend all presentations. Questions were answered in the large group setting to more efficiently cover the most common questions and issues. A post-conference newsletter responding to unanswered questions was mailed to participants.

Participants completed an evaluation of the conference including individual speaker evaluations and the degree to which educational needs were met for the topic as well as an overall conference evaluation that addressed conference objective attainment, resources provided and recommendations for future topic presentations.

Evaluations indicated overwhelming satisfaction with the conference, multiple suggestions for future topics especially

emotional needs of the caregiver and more specific measures to address speech, swallowing, dental care and physical rehabilitation. The recommendation of continued multidisciplinary involvement in the planning was acknowledged by presenters and attendees.

4098

ONE DAY POST CRANIOTOMY HOSPITAL STAY: DEVELOPMENT OF A FAST TRACK PROTOCOL. Aileen Staller, RN, BSN, MSN, CNRN, OCN®, H. Lee Moffitt Cancer Center and Research Institute, Tampa, FL; Allison Fromm, MSN, ARNP, H. Lee Moffitt Cancer Center and Research Institute, Tampa, FL; Keisha Katsares, MSN, ARNP, H. Lee Moffitt Cancer Center and Research Institute, Tampa, FL; Mandy Sullivan, RN, H. Lee Moffitt Cancer Center and Research Institute, Tampa, FL; Steven Brem, MD, H. Lee Moffitt Cancer Center and Research Institute, Tampa, FL

One day craniotomy was developed to decrease nosocomial infections, potential iatrogenic problems, improve bed utilization, patients' sense of control, and improve quality if life (QOL).

The neurosurgical team devised a coordinated pathway with standing orders to insure all needed evaluations and treatments were initiated on an automatic basis and discharge occurred when the patient met the benchmarks.

Education about one day pathway was provided at initial visit and reinforced at the pre-op visit, with evaluation by social service for potential needs. A pathway was put in place with pre op steroids, anticonvulsants, discontinuation of invasive lines, transfer from SCU, PT evaluation, and other hallmarks. Steroid bolus, minimal retraction and osmotic diuretics were used to decrease edema. Patients were discharged with clear, written instructions, follow up appointment times and dates and contact phone numbers. All patients had an MRI prior to discharge and needed to meet the EVA (eat, void, ambulate) criteria for discharge.

Patients included had supratentorial gliomas, Karnofsky Performance Scores (KPS) 70 or greater and adequate support systems. Excluded were posterior fossa / infratentorial tumors, KPS less than 70, post operative seizures, severe headache, and concurrent medical problems.

Of 470 patients, 280 (59.7%) were discharged post op day 1. One patient (0.4%) was readmitted with fever (>102) and atelectasis. Three patients (1.1%) had superficial wound infections and were treated as outpatients. Eleven patients (3.9%) had worsening neurologic deficits that did not lower the KPS by > 20 points.

In the extended stay group 4 patients (2.2%) had superficial wound infections 11 (5.9%) had worsening neurologic deficits, 2 (1.1%) had increased ICP, 1 each (0.6%) had seizure activity, hemorrhage, post operative stroke and death. Three patients (1.6%) had non lethal cardiac arrhythmias or paralytic ileus.

Patient acuity self selects patients requiring extended stay but no increase in morbidity or mortality was seen for early discharge patients, which requires diligent attention to patient education, minimally invasive surgery, clear pathways with unambiguous decision points, staff invested in early discharge and a coordinated effort by all team members, led by the advanced practice nurse, to improve QOL for the brain tumor patient.

4099

THE USE OF A NATIVE MICROSCAFFOLD COLLAGEN DRESSING FOR THE TREATMENT OF SPLIT-THICKNESS SKIN GRAFT DONOR SITES. Cheryl Huang, RN, MS, AOCN®, Arthur G. James and Richard J. Solove Cancer Hospital and Research Institute, Columbus, OH; Molly Pierce, ET, WOCN, Arthur G. James and Richard J. Solove Cancer Hospital and Research Institute, Columbus, OH

The treatment of split- thickness skin graft donor sites has traditionally received little clinical attention. Occurrence of pain during the healing process is common. In the Head and Neck Oncology practice, skin grafting is a common intervention. Current donor site care management led to complaints of discomfort at the site. A study was to start comparing traditional treatment with another dressing on the market when the latter dressing became unavailable. A new dressing was sought which is a product based on 100% native collagen.

The aims of the pilot study were to determine the effectiveness of a proposed study dressing, native collagen, on patients with split-thickness skin grafts and whether this dressing would provide effective comparison in the already approved study.

Margo McCaffey's theory of pain management provided the conceptual framework for the research. Surgery, and the pain associated with it, triggers a number of physiologic stress responses. Procedures such as dressing changes can compound the pain experienced postoperatively with surgery.

In a Comprehensive Cancer Center four otolaryngology patients who underwent skin harvesting procedures as part of their major surgery were treated with the collagen dressing. Dressings were applied at the end of surgery, covered with a polyurethane film, followed by a gauze/compression bandage to keep the collagen in place. On day 2, the gauze/compression bandages were removed, with the polyurethane film left in place. On two of the patients the polyurethane was left in place while on the other two the polyurethane was removed on day 5. Pain was monitored per hospital protocol using the Wong-Baker pain scale. Epithelialization was monitored visually on days 5 to 10 postoperatively on all patients by the APN and ET RN.

Pain was found to be extremely low on the patients during the course of healing and was absent when the polyurethane film was left in place, which is consistent with the principles of moist wound healing. Healing was uneventful. The decision was made to utilize the collagen dressing as a comparison in the approved research study.

4100

DEVELOPMENT OF A PREADMISSION DVD TO EDUCATE PATIENTS ABOUT STEM CELL TRANSPLANT. Christine Rimkus, RN, MSN, AOCN®, Barnes-Jewish Hospital, St. Louis, MO; Lucy Hertel, RN, BSN, OCN®, Siteman Cancer Center Washington University, St. Louis, MO

Educating patients and their families about the complexities of stem cell transplant is challenging. The subject matter can be abstract and has many components: pretransplant work-up, inpatient stay and post transplant care. Patients can become overwhelmed with all of the information. At Barnes-Jewish Hospital, Siteman Cancer Center, patients often travel up to 4 hours, adding to the complexity of education.

The purpose of this project was to create an educational program for patients that gave a consistent message and was available to every patient.

A team of staff from both inpatient and outpatient met to discuss how to proceed. The preadmission DVD was an ideal approach, but quite expensive. The CNS from the BMT unit wrote a proposal to the hospital Grant Foundation whose mission is to offer support for patient related projects. The grant submission was accepted for the entire estimated cost. Next, the BJH marketing department was contacted for help in finding an agency to develop the DVD. From there, the team wrote a script, hired a

professional narrator and began creating the DVD. Patients were included in the implementation of the project.

The DVD was completed in early 2009. We have currently revised our written material to mirror the DVD. An informal evaluation of the DVD from patients and staff has been positive. A formal written evaluation is underway to determine if all patients can access/use the DVD and if they feel it prepared them for their BMT. The results will be presented in this poster.

The APN is often the person who identifies the need for improved patient care. In this case, the APN identified the need, developed the plan, acquired the funding as well as implement the plan. The APN utilized her resources and recruited other staff to help create a DVD the entire team would approve of and use. The future plan is to compile the evaluations and identify how to incorporate the DVD into the total educational plan.

4103

AN EVIDENCE BASED PRACTICE GUIDELINE FOR THE PREVENTION AND MANAGEMENT OF MENORRHAGIA IN PATIENTS WITH THROMBOCYTOPENIA.

Lisa Barbarotta, RN, MSN, AOCNS®, Yale New Haven Hospital, New Haven, CT; Gineesha Abraham, MSN, Greenwich Hospital, Greenwich, CT

High dose chemotherapy, total body irradiation, and stem cell transplantation are common treatment modalities in patients with hematologic malignancies. Thrombocytopenia is a common complication associated with these modalities. Thrombocytopenia places patients at risk for hemorrhagic complications including menorrhagia. Hemorrhagic complications in the oncology setting are associated with poor clinical outcomes and significantly increased resource utilization. As many as 40% of women with normal ovarian function and chemotherapy induced thrombocytopenia experience episodes of either moderate or severe menorrhagia. Menorrhagia can have a negative effect on a woman's overall well-being, including physical activity, sexual activity, social and psychological function. In oncology patients already struggling with fatigue and other side effects of treatment, menorrhagia can significantly add to the symptom burden.

Advanced practice oncology nurses play a key role in managing patients at risk for menorrhagia as well as patients who experience uterine bleeding. The purpose of this project was to develop an evidenced based practice guideline to outline the assessment, prevention and management of menorrhagia in patients with thrombocytopenia.

A comprehensive literature search was performed using MedLine, CINAHL, and Cochrane databases to identify available evidence to support measures to prevent and manage menorrhagia in patients with thrombocytopenia. Research designs, populations studied, interventions, and outcomes were summarized in a detailed table of evidence. Based on the evidence available, a practice guideline and algorithm to drive advanced nursing practice has been developed. Recommendations for the assessment and evaluation of patients with menorrhagia are included.

Measures of success following implementation of the guideline include: 100% of patients with thrombocytopenia at risk for menorrhagia will receive standard menstrual suppression prior to initiation of cytotoxic therapy.

Implementation of this evidence based guideline will assist advanced practice nurses to improve the early identification of patients at risk for menorrhagia and improve timely implementation of preventative measures, minimizing the risk for hemorrhagic gynecologic complications and decreasing platelet transfusion requirements.

4106

BEYOND TRADITIONAL ACADEMIC BOUNDARIES: NEW OPPORTUNITIES FOR COLLABORATIVE RELATIONSHIPS IN NURSING RESEARCH AND PRACTICE.

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Technological advances from EMR to online videoconferencing are ubiquitous throughout the health care arena and must be embraced by advanced practice nurses (APN). The goals of this conference parallel the promise of technology for the APN: innovation, networking, and advanced educational opportunities. Advances in technology have fostered a relationship between nine nurses in advanced practice roles from across the country. This cohort of doctoral students serves as a diversified collective resource for evidence-based and best practice through their current commitment for educational advancement, research collaboration, and clinical practice expertise in their workplace, and their local and national communities.

The purpose of this presentation is to demonstrate how a novel academic program designed for synchronous online delivery: the University of Utah's College of Nursing's Distance PhD program has created strong collaborative relationships which serve to advance oncology nursing science. The program, which was originally funded by NIH and the Utah Telehealth Network, was created to address the shortage of PhD prepared cancer nurse scientists and nursing faculty.

Using interactive IP videoconferencing the students access the live classroom from home or work settings several times a week. The students also have many opportunities to "connect" with fellow students and faculty using the IP videoconferencing during non-classroom hours.

Challenges encountered in the design of the program were creating a community with students located in 8 different states and 4 different time zones, coordinating all of the technical needs of the program in all different settings, coordination of administrative needs for the students in regards to the University at large, and support for students in coordinating efforts to obtain funding from federal or private organizations.

The benefits from this program have been an establishment of ongoing professional relationships between the APNs in various roles and settings including university health care systems, private practice, community based hospitals, hospice and comprehensive cancer centers. Innovation beyond the traditional boundaries of academe has translated into increased opportunities for excellence in advanced oncology nursing collaborations in science and practice.

4107

CNS' COLLABORATE TO COORDINATE CONFERENCE.

Lorna Baker, MSN, ARNP, CCRN, OCN®, H. Lee Moffitt Cancer Center, Tampa, FL; Tina Mason, MSN, ARNP, AOCNS®, H. Lee Moffitt Cancer Center, Tampa, FL

Hematologic malignancies and their treatments are complex and often challenging. At our institution, patients with hematologic malignancies are cared for in multiple departments. Staff reported limited knowledge of care beyond their area. Two CNS' identified this educational need, verified with their respective unit-based education committees, and then obtained support from Nursing Leadership for an all-day conference.

The purpose of this abstract is to describe the collaborative effort of two CNS' in addressing the educational needs of oncology nurses caring for the multifaceted malignant hematology patients and their families.

The CNS' and an expert staff nurse identified content. Clinical experts, comprising of staff nurses and other members of the multidisciplinary healthcare team, were invited to present. The CNS' mentored novice presenters in developing and delivering presentations. Working closely together, they arranged the agenda, speaker confirmation, handouts, contact hour requirements and meals, all within 4 months. Three workshops have been held, reaching 62 nurses.

Staff interest in the first workshop exceeded available classroom space and a waiting list was created. The CNS' accommodated requests and scheduled a second workshop within 6 months. Participants represented multiple clinical areas. The overall program was rated 4.7 and relevance to their job 4.7 on a Likert-type scale, (1 = poor to 5 = excellent). Based on positive feedback, the workshop will continue annually.

Workshops can be a vehicle for promoting excellence throughout the continuum of care. The CNS is essential for planning workshops because the role allows for working closely with staff identifying their needs and expertise; time commitments to projects, access to resources, and comfort level to approach experts in other disciplines. While one CNS could have coordinated this workshop, having two allowed for access to a broader speaker pool, more time spent mentoring, and continuous accessibility if one or the other was unavailable. The workshop allowed expert clinical experts to play a vital role in a comprehensive educational offering by serving as credible resources. Mentoring promoted confidence and presentation skills that resulted in the continual improvement of polished presentations. It also provided support, mutual satisfaction, and anticipation of future joint projects for the CNS'.

4111

ROLE OF NURSE PRACTITIONERS IN THE INPATIENT HOSPITAL SETTING: ENHANCING BOTH PATIENT QUALITY AND CONTINUITY OF CARE.

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With advanced technology, targeted medicine, and the increasing demands of health care, patients have been treated primarily as outpatients, leaving only the critically ill to be hospitalized. In medical oncology, these patients require multidisciplinary needs. NCI designated cancer centers leave these patients and the health care team vulnerable to fragmented care. Contributing factors include multiple consultants, the rotating hospital service, and fellows. Physician responsibilities have increased in patient management, administration, and research.

The concept of incorporating inpatient nurse practitioners with physicians emerged in the 1990's in acute care. Institutions embrace inpatient nurse practitioners as they promote patient satisfaction, improve discharge planning, and provide continuity of care. Nurse practitioners demonstrate positive financial impacts by decreasing hospital stays and staff costs.

At this NCI designated cancer center, the medical oncology team has implemented an inpatient nurse practitioner to provide continuity of care. Incumbent on the scope of practice on the state, federal, and hospital level, the inpatient nurse practitioner may admit, care for, diagnose, treat, and oversee discharge for patients in collaboration with the physician. Specific responsibilities include participating in discharge planning, documentation, medication management, procedures, patient education, and transitioning patients back to the outpatient setting.

Project outcomes for the effectiveness of the inpatient nurse practitioner are measured by length of hospital stay, provider satisfaction and efficiency, medication reconciliation, and improved continuity of care for patients from hospital to home. Transitions are facilitated from the inpatient team to the patient's primary team in the outpatient setting.

Success for the nurse practitioner-physician team requires effective communication skills and collaboration with other health care providers. In a fragile economy, complex patients in an institution and physicians in diverse roles have made the need for an inpatient nurse practitioner invaluable. Additionally, the role promotes autonomy, skill, and enhances meaningful relationships between healthcare providers and patients.