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Oncology Nursing Society 36th Annual Congress Podium and Poster Abstracts

Each abstract has been indexed according to first author and identified as a podium or poster session on page E180.

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1000211

BRIDGING THE GAP: IMPROVED PATIENT OUTCOMES AND INCREASED STAFF SAFETY DIRECTLY ATTRIBUTED TO THE DELIVERY OF THE "SAFE HANDLING OF ORAL CHEMOTHERAPY" EDUCATION PROGRAM AT MATER HEALTH SERVICES. Jane Roach, RN, Mater Education Centre, Mater Health Services, Brisbane, Queensland, Australia

Cancer therapies are used throughout many patient care areas to treat non cancer conditions such as rheumatoid arthritis and multiple sclerosis. Patients diagnosed with cancer are also being managed on outlying wards due to a shortage of beds in the oncology unit. Nurses administering these cytotoxic agents require specialist training to handle these therapies safely. A learning needs analysis was conducted on Registered Nurses (RNs) working outside the oncology environment identifying major knowledge gaps and safe handling concerns. This resulted in an education program designed to bridge this knowledge gap, improve the standard of safe practice and ensure high quality patient outcomes. This education program would ensure a baseline level of competence for every clinician administering oral cytotoxic medications. According to the Cancer Nursing Society of Australia and the Oncology Nursing Society, only RNs with specialised training in cytotoxic administration should administer cytotoxic chemotherapy. Employers must ensure that these requirements are met. These guidelines provided the basis for developing the model of chemotherapy education needed at the Mater. The chemotherapy education included: Reviewing current research articles on safe handling of hazardous drugs, Successful completion of a learning package, attending an 8 hour workshop, Pre and post workshop tests, Supervised practice in administering oral cytotoxics and assessment of competencies in safe handling of cytotoxics and oral chemotherapy administration. Three, six and nine months after completing the program the registered nurses were observed, to determine whether they had integrated the knowledge gained in the program into their clinical areas. If non compliance was realised then further training was given. The oral chemotherapy education program undertaken for RNs working in wards outside the oncology area at Mater Health Services, has resulted in improved safe handling of cytotoxic waste, increased knowledge around safe administration of oral cytotoxics, side effect management and patient education.

1000406

RELAX REJUVENATE REVITALIZE: A NURSING RETREAT TO WELLNESS. Louise Baca, RN, MSN, CCRP, Kennedy Cancer Center, Kennedy Health System, Sewell, NJ; and Lizzie Martinez, RN, BSN, OCN®, Ocean Medical, Brick, NJ

Relax Rejuvenate Revitalize: A Nursing Retreat to Wellness was a collaborative project developed by two Southern New Jersey ONS chapters focused on the concept of "caring for the caregiver". Nurses by nature are nurturers and tend to put the needs of others ahead of their own. Trying to maintain the balance of family, work, household and self often leaves the "self" neglected. The retreat provided oncology health care professionals with an educational and experiential retreat on the prevention/management of stress and anxiety, the importance of proper nutrition and exercise as well as nurturing the body, mind, and soul. Taking the time out of their busy life to care for themselves and ways to accomplish this concept was the focus of this retreat. The Southern Jersey Shore and Central New Jersey Chapter presidents had an initial "brainstorming" meeting to discuss the concept for the "retreat" originating from a grant awarded for a program called 'Fitting Yourself Into Your Own Schedule'. The decision to incorporate education, nutrition and integrative therapies into an all day retreat to offer a relaxing and educational experience for the attendees was established. Local experts in the field of integrative therapies and nutrition were invited to participate as speakers for morning educational sessions. A nutritional session preceded a nutritious lunch. Local and regional integrative therapists were asked to voluntarily participate and provide sessions on reiki, yoga, massage, reflexology, visualization, dance/exercise, healing touch and aromatherapy during the afternoon sessions. Attendees were required to complete an ONS evaluation for 4.75 continuing education credits. Evaluations were exceedingly positive and speakers' goals and objectives were overwhelmingly met. The Retreat was a total and unequivocal success and one hundred percent of the attendees requested that the retreat be offered the following year. Attendees also shared that this was a well needed experience and that they often do not take the time for themselves. In addition, one hundred percent of the therapists/presenters felt that this was a truly positive experience, both beneficial and integral to attendees and have asked to be involved in any future retreats.

1006310

REDUCING CERVICAL CANCER INCIDENCE IN NIGERIA.

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Cervical cancer is an important women's reproductive health problem especially in developing countries like Nigeria. It is the third most common cancer worldwide, four out of every five cases are reported from developing countries including high incidence of mortality. This is because there are little or no facilities for screening programmes to detect precancerous lesions early and treat, especially the preventable ones like breast and cervical cancers, another reason for the high incidence is that there is generally low awareness about the disease in the populace, most women attending public hospitals in Nigeria are not aware that cervical cancer can be prevented by regular screening. The gynae oncology unit is involved in screening women in reproductive age for cervical cancer in order to detect pre-malignant lesions of the cervix using the visual inspection with acetic acid and Lugol's iodine and women with positive VIA/VILI are adequately treated with cryotherapy. The visual screening approaches are employed because it is simple, has the greatest potential of screening and treatment in one visit thus reducing follow-up failures, it is not a cytological based cervical cancer screening and it is affordable. It involves the application of 3-5% of dilute acetic acid to the cervix and observing for one minute for acetowhite areas, a positive reaction is the appearance of a well-defined acetowhite areas in the transformation zone close to the external os. Since the unit was established in 2006 after the INCTR sponsored training in preventive oncology about four thousand women has been screened and 4% of which are positive after further evaluation with colposcopy and a punch biopsy taken by the doctor cryotherapy is done. Visual screening approaches are very effective in solving the challenges of cervical cancer in developing countries like Nigeria.

1015806

DERMATOLOGIC ASSESSMENT AT A DISTANCE: THE USE OF TELEDERMATOLOGY IN AN OUTPATIENT CHEMOTHERAPY INFUSION CENTER.

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Dermatologic toxicities related to cancer treatments, especially the administration of chemotherapy/biotherapy agents, are common for oncology patients. Drugs categories such as tyrosine-kinase inhibitors and epidermal growth factor receptors are known for causing rashes that are both painful and visually disturbing for patients' body images. It is imperative that oncology nurses caring for patients experiencing dermatologic toxicities are properly assessing and managing these side effects. Rashes of this type are best diagnosed and treated by a physician that specializes in dermatologic conditions resulting from cancer treatment. At a new ambulatory off-site chemotherapy infusion center, a pilot for oncology patients was implemented. The nurse could remotely conduct patient visits with a dermatologist located at the main campus, utilizing telemedicine technology. The primary purpose of the project was to determine if telemedicine is an effective mode for conducting a comprehensive skin assessment. Secondary purposes include evaluation of teledermatology on patient and clinician satisfaction. Eligible patients were those that presented with a dermatological condition resulting from chemotherapy, discovered during a pre-chemotherapy comprehensive nursing assessment. Nursing staff and the dermatologist were educated on use of the telemedicine equipment. The dermatologist was contacted in real-time by the nursing staff and the team conducted dermatologic assessments via audio and video telemedicine technology. Post assessment, the dermatologist collaborated with the medical oncologist to manage, treat, and make decisions regarding appropriate treatment. Upon completion of the visit, patients and staff completed surveys to

document satisfaction and success with the process. Implementation of real-time teledermatology eliminates the need for an additional dermatology visit and strengthens clinician collaboration. Early assessment and intervention decreases the likelihood of the patient experiencing an interrupted treatment schedule. The presentation will discuss the oncology nurses role in the pilot, barriers, and benefits experienced and data on patient and clinician satisfaction. Oncology nurses play an integral role in assessing and managing the dermatologic toxicities patients' experience. Use of teledermatology fosters timely assessment and management of dermatologic toxicity which increases patient quality of life and satisfaction. The present and future use of telemedicine is valuable as it increases patients' access to sub-specialized providers during cancer care.

1017680

THE DANGERS OF IRON OVERLOAD: BRING IN THE IRON POLICE.

Angela Lambing, MSN, NP-C, Hematology, Henry Ford Health System, Detroit, MI; Linda Mary Mueller, RN, MSN, Hematology, Henry Ford Health System, Detroit, MI; and Ellen Kachalsky, LMSW, Hematology, Henry Ford Health System, Detroit, MI

Transfusions of packed red blood cells (PRBCs) save lives. In many hematologic conditions, PRBC transfusions are required due to bone marrow suppression or malfunction. Extended exposure to transfusions places the patient at an additional risk; iron overload due to the body's lack of ability to effectively eliminate excess iron. Many institutions lack a monitoring process to identify the transfusion dependent patient at risk for iron overload. The purpose of this presentation is to provide an algorithm to a) identify the patients at risk, b) institute an appropriate monitoring program, and finally, c) provide treatment and ongoing monitoring for the iron overload patient. A nurse driven protocol was initiated where a baseline ferritin level was performed for patients requiring transfusion if one had not been completed in the previous 6 months. A repeat ferritin level is triggered for every 10 units of packed RBCs. When the ferritin level reaches 1,000 ug/mL, the RN initiates contact with the "Iron Police". This team consists of an NP, RN, and social worker. The NP reviews the case, presents the issues to the physician who then determines if iron chelation should be initiated. Once it is identified to begin iron chelation, the Iron Police contacts the patient, provides education, orders the medication, evaluates the insurance issues, initiates iron chelation, and provides contact and ongoing monitoring for the patient. Prior to the initiation of the program, 75 unduplicated patients were receiving PRBC transfusions; a) over 50% of the patients either had a ferritin level > than 1,000 ug/mL without treatment or, b) were without a documented ferritin level within 6-months at the outset of transfusion; c) 1% of patients were receiving iron chelation therapy. Three months after initiation of the protocol, 92% of patients had a documented ferritin level within the previous 6 months; where 72% of patients had ferritin levels > 1,000; of which a) 57% of patients receive iron chelation therapy and b) 15% of patients have iron chelation on hold due to medical reasons. This successful program engages the expertise of the infusion nurse who provides ongoing contact to the patient. The Iron Police allows the nurse to make one phone call, and then the RN supports the activities of the iron police team when iron chelation therapy is in progress.

1018778

DEFINING THE ECONOMIC AND CLINICAL VALUE OF AN ADULT NURSE PRACTITIONER PRACTICING IN A COMMUNITY ONCOLOGY OUTPATIENT SETTING.

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Francisco, CA; and Margaret Barton-Burke, PhD, RN, College of Nursing, University of Missouri St. Louis, St. Louis, MO

By 2020 visits to oncologists will increase by 48% while the expected increased number of oncologists will grow by only 14%. Many of these are new patients who will be seen in community oncology outpatient settings. However, medical oncologists are limited to the number of patient visits daily and many of these community settings are working without the benefit of nurse practitioners in collaborative practice. Often oncologists do not recognize the benefits of nurse practitioners, who are frequently underutilized and only charge for services rendered under incident-to policy. Oncologists working without collaborative practice agreements with nurse practitioners have less time to make rounds, see new patient consults and develop comprehensive treatment plans. The purpose of this presentation is to define and evaluate the economic and clinical value of an adult nurse practitioner in a community oncology outpatient setting. We will present the situation, rationale, and economic metrics including cost benefit, cost utility, cost minimization and cost effectiveness with our economic model. An economic model was developed to justify the creation and maintenance of an advanced practice nurse position. This economic model includes the usual cost benefit considerations including: potential and actual revenues generated on a daily, weekly, and monthly basis; overhead costs; staff costs including overtime; and office operations such as coverage for vacations and conferences. The cost utility and the quality of patient care include analysis of patient assessment, numbers, and time, along with potential errors and patient compliance. Cost minimization and cost effectiveness will be addressed as well. Our economic model includes four specific measurements optimizing various clinical assessments. Nurse practitioners using the presented economic model can quantify the benefits brought to the community oncology practice setting. This presentation is an innovative and cutting-edge topic because it will provide a measure to quantify the economic and clinical value of nurse practitioners. Our model helps nurse practitioners recognize their quantitative and qualitative value, address the associated costs of collaborative practice and specify the components of a collaborative practice agreement in order to bill, either independently or incident- to in community oncology outpatient settings.

1018988

RISING STARS: LEADERSHIP DEVELOPMENT FOR DIRECT CARE CLINICIANS. Deborah Cline, MSN, RN, OCN®, UT MD Anderson Cancer Center, Richmond, TX; Kelly La Frentz, MSN, RN, OCN®, UT MD Anderson Cancer Center, Richmond, TX; and Jan Keller-Unger, PhD, MS, RN, UT MD Anderson Cancer Center, Richmond, TX

Developing clinical leaders at the bedside is essential to support the clinical needs of patients and operational requirements of patient care units. Supporting nurses in developing leadership skills at the bedside is an important component of nurse satisfaction and retention. The Rising Stars Program, a unique nursing initiative at a comprehensive cancer center, was initially implemented in 2006 to provide the opportunity for clinical, bedside nurses to develop their knowledge and skills as informal leaders in their units or clinics. Annually, up to 30 nurses from inpatient and outpatient settings are selected by a committee of previous Rising Star graduates and nurse leaders. Applicants must be registered nurses in non-management positions at the highest level of the professional development model, and highly recommended by their manager. Participants receive one paid eight hour day a month for a year to attend a formally structured program of interactive classes. Class topics include evidence based practice, developing abstracts, accountability for self and practice, effective communication, quality improvement techniques, giving and receiving feedback, team building, presentation skills, conflict management, and systems thinking. Guest speakers from throughout the nursing division and hospital lead the classes,

exposing Rising Stars to key individuals who may serve as resources to them in the future. To demonstrate competency in the skills learned during the program, participants are required to complete individual and group projects, as well as presentations. To date, 84 participants have graduated from the program. Of those, 97% have remained with the organization; 90% remain as high performing clinical nurses in direct care roles at the bedside. Thirty-four percent of the group have returned to school for advanced degrees and 7% have moved into non-clinical leadership positions. Graduates report increased confidence in leadership and more autonomy in their practice. Managers report that graduates continue to use the skills acquired and make positive contributions to their respective units and clinics. As hospitals struggle with turnover rates, education costs, and staff shortages, programs such as the Rising Stars may increase nurse satisfaction and develop strong clinical leaders at the bedside who can deliver and influence patient care outcomes.

1019454

SUCCESS FACTORS FOR ADMINISTERING INTRAPERITONEAL CHEMOTHERAPY. Fiona McCaughan, RN, MS, OCN®, Hematology Oncology, Winchester Hospital, Stoughton, MA; Janet Gallant Wood, MSN, ANP-BC, Hematology Oncology, Winchester Hospital, Stoughton, MA; Sheila Sheilds, MSN, CCRN, RN-BS, Hematology Oncology, Winchester Hospital, Stoughton, MA; Revital Haim, RN, BSN, Hematology Oncology, Winchester Hospital, Stoughton, MA; Louise Pong, RPh, Hematology Oncology, Winchester Hospital, Stoughton, MA; and Arlan Fuller, MD, Hematology Oncology, Winchester Hospital, Stoughton, MA

Ovarian cancer is the fifth most common cancer in women and is the leading cause of death in gynecologic cancers. Studies demonstrate increased survival with intraperitoneal chemotherapy. Current regimens include 6 cycles of intraperitoneal chemotherapy, yet sites report as few as 42% of patients completing all cycles. Nausea, vomiting, dehydration, abdominal pain and catheter related failures account for most of the failure reasons. The oncology nurse facilitates patients being successful through assessment, education and administration of therapy. Develop a treatment plan that would facilitate patients completing intraperitoneal chemotherapy. Developed a multidisciplinary intraperitoneal chemotherapy team to develop workflows, policies, procedures and processes. This team developed teaching materials for staff and patients and a standard order set, which includes support for highly emetogenic chemotherapy. The physician leader of gynecologic oncology at our center also developed a specific tunneling technique for the port. Patients are evaluated for surgery and port placement at the same time by the gynecologic oncologist who completes their surgery. The team developed and delivered staff education. Patient and Family teaching. Patients and their care partners are included in treatment discussions and education. The patient and staff education materials are the same for the inpatient and outpatient staff and include specific interventions for self management of expected symptoms and management of their port. At our center, all of the women receiving intraperitoneal chemotherapy for ovarian cancer were able to complete all 6 cycles of chemotherapy on time. We had no catheter related complications. The gynecologic cancer service has developed a strong multidisciplinary team in the outpatient setting. Intraperitoneal chemotherapy was their first combined inpatient and outpatient staff work group. The development of consistent education materials for staff and patients was successful with this treatment modality. The teaching materials for patients receiving intraperitoneal chemotherapy are more robust and more specific for their treatment than others we use. We plan on improving our patient teaching materials, specifically with regard to self management for all patients and increasing the multidisciplinary team meetings to facilitate communication, education and cohesion.

1020908

COPING IN THE CONTEXT OF UNCERTAINTY AMONG HEAD AND NECK CANCER (HNC) PATIENTS RECEIVING RADIATION THERAPY. Mary Ellen Haisfield-Wolfe, PhD, RN, OCN®, Acute and Chronic Care, Johns Hopkins University School of Nursing, Baltimore, MD; Deborah B. McGuire, PhD, RN, FAAN, University of Maryland School of Nursing, Baltimore, MD; and Sharon Krumm, PhD, RN, Johns Hopkins Medical Institutions, Baltimore, MD

HNC is complex and emotionally distressing due to mortality and morbidity caused by disease and/or treatment. As patients undergo radiation, they cope with daily appointments, emotional stress, symptoms, and disruption to major bodily functions of eating, breathing, and communicating. Each treatment phase has uncertainties for example, the unknowns at start of treatment, severe side effects during treatment, and worry about recurrence after treatment. How patients cope in the context of uncertainty is unknown, thus exploring HNC patients' coping will increase our understanding of psychological and physical aspects of HNC treatment.

To describe coping in the context of uncertainty among HNC patients during definitive treatment at four time points, with the ultimate goal of gaining insights that will guide practice.

The research was guided by Mishel's Uncertainty in Illness Theory.

The study was a descriptive qualitative content analysis. Data were collected during interviews of 21 newly diagnosed oropharyngeal and laryngeal cancer patients using open-ended questions at baseline, and weeks 5, 9, and 12 after radiation initiation. Data was transcribed and independently analyzed for themes. Themes were examined for concurrence by HNC nurse experts and consensus was reached when there were different perspectives.

Emergent themes provide insight into patients' feelings, issues, and assistance received with coping. Patients reported coping adequately or that coping was rough or upsetting and filled with anticipation. Issues that required coping varied over the four time points. Physical treatment side effects were problematic during treatment and one month after completion of treatment. Patients used coping to negotiate the uncertainties of physical and psychological aspects of their experience. Coping consisted of high levels of family and friend support along with additional coping strategies. Interestingly, the high levels of side effects over the four time points corresponded with coping through high levels of support from others. The findings provide information into the ways that HNC patients cope including individual support and suggest directions for clinical nursing practice and future research.

1023435

IXABEPILONE-ASSOCIATED PERIPHERAL NEUROPATHY: RETROSPECTIVE REVIEW OF DATA FROM PHASE 2 AND 3 CLINICAL TRIALS. Diana Donovan, RN, MSN, NP, Weill Cornell Breast Center, New York, NY; Henri Roche, MD, Institut Claudius Regaud, Toulouse, France; Gabriel Hortobagyi, MD, FACP, The University of Texas M. D. Anderson Cancer Center, Houston, TX; Joseph Sparano, MD, Albert Einstein Comprehensive Cancer Center, Bronx, NY; Pralay Mukhopadhyay, MD, Bristol-Myers Squibb, Wallingford, CT; and Linda Vahdat, MD, Weill Cornell Breast Center, New York, NY

Most microtubule stabilizing agents, including ixabepilone, are associated with dose-limiting peripheral neuropathy (PN). PN with ixabepilone is usually mild to moderate, mostly sensory, cumulative and commonly reversible. Early identification of at-risk patients or patients with PN symptoms is the key to managing this effect. To retrospectively evaluate the incidence of ixabepilone-induced PN in clinical databases and to identify potential risk factors for severe PN. We searched databases of phase 2/3 breast cancer trials of ixabepilone as monotherapy or with capecitabine

for incidences of PN. A Cox regression analysis of cumulative dose to severe (CTCAE grade 3/4) PN was used to identify potential risk factors for severe PN in patients across multiple studies. Rates for incidence of ixabepilone-induced grade 3/4 PN ranged from 1% in early untreated breast cancer to 24% in heavily pretreated metastatic breast cancer (grade 4 PN, <=1%). Common symptoms were numbness, paresthesia, and sometimes dysesthesia. A Cox regression analysis of 1540 patients identified pre-existing PN as the only significant risk factor for increased severe PN (HR=1.44, P=0.007). Existing diabetes, age, and prior chemotherapy did not significantly correlate with development of grade 3 or 4 PN. Prior taxane was associated with decreased risk of severe PN; the reasons for this remain to be established. Ixabepilone-related PN is manageable through dose delays and/or reduction, with resolution in a median time of 5 to 6 weeks. Pre-existing PN was significantly associated with the risk of developing ixabepilone-related PN. PN with ixabepilone is manageable and reversible within a period of weeks in most patients.

1025642

DEVELOPING AN ELECTRONIC TELEPHONE TRIAGE DOCUMENT IN THE ADULT AMBULATORY CARE SETTING. Catherine Wickersham, RN, BSN, OCN®, Ambulatory Nursing, Memorial Sloan-Kettering Cancer Center, New York, NY; Young-Shin Park, RN, MSN, CNOR, Ambulatory Nursing, Memorial Sloan-Kettering Cancer Center, New York, NY; and Maryellen O'Sullivan, RN, MSN, Ambulatory Nursing, Memorial Sloan-Kettering Cancer Center, New York, NY

Approximately 200,000 calls are documented and triaged by ambulatory nurses annually at this designated comprehensive cancer center. Telephone interactions with patients, an essential component of ambulatory nursing practice, supports continuity of care, facilitates patient education, emotional support, and symptom management. Nurses are on the front-line of telephone triage and it is imperative that they triage and document in a systematic framework that is accessible to the healthcare team. Ambulatory nursing practice council members redesigned the current text-based document and developed an electronic, structured nursing telephone note to guide nursing assessment with patients. After conducting an evidence based review of 56 symptoms, the symptom assessment component was developed and has standardized nursing practice and improved documentation quality, efficiency, consistency and completeness. A group consisting of nurse informaticists, staff nurses and clinical system analysts developed the structured framework of the note including reasons for the call: symptom management, patient education, reassessment, referral, lab/test result, treatment care, and home care. The note guides the nurse to triage each symptom by severity, quality, onset, duration, associated symptoms, precipitating and alleviating factors. Other functions of the form include the ability to pull patient laboratory values into the document and enter orders, allergies, falls, and infection control precautions. After the pilot, contents were modified based on nurses' feedback and we proceeded with a phased-implementation to all ambulatory services including regional network sites. Four months following implementation, nurses documented 42,683 calls. The top symptoms were pain, cough, constipation, and fever. Nurses also selected "other", which allowed for free texting a symptom not listed. Post implementation survey results demonstrated using this instrument improved documentation by making it more clear and concise. This note provides the ability to standardize documentation of a large call volume, thereby decreasing documentation errors and improving the availability of patient information. As utilization continues to grow, so does our ability to review practice issues and trends in specific populations. The ability to extract data is important to describe nursing practice for future research and education. The development and implementation of this evidence-based document may help nurses triage in all settings.

1027565

THE CLINICAL BENEFITS OF ACTIVE LEPTOSPERMUM HONEY: ONCOLOGIC WOUNDS. Debbie Segovia, RN, MSN, APRN-CNS, CWOCN, Cancer Treatment Centers of America, Tulsa, OK

A fungating tumor wound is a type of skin lesion that is marked by ulcerations and necrosis; usually accompanied by malodor. This type of lesion may occur in many types of cancer, including breast cancer, melanoma, and squamous cell carcinoma, especially in the presence of advanced disease [1]. The presence of a draining malodorous wound is a continual reminder of the underlying disease process and may contribute to low self-esteem, embarrassment, depression, and social isolation. Although a plethora of wound care products exist, consensus of opinion varies about which dressings to choose for the management of these wounds. This presentation will illustrate the properties and use of active Leptospermum honey (ALH) dressings and discuss the outcomes of using the dressings for two patients with fungating tumor wounds. Regardless of the wound etiology, the goal of care when managing a fungating tumor wound is to identify and treat the underlying cause and the symptoms of the wound. One component of the treatment plan includes management of underlying wound infections, exudates, bleeding, pain, and malodor [2] in order to promote comfort and improve quality of life. ALH dressings have been reported to clear infection, manage exudates, decrease pain and inflammation, and reduce or eliminate odor [3]. Several patients with fungating tumor wounds were selected to receive ALH dressings. The wounds were cleansed with surgical scrub, and rinsed with water. ALH paste and ALH calcium alginate dressings were applied and covered with an absorbent cover dressing. The dressings were changed according to the amount of exudate. In these two cases the dressings were easy to use, cleared necrotic tissue, decreased excess exudates, reduced pain, completely eliminated malodor, and did not disrupt friable tissue. Each patient reported satisfaction with the way the dressing reduced pain and completely eliminated odor. ALH dressings provided a moist environment, promoted debridement, reduced pain and inflammation, reduced or completely eradicated malodor, expedited healing in several wounds, and promoted comfort and improved quality of life in these two oncology patients with malignant (fungating tumor) wounds. Further studies are indicated.

1027733

BRINGING THE TEAM TOGETHER: THE BREAST CANCER CONTINUUM. Amy Rettig, MSN, MALM, RN, ACNS-BC, CBCN®, JamesCare Comprehensive Breast Center, The Ohio State University Cancer Program, Columbus, OH

Several considerations must be made when developing a breast continuum of care in a disease specific model. First, breast cancer patients interact, enter, and/or exit our system a variety of ways from diverse departments or units. Second, the health care personnel caring for breast cancer patients are physically located as close as the next exam clinic in the same building to across the city at other sites. Finally, our patients interact with a diverse group of personnel with a diverse set of knowledge, skills, and abilities. Bringing the team together is a challenge. The purpose of this project was to develop a team-building and educational forum that would cross the continuum of breast cancer care with the following parameters: convenient and efficient, relevant and enriching, patient care and safety focused. A 5 week Focus Group, facilitated by the Breast Cancer CNS, was formed to determine the best method for providing a team-building and educational forum. A guideline was developed by the group to assist health care personnel in the breast cancer continuum interested in sharing their expertise. Included in the guideline were: steps to follow, helpful hints for a 1/2 hour presentation, what to expect from a facilitator, a worksheet to develop a topic, and a checklist. The response has been very positive to The Breast Cancer Continuum. Weekly attendance for the educational offering has been 6-15

persons in attendance and 4-8 groups audioconferencing. The website activity has been in the discussion forums and podcast downloads. Feedback has been very positive from team members across the continuum, one such statement: I do believe these discussions will improve how we deliver care to our patients. When there are different schedules and locations, bringing people together - building the team - is challenging. Audioconferencing and a SharePoint Site offer viable alternatives to meeting in person. Each week a topic is audioconferenced to the health system. The website provides the central location for the calendar of events, a repository for documents and podcasts, and an added forum for further discussions about each weekly topic. Future opportunities include: webcasts and patient involvement.

1028604

TAKING MATTERS INTO OUR OWN HANDS: REEDUCATION OF ACUPRESSURE FOR CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING. Curt Haase, BSN, RN, OCN®, Ambulatory Nursing, Memorial Sloan-Kettering Cancer Center, New York, NY

The vast majority of chemotherapy patients report nausea & vomiting (NV) over the course of treatment. Historically, management of chemotherapy-induced nausea & vomiting (CINV) focused around pharmacologic antiemetics, though they have been shown to not be entirely effective and are accompanied by undesirable side effects. Interest exists for support by additional non-pharmacological interventions. Acupressure, the stimulation of an acupoint with either fingers or commercially available elastic wristbands with embedded studs, is safe, low-cost, easy-to-learn, convenient, and effectively combats CINV across different populations, ages, and cancer diagnoses. Implementation by oncology nurses requires little time spent; however, acupressure is wholly underutilized. The primary purpose is to ascertain the incidence of acupressure use for CINV by oncology nurses in an ambulatory chemotherapy infusion unit. Secondary purposes include identification of barriers oncology nurses face in using acupressure with patients, as well as in educating patients and caregivers to incorporate acupressure into their daily activities. In December 2009, the nursing staff of an ambulatory chemotherapy infusion unit was educated in the purpose and technique of acupressure for CINV using the neiguan (P6) acupoint. Informational fact cards were developed to support patient education. One year later, a nursing survey from the same unit assessed the frequency of acupressure use and the nurses' beliefs and attitudes toward acupressure for CINV. The survey elicited barriers from the nurses and their perceptions of patient barriers. One year after initial staff education, only 38% of acupressure-trained nurses surveyed offer acupressure to patients. Busy oncology nurses noted significant barriers and need innovative solutions. Eighty-eight percent of nurses not previously educated are interested in learning. Reeducation of all infusion nurses is needed to overcome barriers, ensuring oncology nurses' daily arsenals of tools includes acupressure for CINV. Stressing the effectiveness, simplicity, and importance of acupressure for CINV with oncology nurses can help make it part of each chemotherapy patient visit. Oncology nurses, having better understanding and an increased comfort level discussing and performing acupressure for CINV, can continue to empower patients and caregivers to take matters into their own hands to combat CINV.

1031488

CREATION AND DEVELOPMENT OF NIGHT EDUCATION TASK FORCE TO PROMOTE CONTINUING EDUCATION TO NIGHT SHIFT NURSES ON A BONE MARROW TRANSPLANT UNIT. Trish Sterling, RN, BSN, Nursing-BMT, Roswell Park Cancer Institute, Buffalo, NY; and Sarah Koff, RN, BSN, Nursing-BMT, Roswell Park Cancer Institute, Buffalo, NY

Educational in-services and programs are often offered during the day; leaving night shift unavailable to attend. Several night

shift employees had reported feeling as though they miss out on these educational opportunities and are often overlooked due to their shift. The education department, in our comprehensive cancer center, had conducted a needs assessment of each employee/floor to determine floor specific educational needs. In coordination with the night time educator; 2 staff nurses from the bone marrow transplant unit started the Night Education Task Force. The Night Education Task Force works to bring in speakers and educational opportunities on the night shift. As staff nurses we understand the importance of continuing education in our practice; the task force is aimed to better educate fellow oncology nurses. A variety of speakers have come in during the night shift to do in-services. Topics have included drug information, cardiac monitoring, ethics committee, Bone marrow transplant orientation for patients and family. Based on the needs assessment or questions that arise on the floor we choose topics that need to be further explained. We then contact the appropriate resources to request in-services. At the end of the year we will survey our staff to see if they feel their educational opportunities have increased. In addition another needs assessment will be done to see if needs were met from the previous assessment. The Task force works to improve nursing knowledge through additional resources and educational opportunities which will in turn improve patient care. For example: Cardiac classes were offered during the day and often staff were unable to make it due to scheduling needs; so we got in touch with the night educator and suggested doing cardiac in-services on nights. She has since broken down the class to several in-services she is offering on night shift.

1032208

CLICK THE LINK: USING AN ONLINE "E-ORDER RESOURCE GUIDE" AS A TOOL TO IMPLEMENT AN ELECTRONIC MEDICAL RECORD EDUCATION PROGRAM AT A MULTI-SITE COMPREHENSIVE CANCER CENTER. Robin Green, RN, MSN, OCN®, NYU Clinical Cancer Center, NYU Langone Medical Center, New York, NY; and Alexis Relucio, BA, MBTI, NYU Clinical Cancer Center, NYU Langone Medical Center, New York, NY

In 2001 the Institute of Medicine (IOM) advocated the use of an electronic ordering system to ensure safety and accuracy in medication ordering. An urban comprehensive cancer center processes approximately 150 chemotherapy orders daily; E-Orders, a computerized physician order entry (CPOE) facilitates the exchange of accurate medical information between all care providers. E-Orders were already in place when two new satellites were incorporated into the center. Implementing E-Orders at the new facilities would be challenging due to their locations and the multi-specialty of their users. The need for a standardized training process was essential. The Clinical Nurse Specialist (CNS) possesses the attributes, clinical expertise to appreciate the complexity of chemotherapy orders, knowledge of Adult Learning Theory and comprehension of organizational workflow, necessary to successfully implement E-Orders education. This presentation will describe the educational strategies employed to meet the institution's medication safety goals by providing education and building competency in the E-Order system to all clinicians. In collaboration with a training specialist, the CNS developed a PowerPoint program designed to delineate CPOE and medication administration guidelines. The program incorporated patient care situations to test user knowledge and evaluate ability to navigate E-Orders. Prior to implementation a multidisciplinary team of stakeholders assessed the application's practicality. The integration of a "test environment" made the program interactive. To facilitate self-directed learning an electronic index was implemented to simplify accessing information. Clinical competency was demonstrated by successfully entering "mock" orders, verifying chemotherapy orders, documenting medication administration and completing patient scenarios according to guidelines. Transference of learned skills was measured by auditing "live"

E-orders. The CNS is uniquely positioned to meet the challenge of facilitating complex educational initiatives. The CNS's clinical expertise was crucial in developing the realistic scenarios used to foster competency. Standardizing E-Orders training and increasing clinician proficiency reduces the margin for error, reinforces institutional medication safety goals and directly impacts the quality of care patients receive. Employing interactive educational experiences helps to keep the learner engaged. The online format enhances user flexibility in accessing content. All information is only a click away for any user, at any time, at any location.

1032478

COMMUNICATION PATTERNS BETWEEN ONCOLOGY SERVICES AND INTERVENTIONAL/PROCEDURAL AREAS: AN ONS SIG PROJECT. Gail Davidson, RN, BSN, OCN®, Nursing, The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, Columbus, OH; Joanne Lester, PhD, CRNP, ANP-BC, AOCN®, Nursing, The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, Columbus, OH; Jenny Shinsky, BS, Oncology Nursing Society, Pittsburgh, PA; and Margaret Irwin, RN, MN, PhD, Oncology Nursing Society, Pittsburgh, PA

With the increasing use of Interventional Radiology, the oncology care team has expanded. As roles of the team become more diverse, care fragmentation is a concern. While provision of care is central, the coordination, teaching, and communication to referral sources are also critical. Fragmentation of care when utilizing Interventional and Procedural areas was a topic of concern for members of the Surgical Oncology Special Interest Group (SIG) at the Congress 2009 Annual Meeting. Nearly all participants felt patients were not receiving ideal care. This presentation will demonstrate the development of a SIG project and its outcomes

The purpose of the study was to:

- 1) explore communication patterns between Oncology and Interventional/Procedural professionals.
- 2) identify barriers and best practices with oncology patients undergoing interventional procedures, and
- 3) describe strategies to be utilized by Oncology and Interventional/Procedural teams to promote safe care for oncology patients.

A SIG workgroup, with the assistance of Oncology Nursing Society staff, created a descriptive study to ascertain gaps in service, and identify best practice scenarios. A blinded, randomized electronic survey was distributed, with responses from various practice settings and multiple countries (n=325).

Communication gaps between oncology and interventional radiology services were commonly reported by registered nurses. Gaps in pre- and post- procedure patient education and communication between professionals were statistically significant ($p < 0.001$), as were a lack of understanding and ownership of roles and responsibilities ($p < 0.00$). Multiple scenarios described supported varying levels of clinical support and patient interventions.

The purpose of the project was to identify gaps, barriers, and best practices in communication patterns, also to ascertain the varying aspects of education and communication delivered, and by which providers. Strategies for improved care and communication were developed. The SIG Project was a success, with international participation that resulted in preliminary strategies. The sharing of this SIG project is important to demonstrate a successful outcome, the collaborative efforts of ONS staff, and the impact on patient care.

Future implications include improved education for patients and staff, dedicated nursing staff in Interventional areas, and standards for communication between referral sources.

1034657

EVIDENCE BASED PRACTICE (EBP) PROJECT: WHAT IS THE MOST EFFECTIVE ROUTE OF ADMINISTRATION FOR

EPINEPHRINE TO TREAT A HYPERSENSITIVITY REACTION IN ADULTS? Marie Swisher, MSN, RN, OCN®, Oncology, The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD

Immediate management of a hypersensitivity reaction is critical to a successful patient outcome. Variations in practice led the nursing staff at this NCI Designated Comprehensive Cancer Center to question which route of administration of epinephrine is most effective in treating these reactions. Twenty six different hospital protocols and order-sets containing epinephrine were identified. The various routes included intravenous (39%), subcutaneous (SQ)(23%), intramuscular or intravenous (8%), and no route specified (30%). The EBP Team set out to determine the most effective route of administration for epinephrine in the management of a hypersensitivity reaction. A literature review was conducted using the following MeSH terms: epinephrine, hypersensitivity, anaphylaxis, injections, and injections-intramuscular (IM). The search resulted in 309 articles. Articles that described use in children were excluded. In addition, a web search yielded two commercial websites (EpiPen® and Twinject™) and four medical reference sites (e.g. MDconsult) that were included in the evaluation process. Selected articles were published from 1997-2010. Thirty four articles were reviewed utilizing the Johns Hopkins Nursing EBP model. 47% recommended IM, 29% IM/auto-injector device and 12% SQ/IM routes of administration. Articles including auto-injectors primarily focused on populations receiving epinephrine in the outpatient setting. Twenty six sources cited one experimental epinephrine study (13 healthy males age 26 +2) to support the IM route. That author concluded that auto-injector (EpiPen®) was equal to IM injection and superior to SQ. This research cannot necessarily be generalized to the female population. EpiPen® needles are shorter than traditional SQ needles. One study looked at this specific issue and concluded that the distance from skin to muscle is higher in women compared to men and EpiPen® may not deliver IM in many women. At present IM cannot be considered superior to SQ as there are no known studies focusing on IM versus SQ (auto-injector) injection in women. There is a limited body of research evidence to support IM only as most effective route to administer epinephrine. There are no known studies that demonstrate inferior results using SQ epinephrine. There is a large body of anecdotal evidence supporting SQ or IM routes for epinephrine dose delivery.

1038962

FAMILY MEMBER'S PERCEPTIONS OF MOST HELPFUL NURSING INTERVENTIONS DURING END-OF-LIFE CARE OF A LOVED ONE. Julie Cronin, RN, BSN, OCN®, Gynecology/Oncology, Massachusetts General Hospital, Boston, MA

Much available literature focused on hospice and end of life care focuses on the dying patients comfort, pain management and last wishes. Many articles also articulate the morbidity and mortality rate of loved ones is greatly increased in the year after a family members death. However, there is very little literature identifying nursing interventions that improve the comfort, well being and quality of life of family members during the difficult time in which a loved one is receiving end of life care. There is a great need for research in this area of patient and family centered care. To identify family focused nursing interventions perceived as most helpful by loved ones of gynecologic/oncology patients during end-of-life care? One to two first degree relatives whose family member is receiving end of life care will be asked to complete two interviews; the first in person, and a second follow up telephone interview four to six weeks after the passing of the loved one. Subjects will be asked a set of five open ended questions seeking information about ways to promote family members' comfort and well being when their loved one is receiving end of life care. Thoughts and reflections of family members following the death of a loved one with a gynecologic cancer will help to guide nurses in meeting their needs most effectively both in the moment so that

they can navigate the crisis of death and best position themselves for recovery and grief resolution. The objective of this research is to improve or change nursing practice in order to better support the needs of family members during a difficult time. Due to the scarcity of information about this topic, it is imperative to conduct this research in order to better understand the needs of family members whose loved one is receiving end-of-life care. Illuminating these needs will help nurses provide better comfort and support to family members as well as better overall patient and family centered care.

1039273

THE CHALLENGE OF DISSEMINATING PATIENT INFORMATION: GETTING YOUR PROGRAMS TO THE PEOPLE WHO NEED THEM. Joanne Finley, RN, MS, Johns Hopkins Kimmel Cancer Center, Baltimore, MD

One of the challenges of patient education is disseminating information that is useful and necessary to patients and families. Nurses lead the multi-disciplinary approach to patient education; developing most of the programs and materials used with patients. They are also usually the professionals who implement the teaching. One comprehensive cancer center developed an audiovisual program for new patients to view prior to visiting the cancer center with the goal that the information would help them navigate a new setting and reduce patient anxiety. The program covers topics such as parking, registration, clinic routines and services and resources available to patients. It is housed on the cancer center's website. Patients are notified of its availability when they call to make their appointment. Program development, funding sources, production strategies and barriers, as well as dissemination strategies and barriers will be discussed. Patients completed a survey when they registered for their appointment, which asked if they were told about the program, watched the program and had computer access, in addition to satisfaction measures. Those results will be shared and have led to systems modifications. The modifications include additional wording in the appointment confirmation letter and verbal reminders to increase awareness of the program. Patient education can only take place if patients are aware of, utilize and have access to the programs that have been developed for them.

1042389

RECOVERY FROM GONADAL DYSFUNCTION AND INFERTILITY FOLLOWING ALLOGENEIC HEMATOPOIETIC CELL TRANSPLANTATION: COMPARISON OF 2-DAY VS. 4-DAY BUSULFAN IN CONDITIONING REGIMENS. Young-Shin Lee, RN, OCN®, MSN, Nursing 5 Team, Asan Medical Center, Seoul, Republic of Korea; Young-Ah Kang, RN, OCN®, MSN, Nursing 5 Team, Asan Medical Center, Seoul, Republic of Korea; Soon-Haeng Lee, RN, MSN, Nursing 5 Team, Asan Medical Center, Seoul, Republic of Korea; Je-Hwang Lee, MD, Departments of Internal Medicine, Asan Medical Center, Seoul, Republic of Korea; and Chung-Hoon Kim, MD, Obstetrics and Gynecology, Asan Medical Center, Seoul, Republic of Korea

Recovery of sexuality and fertility after hematopoietic cell transplantation (HCT) is one of major quality of life concerns in survivors who are successfully treated with HCT. Gonadal dysfunction and infertility have been reported as common problems among patients who receive myeloablative conditioning (MC) regimens, whereas there have been little data on the problems in patients receiving reduced-intensity conditioning (RIC) regimens. In this study, we wanted to compare the recovery from gonadal dysfunction and infertility following allogeneic HCT between patients receiving MC regimens including 4-day busulfan (BU4 group) and those receiving RIC regimens including 2-day busulfan (BU2 group) in a single institute. Johnson's behavioral system model (1980) served as theoretical background for the current

study. This study included 50 years or younger patients without relapse of underlying disease over 2 years following HCT and those who received busulfan (4mg/kg/day po or 3.2mg/kg/day iv) for 2 or 4 days as conditioning therapy. We performed a questionnaire survey for pregnancies, semen analysis, and pelvic ultrasonography. Blood levels of FSH, LH, and testosterone or estradiol were also assayed. A total of 53 patients, 43 males and 10 females, were included in this study. In males, blood levels of FSH and LH in BU2 (n=22) were significantly lower than those in BU4 (n=21) (P=0.003 and P=0.018), whereas testosterone levels were similar in both groups (P=0.817). Sperm counts in BU2 were significantly higher than those in BU4 (P < 0.001). Three patients in each group reported pregnancies of their partners. Among 10 females, 9 were in BU4 and one in BU2. Natural menstruation was reported from only one patient in BU2 who showed normal blood levels of FSH, LH, and estradiol, and normal antral follicle counts and ovarian size measured by pelvic ultrasonography. In contrast, none of 9 females in BU4 reported natural menstruation and none showed normal hormonal blood levels or normal pelvic ultrasonography findings. The results of this study suggest that RIC using 2-day busulfan appear to have more chance of gonadal function recovery compared to MC using 4-day busulfan. Our data will provide some guidance in counseling about recovery of posttransplant sexuality and fertility.

1043581

THE DEVELOPMENT OF A THERAPY INDUCED MENOPAUSE (TIM) EDUCATION PROGRAM FOR NURSES CARING FOR PREMENOPAUSAL WOMEN UNDERGOING A BLOOD OR MARROW TRANSPLANT (BMT). Erin Mutterback, RN, BScN, MScN/NP (c), Bone Marrow Transplant, The Ottawa Hospital, Ottawa, Ontario, Canada; and Linda Hamelin, RN, BScN, MN, Bone Marrow Transplant, The Ottawa Hospital, Ottawa, Ontario, Canada

There has been an increase in the number of patients undergoing a BMT to treat non-malignant and malignant diseases. With advancing treatments, patients are surviving longer after BMT with long-term complications including TIM. It is important that premenopausal patients undergoing a BMT be informed prior to treatment that therapy-induced menopause (TIM) is a probability. However, due to the sensitive nature of TIM and time constraints associated with clinic visits, there are few opportunities for in-depth conversations related to TIM with patients and health care professionals caring for these patients. The education program will increase nursing knowledge, confidence and assessment skills in the care and management of premenopausal patients undergoing BMT; thereby, improving nurse-patient discussions related to TIM and providing an opportunity to identify signs and symptoms before they become problematic. The project consists of a needs assessment of BMT nurses regarding their current knowledge of TIM. Focus groups discussing three questions will provide the basis for the content of the educational program. After the creation of the program a pilot project by the nurses from the focus groups of the program will take place on the BMT unit, with a follow up three months after the pilot for its usability. The majority of women undergoing BMT will experience ovarian damage due to the intensive doses of chemotherapy given with or without radiotherapy. Ovarian damage is usually irreversible and results in TIM. There is a lack of standardization in providing premenopausal patients with information related to TIM before and after BMT. It is evident in the literature that there is a need to address TIM in patients undergoing high dose chemotherapy. The Ottawa Hospital does not have formal nursing or patient education programs despite a large oncology population. Therefore, the development of an educational program for nurses that addresses TIM has the potential to improve patient outcomes at the TOH. This program could also be implemented hospital wide, including The Ottawa Hospital Cancer Clinic, in the future.

1044587

DECISION SUPPORT IN A COMPREHENSIVE NURSING ASSESSMENT IMPROVES DOCUMENTATION OF SYMPTOM MANAGEMENT IN AMBULATORY ONCOLOGY. Joan Moore, APRN, MSN, AOCN®, ACNS-BC, Hematology-Oncology, Smilow Cancer Hospital at Yale-New Haven, New Haven, CT; Judith Grasso, RN, MSN, AOCN®, Hematology-Oncology, Smilow Cancer Hospital at Yale-New Haven, New Haven, CT; and Peggy Simonette, RN, BSN, Information Systems and Technology, Yale-New Haven Hospital, New Haven, CT

Comprehensive nursing assessment is essential in developing nursing interventions which prevent, minimize, or treat the sequelae of cancer therapy. Clinical decision support systems (CDSS) are increasingly used to support nursing care assessments and planning. CDSS are most successful when they are integrated into the workflow at the time of decision making and are imbedded in the nursing assessment without requiring nurse activation. Comprehensive assessment could be improved using a systematic approach that includes decision support and prompts assessment of all symptoms using common language in toxicity assessment. The purpose of this project was to improve symptom management documentation by developing a comprehensive ambulatory flowsheet in the electronic medical record (EMR) that included integrated decision support and the National Cancer Institute (NCI) toxicity criteria terminology. An EMR nursing assessment flowsheet was created, which provided a systems review along with assessment of the most common physical and psychosocial symptoms. The NCI Common Terminology for Adverse Events was built into the assessment responses, allowing for consistency of language in toxicity evaluation. The flowsheet prompts toxicity evaluation for and documentation of fatigue, nausea, vomiting, diarrhea, constipation, mucositis, neuropathy, rash, as well as depression, anxiety and sexuality, which are symptoms that are sometimes overlooked. We audited 185 ambulatory visit flowsheets for documentation of toxicity evaluation. Of the 665 abnormal findings documented, consistent use of toxicity grading criteria was demonstrated, with interventions documented for symptoms graded ≥ 2 . Improved documentation of type and extent of rash was noted. Documentation of depression, anxiety, and sexuality comprised 27% of the easily identified, abnormal findings, compared with previous assessments imbedded in nursing notes. Devising a comprehensive EMR-generated nursing assessment, including toxicity grading and decision support, provides consistent communication and documentation, allowing for more effective interventions and improved outcomes. As more institutions are enhancing their documentation systems with the use of EMRs, the flowsheet devised for our oncology ambulatory settings could be easily replicated in other institutions to enhance communication among healthcare professionals, so that symptoms associated with cancer therapy can be prevented, minimized, or promptly treated.

1044700

RELATION OF COGNITIVE FUNCTION AND FUNCTIONAL STATUS IN WOMEN RECEIVING ADJUVANT HORMONAL THERAPY. Chiu-Ping Su, RN, MSN, Department of Nursing, National Taiwan University Hospital, Taipei, Taiwan; Shiu-Yu C. Katie Lee, RN, MSN, DNSc, School of Nursing, National Taipei University of Nursing and Health Science, Taipei, Taiwan; and Yen-Shen Lu, MD, PhD, Department of Oncology, National Taiwan University Hospital, Taipei, Taiwan

The adjuvant hormonal therapy is one of common treatments for breast cancer. The women with breast cancer often complained about memory loss and attention deficit after cancer treatment. There is limited information about the cognitive function and its relation with functional health. This study was to describe relation of cognitive function and functional status

in women receiving adjuvant hormonal therapy. This was a cross-section, descriptive study. A convenience sample of 129 women with early-stage breast cancer was recruited in a medical center in Taipei. Cognitive function was measured by Montreal Cognitive Assessment (MoCA) to test the visuospatial, memory, attention, language, abstraction and orientation, and by EORTC-CF for perceived cognitive difficulty. Functional health was measured by SF-36. All three instruments were in Traditional Chinese and demonstrated Cronbach's α of 0.70 - 0.82. Data were analyzed by using SPSS 16.0. The women had a mean age of 52.2 and were 2.5 since diagnosis. A majority of them were married, with high-school-or-above education and had stage II breast cancer (56.6%), MRM (53.5%), chemotherapy (74.4%) and Tamoxifen (75.2%). Results showed that the women reported a mild to moderate cognitive difficulty (67.5 ± 21.4); 41.9% of them performed less than 26 on MoCA after adjusted with education; and 24% were compatible with mild cognitive deficit and greater than 1/4 can't perform visuospatial. After control with chronic illness, the visuospatial, memory, abstraction and EORTC-CF were significantly related to the role limitations due to physical function.

1044773

THE IMPORTANCE OF EDUCATING NURSES IN THE COMMUNITY ON ONCOLOGIC EMERGENCIES. Suzanne Brady, RN, BSN, CCRN, ICU, Roswell Park, Buffalo, NY

As the number of people diagnosed with cancer increases, the incidence of oncologic emergencies also increases. Education is needed on oncologic emergencies so that nurses can quickly intervene and save lives. With that in mind, it is important to educate our colleagues and community with current information regarding emergencies in cancer patients. In speaking with our peers, the nursing education council found there was a need to educate nurses including our colleagues in the community about oncologic emergencies. As a result, we offered an opportunity to take part in an Oncological Emergencies education day. The purpose of this program was to provide registered nurses in a comprehensive cancer center and surrounding community an overview of the signs, symptoms and nursing management of malignant pleural effusions, tumor lysis syndrome, sepsis, increased intracranial pressure and superior vena cava syndrome. Once the nursing education council decided there was a need for education among nurses regarding oncologic emergencies, the group organized a day long program including speakers from throughout the medical profession. The speakers included three doctors, a staff development instructor and a nurse practitioner. The program offered 5.25 continuing nursing education credits. Members of the council were involved in planning, advertising and hosting the event. The program had an attendance of 59 nurses. Based on the evaluation results, the goal of the council had been met. The evaluations included the comment, "good presentation, very informative." By providing education to nurses and the community we can recognize and intervene in these emergencies earlier and may even prevent a life threatening complication.

1045559

LIVING MY FAMILY'S STORY: CARING FOR AND IDENTIFYING THE SELF WITHIN THE CONTEXT OF HIGH RISK FOR HEREDITARY BREAST CANCER. Meghan L. Underhill, FNP-BC, School of Nursing, University at Buffalo, State University of New York, Buffalo, NY; Robin M. Lally, PhD, RN, AOCN®, CNS, School of Nursing, University at Buffalo, State University of New York, Buffalo, NY; Suzanne S. Dickerson, DNS, RN, School of Nursing, University at Buffalo, State University of New York, Buffalo, NY; Marc T. Kiviniemi, PhD, Community Health and Health Behavior, University at Buffalo, State University of New York, Buffalo, NY; and Christine Murekeyisoni,

MPH, Surgical Oncology, Roswell Park Cancer Institute, Buffalo, NY

In the past decade, advancements in genetic science have given rise to an influx of research and information regarding hereditary risk for breast cancer. Genetic information allows for clinicians to quantify breast cancer risk, subsequently identifying a population of women now living with knowledge of increased risk based on personal or familial cancer history. In turn, there are healthy individuals living with knowledge of a potential vulnerability to cancer that may never occur. As science moves forward, it is important to step back and understand what all of this knowledge means to the persons living with hereditary breast cancer risk. To explore how women at high risk for hereditary breast cancer incorporate this risk into their lives. Aims: (1) understand how women living with knowledge of hereditary risk form self-identity, (2) explore practical knowledge and self care strategies women apply to managing this risk, and (3) describe the personal meaning of experiencing care through a high risk breast program. An interpretive hermeneutic phenomenological approach, based on the philosophy of Martin Heidegger, guided the qualitative research design. Twenty women at high risk for hereditary breast cancer were recruited from a high risk breast program. Open ended interview questions focused on personal experiences living as a women managing high breast cancer risk. Consistent with hermeneutic methodology, the principal investigator led a team to analyze the deidentified interview transcripts based on a modified Diekelman, Allen and Tanner (1989) method. Results demonstrated that these women are living their family story and actively grieving over family members lost to cancer. This familial story forms the basis of their self identity, directly influencing their self care strategies. One component of these strategies is seeking out care from a hereditary breast cancer risk expert not only for early detection and prevention, but for early treatment "when" diagnosis occurs. Findings present important practical information regarding health promotion, psychosocial assessment and support for women living with this risk.

1045575

REDUCING NON-VALUE-ADDED NURSING TIME IN THE OUTPATIENT ONCOLOGY SETTING TO IMPLEMENT A PERSONALIZED PLAN OF CARE. Lynda Tunon, RN, MSN, OCN®, Patient Education, UPMC Cancer Centers, Pittsburgh, PA; Doris Dickinson, RN, BSN, OCN®, Outpatient Services, UPMC Cancer Centers, Pittsburgh, PA; Tammy Gatto, RN, MSN, MBA, Outpatient Services, UPMC Cancer Centers, Pittsburgh, PA; Nikki Urban, RN, BSN, OCN®, Outpatient Services, UPMC Cancer Centers, Pittsburgh, PA; Susan Frank, RN, MSN, Outpatient Services, UPMC Cancer Centers, Pittsburgh, PA; and Kyle Bird, MHA, Process Improvement, UPMC Cancer Centers, Pittsburgh, PA

Central to clinic visits in the outpatient oncology setting is teaching patients the Plan of Care (POC) which includes educating patients about their treatment, possible side effects, symptom management and types and frequency of blood work and imaging tests. A review of the literature supports the value of assessing the work environment and activities of nurses to determine optimal ways to utilize nursing knowledge and skills. Non-value-added work for nurses (gathering patient records, responding to non-clinical phone calls, and scheduling tests for patients) can be reassigned to ancillary staff (medical assistants, registrars, and secretaries) allowing nurses to increase their time spent in direct patient care activities such as patient teaching and psychosocial support. Through work redesign processes, nursing care delivery can be improved in the outpatient oncology clinic. The goals of this project were to increase direct nursing time with patients by reducing the non-value-added work for nurses and to present each patient with a personalized POC. A multidisciplinary team developed a unique POC document which serves as an itinerary and teaching tool for the patient. A Neuro-Oncology Clinic within

our NCI-designated Comprehensive Cancer Center served as the test of change for this educational initiative. Outcome data at six months showed a 31.5 % reduction in non-value-added work for nurses from baseline. Nurses were able to be present with the patient when the oncologists discussed the treatment plan and had additional time to educate the patient about the drugs, labs and imaging tests that were scheduled. Each patient received an electronically generated treatment calendar and personalized patient notebook as they left the clinic. The project was then rolled out to the 16 medical oncology and hematology oncology clinics in our outpatient cancer center. We will present baseline data, work redesign processes, a sample POC, outcome results, barriers, lessons learned, and data from follow-up surveys of nurses and patients to evaluate time spent with each patient and the personalized POC with appropriate education and support. These processes can be adopted by other outpatient cancer centers nationwide to improve patient education related to the POC.

1046034

IMPROVING NURSE AND PATIENT CARE ASSISTANT COMMUNICATION TO PROMOTE PATIENT SAFETY. Karen Lege-re, BSN, RN, OCN®, Oncology Nursing, Dana-Farber/Brigham and Women's Cancer Center, Boston, MA; Debra Moody, BSN, RN, Oncology Nursing, Dana-Farber/Brigham and Women's Cancer Center, Boston, MA; Alice Laplante, PCA, Oncology Nursing, Dana-Farber/Brigham and Women's Cancer Center, Boston, MA; Escel Stanghellini, RN, MSN, CPHQ, Oncology Nursing, Dana-Farber/Brigham and Women's Cancer Center, Boston, MA; Eileen Molina, RN, MSN, Oncology Nursing, Dana-Farber/Brigham and Women's Cancer Center, Boston, MA; Mona Parker, PCA, Oncology Nursing, Dana-Farber/Brigham and Women's Cancer Center, Boston, MA; and Rose Romain Charles, PCA, Oncology Nursing, Dana-Farber/Brigham and Women's Cancer Center, Boston, MA

Reducing patient falls and subsequent harm is a priority for the oncology service at Dana-Farber/Brigham and Women's Cancer Center. Review of data suggested that falls commonly occur around change of shift. Further root cause analysis revealed that falls were related to the need for toileting or an unmet personal need. The primary goal was to reduce harm to patients occurring as a result of falls, focusing on hand-off communication at change of shift. Reducing gaps in communication between nurses and patient care assistants(PCAs) was of major importance. Clarifying role expectations of both nurses and PCAs would help facilitate this goal. Additionally, variations in practice would be eliminated by implementing a safety check plan which included fall risk score using the Morse Fall Risk Score. Plan-Do-Study-Act was used for planning and implementation. A new hand-off tool was developed to improve communication between nurses and PCAs. Using the tool the outgoing and incoming PCAs would round together, visiting all patients with a fall score of 45 or greater. High risk rounds at change of shift include; supervised toileting of patients, ensuring bed alarms are set, and environmental safety checks. Daily huddles were conducted to evaluate and help sustain the change for the first month. The results of this intervention have been excellent. Since implementation 7 months ago, there have been no patient falls at change of shift. An unexpected benefit of the high risk rounds has been improved teamwork between nurses and PCAs. Additionally, PCAs have felt empowered by having tangible evidence of the importance of their work, resulting in better performance. Preventing falls in the oncology population is of great relevance to current nursing practice. Improving hand-off communication and clarifying role expectations for both nurses and PCAs has enabled this oncology service to reduce harm to patients by preventing falls. An efficient and thorough communication tool has been of key importance in facilitating this process. The PCAs on the unit played a major role

carrying out this project which has enhanced communication and teamwork between nurses and PCAs.

1046704

COPING WITH BREAST CANCER AND LONG-TERM HEALTH PROMOTION: EXAMINING MALADAPTIVE COMMUNICATION BETWEEN MOTHERS AND YOUNG-ADULT DAUGHTERS. Teri Pipe, PhD, RN, Nursing Administration, Mayo Clinic Arizona, Phoenix, AZ; Carla Fisher, PhD, Social and Behavioral Sciences, Arizona State University, Tempe, AZ; Sharon Levey, BSN, OCN®, Mayo Clinic Cancer Center, Mayo Clinic Arizona, Scottsdale, AZ; Katherine Hunt, MS, CGC, Mayo Clinic Cancer Center, Mayo Clinic Arizona, Scottsdale, AZ; and Anita Wood, PhD, Nursing Administration, Mayo Clinic Arizona, Phoenix, AZ

This project examines breast cancer as a mother-daughter experience. Diagnosed mothers and their daughters often take on the disease together. For instance, daughters often provide support to their diagnosed mothers for the first time and even provide caregiving during treatment. They also face disease risk. Daughters battle a chronic psychological disease risk for themselves and recurrence for their mothers. Based on these shared experiences, it is not surprising that their mental and physiological stress responses are highly correlated. How mothers and daughters adjust is in part determined by their interactions. The purpose is to investigate the maladaptive functioning of communication patterns (daughters' withdrawal competing with mothers' desire to talk to communally cope and address prevention) previously identified. Avoidance during such talks is associated with psychological and physiological distress. This study investigates contributors to this pattern to ascertain healthier ways of coping. A secondary focus concerns health promotion and prevention, to identify daughters' reticence to talk about or engage in such behavior. Conceptual Model/Theoretical Framework: The Family System Genetic Illness Model explicates the intersection of health and family communication and demonstrates the centrality of kin interaction when one member is afflicted with a disease, illness, or stress. Methods/ Analysis: A mixed-method design with interviews, longitudinal diaries, diary-interviews, coping and quality of life measures are employed to obtain authentic narratives of mother-young-adult daughter communication as they cope with the disease and discuss health prevention issues, like genetic testing and coping with results. Sample is 20 mother-daughter dyads (40 women). The emergent stories will be used to create a program to teach mothers and daughters how to cope by providing behavior-modeling scripts of healthy communication and coping. Mixed methods, qualitative and quantitative. This study has particular relevance for nurses because effective coping can play a positive role in patients' and family members' ability to cope with the disease and encourage proactive health promotion strategies including cancer risk management. Knowledge gained will be useful in developing services that can improve mother-daughter communication when coping and talking about health prevention.

1046763

SICKLE CELL DISEASE MANAGEMENT QUALITY IMPROVEMENT AT THE UNIVERSITY OF CALIFORNIA DAVIS MEDICAL CENTER. Helen Rice, Cancer Center Clinics, UC Davis, Past Hematology Specialty Nurse, VA Medical Center Madison Wisconsin, University of California Davis, Sacramento, CA; Anne Beattie, Infusion Center, UC Davis Cancer Center, University of California Davis, Sacramento, CA; Quy Tran, Hematology/Oncology, UC Davis Medical Center, University of California Davis, Sacramento, CA; Paul Kaesberg, UC Davis Medical Center, University of California Davis, Sacramento, CA; Patricia Palmer, AOCN®, UC Davis Cancer Center, Univer-

sity of California Davis, Sacramento, CA; and Margo Bolander, UC Davis Sickle Cell Program

Barriers to effective care of sickle disease include lack of staff education and experience, mutual lack of trust between patients and providers, and lack of standardized protocols. In 2008, there were 83 unique admissions for sickle cell disease complications at UC Davis Medical Center, with an average LOS of 7.75 days and 12 outlier admissions of 20-60 days. 73% of staff indicated they had received no training in sickle disease management and 61% indicated they had inadequate knowledge. There was no standard for inpatient or outpatient care of sickle cell disease at that time. The purpose of the project was to improve care in several aspects including pain control, emergency room care, opioid prescription management and staff education. A multidisciplinary committee of RNs and physicians at UC Davis Medical Center met monthly. Patient care protocols and order sets were developed and implemented across the system. Results of this project were 1) creation and use of a day care sickle cell pain control protocol to avoid hospitalizations and ER visits. 2) UC Davis and the committee hosted the California Sickle Cell Symposium in 2009 and 2010. 3) implementation and consistent use of a) standard inpatient sickle pain crisis order sets b) a standard protocol and order set for ER treatment of sickle pain crisis; c) a standard opioid use patient agreement and refill plan. In 2009, average LOS decreased to 7.1 days and outliers decreased to 6 (25-63 days). Standardization of protocols and staff education can lead to decreased length of stay. They will also allow further evaluation of effectiveness of care and patient satisfaction, which is in progress.

1046815

NON-TRADITIONAL FUNDING MECHANISMS: FOSTERING ONCOLOGY NURSING RESEARCH IN THE CLINICAL SETTING. Teri Pipe, PhD, Nursing Administration, Mayo Clinic Arizona, Phoenix, AZ; Jocelyn Pearson, MS, RN, Nursing Administration, Mayo Clinic Arizona, Phoenix, AZ; Wendy Greer, MS, RN, Mayo Clinic Cancer Center, Mayo Clinic Arizona, Scottsdale, AZ; and Jay Maningo-Salinas, PhD, Nursing Administration, Mayo Clinic Arizona, Phoenix, AZ

It has become increasingly recognized that nurses participate in a diverse number of oncology research projects. However, often these projects focus on medical treatment rather than nursing phenomena. While the bulk of medical research is in the areas of new drug development and devices, the areas pertinent to nursing research are less well supported and developed. We believe that a comprehensive team approach to clinical research and care would result in optimal patient outcomes, including an improved quality of life and potentially an improvement in patient survival. While there is inherent interest from the nursing staff, resources are not readily available to support the development of research skills needed to conduct studies and time away from clinical priorities in order to accomplish nursing research. To recognize the contributions of the nursing staff toward cancer clinical research and to provide a seed funding mechanism through which we could invigorate these activities we made a request for an unrestricted educational grant from a pharmaceutical company. The goals and purpose of this grant intended to stimulate ongoing and future activities in the area of nursing research. We applied and received funding for educational activities that would support oncology nursing research. As part of the grant, we convened an advisory panel, designed a call for proposals, scientific review criteria and budgetary processes. We provided one-on-one consultations for applicants about the proposal process. Two finalists were selected. Both proposals have been approved by the IRB and are ready for implementation. Details of both projects will be described in the presentation by the nurses who are leading each initiative. The presentation will highlight lessons learned regarding garnering external funding from non-traditional sources for nursing and using the resources to develop oncology nursing research proposals.

1047221

USING A VIRTUAL CLASSROOM TO MAKE LEARNING EASY AND ACCESSIBLE. Abigail Baldwin, RN, MSN, Memorial Sloan Kettering Cancer Center, New York, NY; and Ethel Law, RN, MA, OCN®, Memorial Sloan Kettering Cancer Center, New York, NY

Oncology nurses face the challenge of delivering quality patient care while integrating technology into everyday practice. Nurses struggle with maintaining competency while staying abreast of a large number of evolving technologies, such as electronic medical records, clinical documentation, e-mail communication, smart pumps and computerized physician order entry. In response to the growing need of timely, efficient education in the field of nursing informatics, the Ambulatory Nursing Informatics Council developed a virtual classroom. The purpose of the virtual education sessions are to: acknowledge and address the learning needs of ambulatory nurses; provide education to nurses in their clinical setting, thereby eliminating the need to travel and interrupt nursing care delivery; increase technological proficiency with the systems used and capture a large number of nurses in one session. A learning needs assessment conducted with over 200 outpatient nurses, identified specific areas of educational need. The virtual classroom was created by utilizing Cisco Unified MeetingPlace™. This is a web based application that integrates audio, visual, and web conferencing capabilities to conduct remote meetings. The web based application allowed the session facilitator and the attendees to be in multiple locations. With the focus on one topic, the sessions lasted no longer than 15 minutes and provided concise information. The nurses attending the sessions remained in their clinical area resulting in minimal disruption to patient care. Post-test results scored higher than the pre-test indicating overall increased knowledge in the topic that was presented after attending the virtual classroom. 100% (n=14) of nurses surveyed found this more helpful and convenient to attend than in the classroom. Anecdotally, nurses reported improved satisfaction in this method of learning overall. Both novice and experienced nurses found that the virtual classroom reinforced the information taught during regular classroom educational sessions. This eliminated traveling time thereby increasing time for learning. This educational intervention is an effective and efficient strategy to assist nurses in staying current with technology applications that fundamentally impact patient care delivery. Nurses are encouraged to utilize and participate in virtual education for pertinent learning needs to improve patient outcomes.

1047273

PARTNERS IN PRACTICE: INNOVATIVE EDUCATION FOR ONCOLOGY UNLICENSED ASSISTIVE PERSONNEL. Janice Reid, RN, MA, OCN®, Professional Development, Memorial Sloan Kettering Cancer Center, New York, NY; Gretchen Copeland, EdD, RN, OCN®, Professional Development, Memorial Sloan Kettering Cancer Center, New York, NY; Michelle Cavuoto, RN, BSN, OCN®, Critical Care and Pediatrics, Memorial Sloan Kettering Cancer Center, New York, NY; and Robina Kitzler, RN, MSN, CPAN, Perioperative Services, Memorial Sloan Kettering Cancer Center, New York, NY

In the fast-paced oncology setting, education is typically driven by regulatory requirements, new equipment and patient care initiatives. With education resources often directed toward professional nursing staff, unlicensed assistive personnel (UAP) may be an underserved learner population. While performing vital direct patient care and clerical responsibilities, UAPs may not receive the educational support needed to foster exemplary practice. Based on informal learning needs assessment from nursing leadership and UAPs, the project described was a collaborative effort between nursing education and practice aimed at providing knowledge and fostering teambuilding in UAP staff. Conceptually rooted in

adult learning theory and the Relationship Based Care Nursing Model, a plan for UAP education was devised. A variety of teaching strategies were used in a one day education program, followed by a series of unit-based staff development offerings. The goals of the programs were to 1) recognize the contributions of UAPs in providing safe, quality patient care; 2) impart knowledge about nursing programs, policies and equipment; and 3) foster camaraderie and collaboration. The Relationship Based Care Model framed the key curriculum threads of patient care, teambuilding and self-care. The one day education program included information on scope of practice, delegation, geriatric and psychosocial care, patient safety, career development and a wellness roundtable panel. Creative teaching strategies were used in the unit based inservices including games, case studies and learner participation on topics including tubes/drains, safety and pain management. In a creative use of education resources, two unit programs were implemented by nursing graduate students mentored by Nurse Educators. In program evaluations, UAPs expressed an appreciation for the opportunity to come together to build their knowledge base, interact with one another and feel valued for their contributions to patient care. This project highlights the importance of education for UAPs in recognition of their contributions to quality patient care in a healthcare environment increasingly challenged to maximize resource efficiency. The programs were grounded in a relationship-based nursing model focused on valuing care providers, promoting knowledge, teamwork and self-care. Next steps include more one day and unit inservice programs with interactive teaching strategies.

1047283

INCORPORATING A DISTRESS THERMOMETER TO IMPROVE PATIENT OUTCOMES IN PANCREATIC CANCER.

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Pancreas cancer carries a poor prognosis and increasing access by patients to these bleak statistics is associated with high levels of anxiety and distress. Since 2005, we have collected a Distress Thermometer score (DT) (visual analog scale 0-10) at each clinic visit to identify and characterize patient distress. Here we provide analysis of 140 paired measurements to better understand issues that contribute to that distress and means to alleviate it in patients with a pancreatic cancer diagnosis. 1. To determine if initial consultation in a multi-disciplinary pancreatic cancer clinic and the development of a treatment plan serves to decrease distress in patients by comparing the change in DT between initial and subsequent clinic visit. 2. To determine the correlation if any between the DT and demographic variables of age, gender, ethnicity, performance status, stage of disease, treatment with curative versus non-curative intent and weeks to death. 3. To describe psychosocial concerns leading to increased distress in patients with pancreatic cancer. Multi-disciplinary clinic evaluation to establish diagnosis, complete staging, and initiate a treatment plan including collection of DT score initially and 1-8 weeks follow up. A DT ≥ 5 prompted social work evaluation to identify patients at high risk for psychosocial distress and triggered increased participation of the interdisciplinary team in psychosocial care of these patients. Average initial DT was 5.29 (range 0-10). Subsequent DT decreased in 60%, remained the same in 18.6% and increased in 21.41%. The sample data from 140 patients with paired measurements and associations of distress with patient, disease and treatment variables will be presented. Correlation of the DT with specific concerns noted by patients reported at the clinic visit will also be analyzed. DT screening has enhanced participation

of nursing, social work and physicians in working together to address psychosocial concerns with a goal of lessening distress. Intent will be to identify factors that significantly increase distress levels so that interventions can be designed and incorporated into the plan of care for these patients and their caregivers.

1047336

ASSESSING QUALITY OF LIFE CONCERNS FOR THE DEVELOPMENT OF A MELANOMA SURVIVORSHIP PROGRAM.

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Melanoma survivors make up seven percent of the estimated number of cancer survivors in the United States. Due to advances in early detection and improved treatment options Melanoma survivorship periods are extending. Quality of life (QOL) in Melanoma survivors is becoming an increasingly important concern. The Institute of Medicine (IOM) has researched the care of cancer survivors and found that little information or guidance is available to care for the medical and psychosocial problems that may arise post treatment in these cancer survivors. The purpose of this study is to perform a needs assessment of the concerns in Melanoma cancer survivors. Based on the results a comprehensive Melanoma survivorship program will be developed and will address emotional, physical, and psychological quality of life issues. Support will be provided through a multidisciplinary and supportive care services approach, regardless of stage or age. The Rodgers Evolutionary Concept Analysis will be used to evaluate the data. This framework is a systematic data collection process by which multiple phases are used to quantify and clarify information collected. We will be utilizing the Quality of Life-Cancer Survivors (QOL-CS) visual analog scale. This is a 41-item questionnaire that is comprised of four sub-scales which address physical, psychological, social, and spiritual well-being. The survey will be mailed out to 200 melanoma survivors stages II-IV. The subjects will then be stratified into groups based on stage of melanoma and age. An evaluation of the surveys will determine the physical and psychological burdens which are of greatest concern for melanoma survivors. The findings of the study will be used to direct the focus and resources of the survivorship Melanoma program. The results will help to establish a comprehensive care plan for melanoma survivors. The nurses involved in the survivorship program will integrate the findings to improve quality of life in the Melanoma survivors.

1047393

OUTCOMES OF A PATIENT HAND WIPE TRIAL ON THE ONCOLOGY UNIT.

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Evidence shows hand hygiene is an important part of preventing Hospital Associated Infections (HAIs). Nurses stated they frequently encourage patients to cleanse hands, but patient interviews and direct observation showed patients were rarely offered materials or encouraged to cleanse hands especially before meals. Nurses stated that few patients receive hand hygiene before eating due to inability to get to the sink independently, not asking for help, or ease of materials for cleaning hands. One thousand hand wipes were initially supplied to the oncology unit for placement on each meal tray. No education was provided to the patients, and a simple email announcement was sent to the nursing staff. Goal

was to increase patient hand wipe usage from baseline assessment using patient and staff education tools, and to show a cost benefit for purchase of hand wipes to supply entire hospital. After a baseline trial, it was found that education at multiple levels needed to occur. Two months worth of hand wipes were supplied by Professional Disposables International, Inc. Dietary aides were educated on the importance of patient hand hygiene, and were provided a script to say while delivering meal trays. Email blasts to nursing staff, signage throughout unit, and sign-off acknowledging trial was completed. Posters were placed in each patient room and brochures handed out to newly admitted patient. Dietary staff kept a log of how many wipes went out and how many came back unused. The baseline trial yielded 30% usage rate. With added education of nursing staff, dietary staff, and patients the second trial has shown a 70% usage rate at one and half months into the trial. Patient hand hygiene has a role in decreasing infections and environmental contamination. Oncology nurses play a role in educating their patients about the risks of HAIs, especially those patients at increased risk due to neutropenia post chemotherapy. With HAIs contributing to an increased cost to today's healthcare environment we need to take a multifaceted approach to reducing this cost. Patient hand wipes can be one intervention to help decrease the cost of HAIs.

1047438

A COMPARISON OF TWO ANTIBIOTIC PROTOCOLS USED FOR PREVENTION OF INFECTION IN PATIENTS UNDERGOING TRANSRECTAL PLACEMENT OF FIDUCIAL MARKERS USED AS LOCALIZATION DEVICES FOR THE TREATMENT OF PROSTATE CANCER WITH IMRT. Joanne McCarvey, RN, BSN, OCN®, Radiation Oncology, Fox Chase Cancer Center, Philadelphia, PA; Lisa Campopiano-Hicks, RN, OCN®, Urology Surgical Oncology, Fox Chase Cancer Center, Philadelphia, PA; Susan Burke, RN, BSN, OCN®, Urology Surgical Oncology, Fox Chase Cancer Center, Philadelphia, PA; Patricia Thompson, RN, OCN®, Urology Surgical Oncology, Fox Chase Cancer Center, Philadelphia, PA; Janet Farley, RN, BSN, OCN®, Radiation Oncology, Fox Chase Cancer Center, Philadelphia, PA; and Monica Domenick, RN, BSN, OCN®, Urology Surgical Oncology, Fox Chase Cancer Center, Philadelphia, PA

To prevent infections due to fiducial placement for prostate cancer treatment, antibiotics are typically used prior to, during, and after the procedure. Fluoroquinolones (ciprofloxacin) have been the antibiotic of choice for prophylaxis because of their potent activity against the spectrum of pathogens in the urogenital tract. However, controversy has developed over this practice because of emerging evidence of bacterial resistance to this class of drugs. Alternative protocols with broad coverage of pathogens without the antibiotic resistance are being sought. The purpose of the study is to conduct a retrospective comparison of the effectiveness of two antibiotic protocols in reducing the incidence of post procedural infections following placement of Gold Seed fiducial or Calypso Beacon radiation localization for prostate cancer: parenteral rocephin versus oral fluoroquinolones. The oral fluoroquinolone protocol was used from 9/2008 through 6/2009. The current protocol of parenteral rocephin was initiated in 6/2009 and continues to the present. Under the rocephin protocol, penicillin allergic patients are given Bactrim DS BID for 5 days. If allergic to penicillin and sulfa, they receive Cipro for 5 days. This project examines clinical evidence in our own setting for prevention of infection by comparing the effectiveness of these two antibiotic protocols. All cases from 9/2008 to 6/2009 that received the fluoroquinolone protocol have been reviewed. These cases are compared with all cases from 6/2009 through 9/2010 that followed the rocephin protocol. Variables of interest include post-procedure urinary tract infection, antibiotic used, pathogen cultured, and antibiotic resistance. 284 records have been reviewed. Statistical

analysis will be conducted to determine whether this difference is statistically valid. This project will ascertain whether the change in antibiotic protocols was associated with a decrease in the number of infections. This result will provide evidence to guide the development and modification of practice guidelines. Preventing adverse events such as infection is the nursing-sensitive patient outcome oncology nurses strive to achieve.

1047497

CHARACTERISTICS ASSOCIATED WITH MEMBERSHIP IN SMOKING CESSATION SUBGROUPS AFTER THE DIAGNOSIS OF CANCER. Mary E. Cooley, RN, PhD, Research in Nursing, Dana Farber Cancer Institute, Boston, MA; Qian Wang, PhD, Biostatistics and Computational Biology, Dana Farber Cancer Institute, Boston, MA; Shoshana Rosenberg, MS Society, Health and Human Development, Harvard School of Public Health, Boston, MA; Karen M. Emmons, PhD, Society, Health and Human Development, Harvard School of Public Health, Boston, MA; Bruce E. Johnson, MD, Thoracic Oncology, Dana Farber Cancer Institute, Boston, MA; and Robert Haddad, MD, Head and Neck Oncology, Dana Farber Cancer Institute, Boston, MA

Smoking cessation interventions are an essential component of cancer care to enhance clinical outcomes. Understanding the characteristics associated with membership in smoking cessation subgroups may help inform future interventions. The purposes of this study were to identify patterns of smoking behavior after the diagnosis of cancer and to identify differences in demographic, psychosocial and behavioral characteristics among the subgroups of smokers. The Biopsychosocial and Social Cognitive Models guided this study. Data were collected from 163 smokers or recent quitters with lung or head and neck cancer at entry to the study, 132 and 116 had data collected at 3 and 6 months later. Standardized questionnaires were used to collect demographic, psychosocial and behavioral data. Biochemical verification with urinary cotinine was used to define continuous abstinence smoking status. Descriptive statistics, Chi-Square, Fisher's Exact, Analysis of Variance, and Kruskal-Wallis tests were used for analyses. Three main patterns of smoking behavior were identified; continued quitters, delayed quitters, and continued smokers. Sixty-three (48%) and forty-six (40%) patients were continued quitters at 3 and 6 months, 27 (20%) and 26 (22%) were delayed quitters at 3 and 6 months and 42 (32%) and 44 (38%) were continued smokers at 3 and 6 months, after entry to the study. The presence of household smoking, craving, symptom distress, and self-efficacy were significantly different among the subgroups at 3 months and the presence of household smoking, craving, self efficacy and perceived control were significantly different at 6 months. Continued quitters had lower craving and higher self-efficacy as compared with delayed quitters and continued smokers at 3 and 6 months. Delayed quitters had lower symptom distress at 3 months as compared with continued quitters and continued smokers, whereas they had higher perceived control at 6 months as compared to continued quitters and continued smokers at 6 months. Continued smokers were more likely to live with other smokers as compared to continued quitters and delayed quitters. A small but notable proportion of cancer patients continue smoking after their diagnosis. Significant differences in psychosocial and behavioral characteristics exist among the smoking behavior subgroups. Interventions that include symptom management, self-efficacy, perceived control and family members who are smokers may help promote cessation after the diagnosis of cancer.

1047792

A COMPARISON OF QUALITY OF LIFE TO SPIRITUAL WELL-BEING AND USE OF RESOURCES THROUGHOUT THE HEMATOPOIETIC STEM CELL TRANSPLANT PROCESS. Janet

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Survivors of Hematopoietic Stem Cell Transplant (HSCT) report negative effects on their quality of life (QOL) post transplant. An IRB-approved descriptive study with a longitudinal design was completed at a Midwest NCI-designated comprehensive cancer center. The aims of the study included exploration of the relationship between QOL and spiritual well-being post transplant and the relationship between QOL and use of various resources pre- and post-transplant at multiple intervals. This study was based on a conceptual model developed by Ferrell and colleagues that described how HSCT potentially impacts four domains of QOL: physical, psychological, social, and spiritual well-being. To assess these domains in HSCT survivors, the following instruments were utilized: (1) Functional Assessment of Chronic Therapy, Bone Marrow Transplant (FACT-BMT) (2) Functional Assessment of Chronic Illness Therapy - Spiritual Well-Being (FACIT-SP-12), and (3) instrument developed by the researchers to explore the use/need of resources at various intervals. The resource questionnaire was tested for clarity, readability, and content validity. Data was obtained on 161 participants. The data revealed a positive correlation between QOL and spiritual well-being ($r = 0.50$ to 0.76). This correlation was greatest at six (6) months after HSCT in allogeneic survivors ($r = 0.78$) and reached a plateau at ninety (90) days after HSCT in autologous survivors ($r = 0.72$). There was mild positive correlation between QOL and overall use of resources ($r = -0.13$ to -0.37) indicating that as QOL improved the use of resources decreased. The strongest correlation existed in allogeneic HSCT survivors' use of financial resources ($r = -0.15$ to -0.47). The resources identified most frequently included: (1) patient education resources such as brochures, information from the physician or nurse, and the internet, (2) faith, prayer or spiritual healing, (3) family, friends, or other help in the home, and (4) insurance benefits. This study provides evidence that spiritual well-being positively impacts QOL in HSCT survivors. In addition, the data suggests that those HSCT survivors who utilized resources pre- and post-transplant had improved QOL, specifically as related to financial concerns. Future study of specific spiritual interventions and resource management would guide organizational and nursing interventions.

1047826

MEETING HOLISTIC NEEDS THROUGH ANIMAL ASSISTED THERAPY IN RADIATION ONCOLOGY. Mary Ann Plambeck, RN, MSN, OCN®, Radiation Oncology, Duke University Medical Center, Durham, NC

Pets play an important role in many people's lives by offering companionship, sensory stimulation and an unbiased audience. Numerous articles and studies have demonstrated the benefits of animal assisted therapy (AAT) from a physiological and emotional standpoint among hospitalized patients. The Joint Commission has also noted the importance of addressing the holistic aspect of patient care. Many AAT programs are already established in major hospitals across the country for pediatric and adult oncology services. With the trend in healthcare moving from the inpatient to the outpatient setting, the Duke radiation therapy department decided to implement an AAT for their patients. To provide outpatient cancer patients with a proven method of reducing stress, improving mood, and decreasing anxiety during their radiation therapy visit. The first step in the process was to partner with oncology recreation therapy that coordinates the inpatient AATP for the oncology inpatients units. The inpatient policies

were reviewed and revised to accommodate the outpatient setting. The proposal along with the policy was sent to infection control, hospital administration, and the radiation therapy staff for review. A literature review was done to mitigate infection control concerns regarding spread of MRSA and other communicable diseases. Once the plan was approved, staff were asked to volunteer for the program. Training occurred on how to assess the animal and trainer during the visit to the department and on how to approach patients and visitors regarding visiting with the animal. The program was started in October 2010. We have had a total of 15 animal visits and 207 patients have visited with the animals. Feedback from patients and staff has all been positive with several poignant and emotional patient/dog interactions. The program has proven to be successful in the short time it has been implemented. In the future we plan to look into several research projects that will assess if the animals can have a great role in further reducing anxiety such as during treatment planning.

1047862

THE TRANSFORMATION OF BEDSIDE NURSES TO BEDSIDE LEADERS DURING ONE CANCER INSTITUTE'S JOURNEY TOWARDS MAGNET DESIGNATION.

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Empowering oncology bedside nurses allows administrators the opportunity to develop bedside leaders among their nursing workforce. Envisioning independent leaders in the care of patients has enabled one Institute to achieve success in the implementation of quality care for patients while successfully achieving Magnet Designation. The purpose is to describe the challenge of initiating an educational process to disseminate components of the Magnet application to oncology nursing staff. Volunteers lead their clinical areas in educating staff on the 5 components of Magnet. These leaders were identified as Unit Magnet Leaders. The Director and Coordinator of the Magnet Program educated Institute personnel through scheduled in-services as well as meetings for Unit Leaders. Educating these leaders allowed dissemination of vital information to their colleagues in preparation for the ANCC site visit. Debriefing meetings for the Unit Leaders ensued following the ANCC Magnet site visit. Feedback from the leaders included beginning the process of the Magnet journey earlier, and permitting every staff member the opportunity to partake as a Unit Leader. The leaders also felt all enthusiastic nurses should share in the attendance of the Unit Magnet Leader meetings. Thus making it possible for all nurses to experience the dissemination of knowledge from other nursing areas first hand. Leaders commented on the success of the ANCC site visit to their particular nursing areas, and the pride they felt discussing the oncology bedside nurse's leadership in patient care. Magnet leaders were given the authority, responsibility and autonomy of the Magnet application. The measurement of their success was witnessed during this Institute's ANCC Magnet site-visit as the staff spoke openly and freely regarding the Magnet process and the nursing quality of care for the oncology patient. The ANCC appraisers commented that the Institute's nurses pride in their professional practice was "palpable". The bedside oncology leaders were an important component of assessing quality patient care as well as unit needs. Empowering the bedside nurse to direct their unit towards Nursing Excellence directed the entire Institute to achieve Magnet status. This abstract will be beneficial in providing practical advice for other oncology facilities in their quest for Magnet designation.

1047874

FOLLOW-UP CARE PLAN AND GUIDE FOR PATIENTS TRANSITIONING TO SURVIVOR STATUS FROM ACTIVE TREATMENT. Beverly Wiley, RN, OCN®, UPMC, Windber, PA

Many of our patients express fear and uncertainty at the completion of treatment. They need reassurance of continued support. A review of the literature showed this to be an area of increasing concern in oncology. Expanding numbers of survivors are asking for more information and support to meet their needs as they move forward after treatment. To assist patients in transitioning from active treatment to survivorship. To educate them about their individual treatment, follow-up care, and to provide them with guidelines and resources for moving ahead confidently with their lives. The information and forms already available were adapted to meet the needs of our patients as they had expressed them to us. 1) A letter was designed to accompany the information, letting the patient know we understand his/her feelings and reassuring him/her of our continued support. Also, the letter expresses confidence in the patients ability to adapt and move forward. 2) An individual treatment summary and NCCN guidelines for follow-up care that the patient can keep for his records and share with other health care providers. 3) The NCI booklet- Facing Forward. This booklet contains information about managing long term side effects, healthy lifestyle changes and resources for other areas of concern. In this pilot study information packets were given to 16 of our breast cancer patients who had just completed chemotherapy. When questioned at follow-up 82% found the information helpful and comforting. They also said it was a resource they would return to for guidance. The doctors in our practice would like to see the Treatment Summary form placed on the chart. They would also like to see line items added to include BCR1 and BCR2 testing and to identify patients participating in a clinical trial. Our next step would be to share this project across the other 26 UPMC Cancer Center locations and branch out to include other cancer diagnosis.

1047932

CHANGING THE CULTURE: CLINICAL RESEARCH, CLINICAL TRIALS (CR/CT) AND UNDERGRADUATE NURSING EDUCATION. Annette Galassi, RN, MA, Office of Communications and Education, National Cancer Institute, Bethesda, MD; Linda Parreco, RN, MS, Office of Communications and Education, National Cancer Institute, Bethesda, MD; Elizabeth Ness, RN, MS, Center for Cancer Research, National Cancer Institute, Bethesda, MD; Meredith Grady, MPH, Office of Communications and Education, National Cancer Institute, Bethesda, MD; Ann O'Mara, RN, PhD, Division of Cancer Prevention, National Cancer Institute, Bethesda, MD; Anne Belcher, RN, PhD, School of Nursing, Johns Hopkins University, Baltimore, MD; Clare Hastings, RN, PhD, School of Nursing, Johns Hopkins University, Baltimore, MD; Cheryl Fisher, RN, EdD, Nursing and Patient Care Services, National Institutes of Health, Bethesda, MD; and Shaunagh Browning, RN, MS, Clinical Research Unit, Georgetown University Medical Center, Washington, DC

The majority of the general public mistrusts CR and less than 5% of eligible patients participate in CT. However, the public does trust nurses. The nursing profession has the opportunity to affect CT accrual, but most nurses know little about CR/CT. As health care becomes increasingly evidence-based, as the settings in which CR/CT expand, and as more patients gain access to CTs, it will become imperative that nurses possess the requisite skills and knowledge to safely care for patients participating in CR/CT. We have undertaken a project to gain a better understanding of CR/CT content in the undergraduate curriculum. This presentation will describe the formative research done to better understand the

current environment surrounding CR/CT and to describe nurses' knowledge and attitudes toward CR/CT in nursing education and practice. Individual, one hour telephone interviews were conducted with a sample of nurses representing schools of nursing faculty, nurse executives, staff development directors, and nurses. In addition, a 90 minute online focus group was conducted with 25 SON deans to explore issues related to CR/CT content in the undergraduate curriculum. Though recognized as an area of increasing importance in health care, most nurse faculty, nurse executives, and staff development directors believe that competing priorities in their respective institutional and employment environments would preclude CR/CT from assuming a higher priority in undergraduate curricula and new graduate nurse orientation. Faculty generally believes that CR/CT content should be included in the curriculum, despite institutional/logistical challenges. All practicing nurses believe that CR - at least human subjects protection and assessment of evidence - should be included. Deans strongly support inclusion of CR/CT content in undergraduate curricula but recognize the need to bolster faculty expertise in this area. Most participants expected that expansion of CR/CT would serve as a driver of change. Some misconceptions among faculty and nurses include the beliefs that CT is largely physician-driven, is not as patient-centered as other nursing work, and is limited to select fields. Generally respondents were supportive of development of CR/CT curricula for undergraduate education as well as competencies, and materials demonstrating the differences CR/CT make and how nurses contribute.

1048197

INCREASING HUMAN PAPILLOMAVIRUS (HPV) VACCINE ACCEPTABILITY: RESULTS OF A SYSTEMATIC REVIEW ON MESSAGE FRAMING. Cheryl Lee, MS, RN, ACNP-BC, M. D. Anderson Cancer Center, Houston, TX

Human papillomavirus (HPV) causes most cervical cancers and is associated with many other malignancies. HPV-related cancers are preventable, especially with the recently-launched HPV vaccines, yet uptake remains low. In addition to knowledge and cost, personal beliefs and attitudes remain the biggest barrier. Message framing is one way to address negative beliefs and attitudes. Nurses are in a prime position to communicate with patients regarding the vaccine and should know how to frame their recommendation for maximum effectiveness. The way in which the vaccine is presented is integral to acceptance and subsequently uptake. The purpose of the systematic review was to assess message framing as a communication strategy to increase HPV vaccine acceptability in males and females. A systematic search was conducted in Cochrane, Medline-PubMed, SCOPUS, CINAHL Plus, PsycInfo, PsycARTICLES, and Psychology and Behavioral Sciences Collection-EBSCO for studies in English on framing and the HPV vaccine. Additional limits were: clinical trial, randomized controlled trial, review, and meta-analysis. No date limits were set. Forty-three papers were reviewed; seven were relevant and analyzed using the Critical Appraisal Skills Programme tool. Acceptability of the HPV vaccine was higher when framed as preventing cancer rather than preventing sexually-transmitted infection. Acceptability was also higher when the message was framed positively, instead of negatively. All seven studies were cross-sectional. Six had moderate to large sample sizes. Three studies attempted randomized selection but true representativeness was questionable. All used different measures with questionable validity and inconsistent terminology (e.g., acceptability, intention, and interest). Four studies reported a conceptual framework. Additional studies are needed on communication strategies to increase acceptability and ultimately uptake of the HPV vaccine. Although the studies are few and have limitations, the literature thus far suggests that healthcare-provider recommendation would be more successful in increasing acceptance when framed in terms of preventing cancer, and safety and efficacy are acknowledged. Nurses should be aware of

a stigma surrounding HPV vaccination noted in some studies and factor that into their communication with patients. Mediators of acceptability such as perceived susceptibility and severity based on conceptual frameworks such as the Health Behavior Model may also help frame recommendations.

1048742

A MULTIDISCIPLINARY APPROACH TO INITIATING A COMPREHENSIVE TOBACCO ASSESSMENT AND SMOKING CESSATION PROGRAM IN AN NCI DESIGNATED COMPREHENSIVE CANCER CENTER. Maegan Chmura, BSN, RN, Roswell Park Cancer Institute, Buffalo, NY; Mary Ann Long, MS, RN, Roswell Park Cancer Institute, Buffalo, NY; K. Michael Cummings, PhD, MPH, Roswell Park Cancer Institute, Buffalo, NY; Graham Warren, MD, PhD, Roswell Park Cancer Institute, Buffalo, NY; Jennifer Epstein, BA, Roswell Park Cancer Institute, Buffalo, NY; and Teresa Houston, BSN, RN, Roswell Park Cancer Institute, Buffalo, NY

According to the US Department of Health and Human Services, tobacco use is the leading cause of premature and preventable death in our country today. Tobacco use is responsible for approximately 443,000 overall deaths and 30% of cancer deaths annually. National cancer treatment guidelines advocate for smoking cessation in cancer patients and studies demonstrate that smoking cessation initiatives with a person-to-person venue are effective in assisting patients to achieve increased abstinence rates; however, implementation of a comprehensive assessment and cessation program is often limited by institutional resource allocation. An institutional initiative was developed to administer standardized evidence based medicine practices through the electronic medical record (EMR) to accurately assess tobacco use and provide dedicated cessation services to a comprehensive cancer population. A Smoking Cessation Program was initiated by a multidisciplinary team in a comprehensive cancer center to include: development of an EMR based nursing assessment for all new and established patients at every clinic visit, a logic based automated patient referral system, an algorithm to develop an individualized treatment plan for each patient, development of patient education materials, and implementation of a patient specific follow-up and maintenance schedule. Program implementation occurs in a staged manner after nursing education in individual outpatient and inpatient settings. This presentation provides information on program development as well as early stage results including initial patient screening, enrollment, and outcomes. A multidimensional and comprehensive approach is required for effective tobacco cessation programs and can improve clinical outcomes. An efficient model can be developed to assess large patient populations using standardized assessments and interventions tracked and administered through the EMR. This program will be informative for oncology nurses who are initiating tobacco cessation programs in other oncology settings.

1049035

SYMPTOM BURDEN IN PATIENTS WITH CHRONIC MYELOID LEUKEMIA. Loretta A. Williams, PhD, RN, AOCN®, OCN®, Department of Symptom Research, The University of Texas MD Anderson Cancer Center, Houston, TX; Araceli Garcia-Gonzalez, MD, PhD, Department of Symptom Research, The University of Texas MD Anderson Cancer Center, Houston, TX; Patricia Ault, MS, ACNP, Department of Symptom Research, The University of Texas MD Anderson Cancer Center, Houston, TX; Janet L. Williams, MPH, Department of Symptom Research, The University of Texas MD Anderson Cancer Center, Houston, TX; Charles S. Cleeland, PhD, Department of Symptom Research, The University of Texas MD Anderson Cancer Center, Houston, TX; and Jorge

E. Cortes, MD, Department of Leukemia, The University of Texas MD Anderson Cancer Center, Houston, TX

Symptom management is a primary oncology nursing role and crucial for patients with chronic diseases, such as chronic myeloid leukemia (CML), who receive therapy for years. Lack of symptom recognition may result in failure to address symptoms and maximize patient functioning. No measure for CML symptoms currently exists, and there is little knowledge of symptom burden (SB) in CML and its treatment. The purposes of this study are to develop a valid and reliable patient-reported measure of CML SB and to describe the SB. The ONS Research Agenda identifies development of an in-depth understanding of cancer-related symptoms as a priority for 2009-2013. The conceptual model for this study is symptom burden. SB is the combined impact of all symptoms on one's ability to function as one did prior to onset of disease and therapy. This is a three part study: Part 1 - 35-subject cross-sectional qualitative data and exploratory analysis to define content domain for a measure of CML SB; Part 2 - item reduction by 15-member expert panel based on relevance of symptoms for patients with CML; Part 3 - 1-year longitudinal descriptive study of 160 subjects with CML to determine validity and reliability of MD Anderson Symptom Inventory-CML (MDASI-CML) using standard psychometric techniques and to describe symptom patterns and risk factors using descriptive and modeling statistics. Preliminary analysis of Part 3 is described in this abstract. Three-month data is available on 101 patients. Average age at study enrollment is 51.7 years, 42% male, and 97% in CML chronic phase. Four patients have dropped the study because of time requirements. The reliability index (Cronbach alpha) of the MDASI-CML ranges from 0.73 to 0.95. Fatigue, muscle soreness/cramping, disturbed sleep, drowsiness, swelling, and difficulty remembering were the 6 most severe symptoms for 71 patients receiving a kinase inhibitor (KI) (imatinib, dasatinib, or nilotinib). There is a trend toward lower symptom burden in nilotinib patients. CML patients experience moderate levels of SB over long periods. Different KI drugs may influence the level of symptom burden, and oncology nurses should be aware of these differences in caring for patients. Data collection continues.

1049068

COMPASSION FATIGUE AND SPIRITUAL CARING IN ONCOLOGY NURSING STAFF. Ingrid R. Blöse, RN, OCN®, CMSRN, Oncology, Providence Holy Cross Medical Center, Valencia, CA

Compassion fatigue in oncology nurses frequently manifests as physical, emotional, social and spiritual exhaustion. This causes a pervasive decline in staff's ability to feel and care for others. Interventions are geared towards improving the staff's ability to cope and handle stress while improving both individual and group spiritual and emotional well-being. Interventions undertaken in this study were aimed at addressing and reducing compassion fatigue by improving spiritual and emotional well-being and staff caring for oncology patients. The conceptual model that guided the study was Jeanne Watson's Caritas Theory that emphasizes the emotional and spiritual dimensions of human existence. These concepts flow within both patients and staff and become interrelated for optimum caring relationships. Semi-annual group bereavement meetings and change of shift inspirational readings with staff. Members of the oncology staff were asked to participate in a one group repeated measures study. Oncology team members included in the study group were nurses, nursing assistants, case managers, chaplains, social workers and clerks. Interventions were aimed at addressing and reducing compassion fatigue by improving spiritual well-being in oncology staff. IRB approval and consents were obtained prior to participation. The Spiritual Involvement and Beliefs Scale (SIBS-R) was used pre and post intervention to measure any change in spirituality in oncology staff. Analysis of variance was computed for the total score of the pre and post intervention of the SIBS-R. Patient satisfaction

scores were also tracked. Patient satisfaction scores significantly increased and were used as a measure of decreased staff compassion fatigue. Team members wanted to continue this intervention after the study concluded and morale on the unit measurably improved. Staff members from other areas joined the twice daily inspirational readings on the oncology unit and in tribute to this project, a poem was written by a staff member of another department and presented at the ANCC Magnet Congress. The research study was presented at the Nursing Research Day at our hospital and was well received. In addition, a neighboring hospital was interested in adopting the same project on their unit.

1050138

AN ONCOLOGY NURSING COMMUNITY OUTREACH TASK FORCE. Paula Absolon, RN, MA, OCN®, ANP-C, MSKCC, New York, NY

A need to deliver community education in oncology was identified through the Ambulatory Nursing Recruitment, Retention and Recognition (RRR) council at this NCI-designated comprehensive cancer center. The Community Outreach Task Force (COTF) was formed, and is made up of a group of ambulatory nurses with specialized expertise in disease-specific cancers. The purpose of the COTF is to bring to the community educational needs in oncology, based on age, gender, prevalence, and request. In addition, the goal is to maintain this project through a sustainable structure, nursing participation, and collaboration with the office of public affairs. The task force is currently comprised of over forty nurses practicing in solid and liquid oncology services. Staff presenting attend training sessions on public speaking, and develop and tailor presentations to be utilized when various requests are made from the community to our institution. The COTF provides education in various community settings on disease-specific content, preventative and wellness initiatives, screening resources, and counseling referrals. At this time, the task force has presented at high schools, community centers, and wellness fairs. Specific programs have included: cancer prevention and wellness sessions, breast cancer screening at “lunch and learn” seminars, prostate cancer screening, and the “Breast Cancer Symposium” at the community YMCA. Nurses have given both English and Spanish presentations to capture a larger population. The programs presented are tracked to monitor success and share feedback. Staff is supported to participate in this endeavor through nursing leadership. Experiences attained throughout these presentations are shared with other nursing staff at this institution through the division newsletter, ambulatory councils, and staff meetings. Task force members have verbalized great satisfaction seeing this initiative come to fruition and achieve success, and attendees have provided extremely positive feedback and gratitude. Going forward, the task force will continue to evolve, develop additional program content, attract new members, and seek other valuable opportunities to bring education related to oncology to the community.

1050178

HOW THE BREAST CARE SPECIAL INTEREST GROUP (SIG) EXPLODED ONTO THE SOCIAL MEDIA SCENE. Julia Whitekter, MSN, RN, AOCNS®, Clarian North Medical Center, Carmel, IN

As the Internet has matured, the blogosphere has diversified, and social networks have grown exponentially, the ability to laser-focus a desired stream of information to one's computer has become a powerful tool to connect people worlds apart on very specific commonalities. However the power of new media to bring nurse specialists together has just begun to be tapped. Nursing organizations such as ONS and AWHONN have led the way, but the level of interest specificity, and the limited barriers to leverage the Internet has opened the door for very specific sub-specialties to also create networks. Our purpose was to build an online presence for the ONS Breast Care SIG that would inform and promote breast care nursing. Our specific goals were

to connect isolated breast care nurses, provide a space to share evidence-based practices and news, promote the SIG as the go-to organization for breast cancer nursing information, and bring new members, especially younger nurses, to the Breast SIG and ONS. The media venues chosen were Facebook, Twitter, and a blog on the Breast SIG virtual community site. The Breast Care SIG Social Media Editor (a new leadership position), and new social media policies were created and approved. A database of online sources of real-time information to inform the media streams and a process for providing regular updates was developed and implemented. A plan to add a YouTube channel is underway. Project goals were evaluated using the Facebook Insights tools, Twitter counts, response to calls for bloggers, and monthly SIG membership reports from ONS. Within six months of creating an active presence on the web, the Breast Care SIG has developed over 190 Twitter followers and over 1800 Facebook likes from 24 countries; significant growth has also been seen in SIG membership. Our Facebook page which is still growing rapidly, is our most successful implementation, achieving many of our goals. Our challenges going forward include bridging breast care nurses from Facebook membership to active SIG participation. By sharing our experiences, processes and results, we hope to help other SIGs better leverage the new media to grow their online presence.

1050350

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION: IMPROVING SAFETY AND QUALITY ONE INFECTION AT A TIME. Mary Dougherty, MSN, RN, AOCNS®, Oncology, Spectrum Health, Grand Rapids, MI

Central line-associated bloodstream infections are a serious safety concern for hospitalized oncology patients. Monitoring infection rates and introducing interventions to eliminate this preventable condition is the way to advance nursing care in as we move forward in a complex healthcare environment that supports a culture of safety. The purpose of this work was to establish a process for tracking CLABSI's in the inpatient setting and shift the culture to support and promote safe care of central lines. The Clinical Nurse Specialist partnered with the Quality department and Infection Control to establish a process for monitoring CLABSI rates on the unit level. An interdisciplinary Oncology Fighting Bloodstream Infection (FBI) Team was developed. Work of the group to date has been to: Establish a process for sharing CLABSI rates on the unit level; Create a mechanism for follow up on each CLABSI as a serious safety event; Survey staff related to gaps in both knowledge and practice from standard of care; Develop a maintenance bundle; Develop of staff-led education based on gap analysis from survey and maintenance bundle; Develop patient education specific to prevention of CLABSI and create a process for attending to an ongoing “issues” list of questions related to central line care and documentation. Bedside clinicians are able to verbalize their role in the central line-associated bloodstream infections as a serious patient safety event as well as opportunities for improvement. The unit looks at these much differently than prior to these efforts and owns each infection looking for personal accountability. CLABSI rates have declined since development of the team and reporting out infections on a unit-level. Nurses need to understand their role in these infections as well as their role in the prevention of these potential life-threatening complications of cancer therapy. Through interdisciplinary collaboration, there is opportunity to change our unit culture from one of acceptance of these complications to one that does not tolerate harm to the patient in our care.

1050425

ANSWERING A QUESTION FROM PRACTICE: EVALUATING THE RELATIONSHIPS BETWEEN THE USE OF ANTIPERSPIRANT, SKIN REACTION INTENSITY, AND THE REPORTED QUALITY OF LIFE IN WOMEN RECEIVING EXTERNAL BEAM

RADIATION FOR THE TREATMENT OF STAGE 0, I, II BREAST CANCER USING A RANDOMIZED CONTROL STUDY. Linda Watson, RN, PhD(c), CON(C), Community Oncology, Alberta Health Services-Cancer Care, Calgary, Alberta, Canada; Donna Gies, RN, CON(C), CHPCN(C), Radiation Therapy Department, Tom Baker Cancer Center, Calgary, Alberta, Canada; Diane Jahraus, RN, SBcN, Radiation Therapy Department, Tom Baker Cancer Center, Calgary, Alberta, Canada; and Bejoy Thomas, PhD, Psychosocial Oncology, Tom Baker Cancer Calgary, Alberta, Canada

Standard care regarding the use of antiperspirants during radiation treatment to the breast varies across North America. Women have articulated the potential for body odor bothers them when instructed to not use antiperspirant. Historical practices and individual opinions have often guided practice in this field, as little evidence exists. 1. To evaluate if the use of antiperspirant while receiving external beam radiation treatment for stage 0, I, or II breast cancer will affect the intensity of the skin reaction. 2. To evaluate if the use of antiperspirant during external beam radiation treatment has an effect on quality of life of the individual receiving treatment. Through strategic leadership from a practice leader with research experience, front line staff nurses from the Radiation therapy department were empowered and supported to create and conduct this research study. When questions from nursing practice are the basis for research studies, knowledge translation is ensured. 198 participants were randomized to either the experimental group (antiperspirant) or control group (standard care-wash only). Skin reactions in both groups were measured weekly during treatment and 2 weeks post treatment using the NCI CTC AE v.3 toxicity grading criteria. Both groups completed the FACIT-B Quality of Life Assessment Tool with additional questions regarding the impact of underarm deodorant usage on quality of life at three points during the study. Data in both groups were stratified based on the # of fractions and analyzed with a generalized estimating equation. No statistical difference in skin reactions or reported quality of life between groups was found. Findings from this study indicate that using antiperspirant routinely during external beam radiation treatment for stage 0, I, or II breast cancer does not affect the intensity of the skin reaction. This evidence supports that there is no purpose to restrict these women from using antiperspirant during their treatments. As no significant difference in self reported quality of life between groups could be found these findings create an opportunity to empower patients to make their own decision about using or not using antiperspirant, in relation to their own personal hygiene concerns.

1050456

IMPROVE EFFICIENCY, PATIENT SATISFACTION, AND NURSING PRODUCTIVITY BY IMPLEMENTING A STEM CELL TRANSPLANT CLASS FOR PATIENTS. Julie Phillips, MSN, CRNP, BC, Stem Cell Transplant, UPMC, Pittsburgh, PA; Jennifer Jenkins, BA, BSN, OCN®, Stem Cell Transplant, UPMC, Pittsburgh, PA; Melissa Hornyak, MSN, RN, Stem Cell Transplant, UPMC, Pittsburgh, PA; and Susan Frank, MSN, RN, Stem Cell Transplant, UPMC, Pittsburgh, PA

Problems that were identified difficulty scheduling Decrease in nursing productivity Coordination of care among the multidisciplinary team, difficult to have research, financial counselor and social worker all available consistently. Improve Efficiency, Patient Satisfaction, and Nursing Productivity by Implementing a Stem Cell transplant Class for Patients -Designed a class format in which up to 3 patients can be seen at once. -Patients/families listen to the transplant presentation as a group. -Followed by one on one discussions with the nurse coordinator, the social worker, the research coordinator & the financial counselor. -Designed a power point presentation for the class to be used as a patient education

tool. -Patient still meets with physician, once the education is presented and patient/family has time to formulate questions. Patient Outcomes: -A patient satisfaction survey was distributed Scale ranging 1(not good) through 5 (very good) Average score was 5 -There were a total of 43 patients who completed the class since 1/2010 -All patients who responded on the survey responded that the class format enhanced and encouraged patient to patient interactions. Examples of patient comments: Open format of class for questions Ease at which they could develop relationships with other patients Commented that the class format was very helpful. Nursing Outcomes: -Baseline data-total weekly nursing time spent organizing patient intakes~ 16 hours/week New Process: ~4 hours/week to complete patient education Nursing time saved ~12hrs/wk, which totals 576hrs/year 75% improvement in productivity to perform transplant education -Nursing time saved means more time for direct patient care -Increase time to implement changes and sustain the quality management of the stem cell program. Ease of scheduling for entire multidisciplinary team Future process Improvement Initiatives: -Offer patients/families a tour of the inpatient transplant -Develop the class format for the allogeneic transplant patients. -Send patients a copy of the slides prior to their class to allow them more time to formulate questions. -Develop an Emmi Program online for the patients.

1050590

USING QUALITY OF LIFE INDICATORS TO PREDICT SURGICAL COMPLICATIONS AND SURVIVAL FOR PATIENTS WITH GASTRIC CANCER TREATED WITH SURGICAL RESECTION.

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Current preoperative screening concentrates on disease status and medical co-morbidities. Preoperative quality of life (QOL) indicators have been shown to predict surgical complications and survival in patients treated for colorectal and esophageal cancers, respectively. However, the predictive value of QOL in anticipating the probability of postoperative morbidity has not been studied in patients undergoing resection for gastric cancer. The purpose of this study is to explore the role of QOL as a preoperative screening tool for gastric cancer patients undergoing surgical resection. Study objectives are to determine whether preoperative QOL indicators predict surgical complications and survival in this patient population. QOL serves as the framework for this study. QOL is an individual's perception of well-being and includes physical, psychological and emotional parameters to provide a comprehensive measure of health. A secondary analysis was conducted using preoperative QOL data collected from 170 patients with adenocarcinoma of the stomach. The European Organization for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC) was used to measure QOL. The minimally important difference (MID) for the EORTC domains (10 points) was used to evaluate changes in QOL. Demographics, surgical complications and survival data were obtained through chart reviews. Univariate regression models were used to investigate relationships between three domains of QOL felt to be most clinically relevant (e.g., global QOL, physical functioning and fatigue) and surgical complications. Cox proportional hazards models were used to analyze the association of these QOL variables on survival. Postoperative complications were reported in 44% of patients. No mean differences were found between QOL scores and complications. Median survival was 49 months with 1, 3 and 5-year survival rates of 84%, 58% and 47%, respectively. Risk of death was associated with baseline global QOL (Hazard Ratio (HR) 0.886 for increase in 10 points (MID), $p = 0.030$), physical functioning

(HR 0.886 for increase in MID, $p = 0.004$) and fatigue (HR1.10 for increase in MID, $p = 0.013$). Findings suggest that preoperative QOL indicators may supplement existing selection criteria. We are currently examining the influence of other factors, such as stage of disease, on the association between QOL and survival.

1050603

ONCOLOGY NURSING M AND M: A QUALITY, OUTCOME-ORIENTED REVIEW OF NURSING PRACTICE.

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Academic medicine has long offered a forum M and M (Moribidity and Mortality) Rounds, for medical residents in training, to discuss difficult cases and problem-solve to improve outcomes in the future. Nursing can also benefit from reviewing cases, be it a challenging case, or a case which prompted a quality review, and develop meaningful, evidence-based strategies for future management. To decrease the intimidation factor that Medical M and M holds, the name "Mishaps and Mendings" was applied, and participants are given M and M candies when attending. Purposes include 1) an opportunity for retrospective review of quality issues in a safe environment 2) improving clinical care, critical thinking, and the use of evidence-based practice 3) learning through sharing and examining rather than criticizing 4) identifying strategies to address quality issues with actionable outcomes Ground rules for discussion are established at the opening of the conference. After a facilitated peer discussion of a case, staff identify -actual/potential knowledge deficits -critical thinking and judgment skill concerns -workload and system issues involved in the case. A summary of findings and 'next steps' are developed, and the conference concludes with a specific quality improvement action plan. The summary and plan are escalated to the appropriate authority - Nursing Quality Council, or for multidisciplinary issues, the Hospital Quality and Patient Safety Committee. The monthly nursing newsletter includes a summary and action plan. Using a structured and facilitated approach for the discussion of quality issues, and ensuring a safe environment, staff are empowered to have an open dialogue to address clinical and operational concerns. Frank conversation leads to specific, actionable plans, making the hour conference productive, positive, and outcome-oriented. Conferences have been conducted on topics from safe medication administration (multidisciplinary manipulation of the system) to failure to rescue. In each case, some aspects of "this couldn't happen where I work" to "this did happen where you work" stimulates supportive conversation between staff who desire to provide the highest quality of care at all times. Future direction includes the addition of members from the multi-disciplinary team for a broader impact.

1050665

INCLUDING PATIENT INPUT IN PATIENT-REPORTED OUTCOME INSTRUMENT DEVELOPMENT: EXAMPLES FROM THE MD ANDERSON SYMPTOM INVENTORY FOR CHRONIC MYELOID LEUKEMIA.

Loretta A. Williams, PhD, RN, AOCN®, OCN®, Department of Symptom Research, The

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According to the United States Food and Drug Administration, patient input should be included in development of patient-reported outcome measures (PROs). Symptom assessment is a primary oncology nursing role, and oncology nurse scientists frequently develop PROs. Development of cancer-related symptom measures is a priority in the 2009-2013 ONS Research Agenda. The purpose of this abstract is to describe a method of including patient input into PRO development. The philosophical framework is Story Theory. Using story, a patient can share the experience of a health challenge in an understandable way. We are using a 3-step process that includes patient input in each step for development of a multi-symptom PRO, the M. D. Anderson Symptom Inventory (MDASI) for chronic myeloid leukemia (CML). The first step in the process was qualitative, story-theory-based interviews with 35 patients with CML. Symptoms were extracted by exploratory analysis from interview transcripts. Step 2 was grading of symptom relevance by an expert panel including patients. Symptoms with the highest mean relevance ratings were tested in Step 3. In Step 3, 160 patients with CML completed the experimental MDASI-CML, which is being validated using psychometric techniques. The first 30 patients completed a cognitive debriefing interview about the MDASI-CML. Thirty-nine symptoms, including 13 core MDASI symptoms, were extracted from Step 1 interviews and rated by the expert panel of 4 physicians, 5 nurses, 3 patients, and 3 family caregivers. Six of 26 CML-specific symptoms had mean relevance ratings of > 3 (0-4 scale). During cognitive debriefing, over 80% of patients reported the MDASI-CML items were easy to complete and understand. Nine patients suggested 12 additional symptoms, but each symptom was mentioned only once and had already been eliminated in the expert-panel relevance rating. A symptom related to a new therapy identified by several patients was added. The experimental MDASI-CML includes 13 core MDASI symptoms, 7 CML-specific symptoms, and 6 core interference items. Inclusion of patient input at each step of PRO development guarantees measurement of what is important to patient, enhances content validity, and improves understanding of symptom experience. It further ensures the instrument is easy to understand and complete.

1050777

THE EFFECTS OF A 6-WEEK DYADIC SUPPORT INTERVENTION IN PATIENTS WITH BREAST CANCER IN KOREA.

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Breast cancer treatment can affect the physical, psychological and sexual function of an individual. These functional declines lead to decreased self-efficacy and a complicated pattern of change in the health-related quality of life (HRQOL). Although interventions designed to enhance self-efficacy through a peer-to-peer support (dyadic support) program have been beneficial in improving the HRQOL, little is known about the effects of dyadic support in Asian culture. To test the effects of a dyadic support intervention on self-efficacy, anxiety, depression, and HRQOL among patients with breast cancer in Korea. Bandura's self-efficacy theory guided the development of the dyadic intervention assessed in this study. The study design was a randomized controlled trial. One hundred

twenty-seven patients with breast cancer were recruited from a comprehensive cancer center in South Korea. The study participants were awaiting adjuvant therapy after breast surgery. The patients were assigned to either the experimental (n = 62) or control group (n = 65). The experimental group underwent a 6-week dyadic support intervention, and the control group received the usual health care. The dyadic meetings were held once a week for 6 weeks, and were performed by breast cancer survivors whose time since the completion of their cancer therapy was 6 months. The intervention focused on meeting the informational and emotional needs of the patients through strategies that can be included in individually tailored programs of peer-to-peer support. The measured pre- and post-test was self-efficacy (Breast Cancer Self-efficacy Scale), anxiety and depression (Hospital Anxiety and Depression Scale), and HRQOL (EORTC QLQ-C30). After dyadic support intervention, the experimental group only showed significantly higher scores for self-efficacy than the control group (p = .035). The two groups showed no significant differences in anxiety (p = .249), depression (p = .894), and HRQOL (all p of the subscales > 0.05). The dyadic support intervention improved the self-efficacy but did not lead to better mental health and HRQOL outcomes. These findings suggest the need for the development and testing of more intensive or culturally-sensitive peer support intervention programs for Asian populations.

1051108

PREPARING FOR DISCHARGE: CARING FOR YOUR TUNNELED CATHETER. Kelly Keane, RN, BSN, OCN®, Duke University Health System, Durham, NC; Nikki Brooksbank, RN, BSN, OCN®, Duke University Health System, Durham, NC; and Susan Green, RN, OCN®, Duke University Health System, Durham, NC

Tunneled catheters (TC) are routinely required for patients receiving chemotherapy and laboratory monitoring. Many chemotherapies cause neutropenia, increasing risks for infection. Although patients on a 31-bed adult hematology-oncology unit were provided education regarding infection prevention and TC home-care instructions, increasing blood stream infection (BSI) rates and decreasing patient satisfaction scores on "Readiness for Discharge" (RAD) prompted development of a TC home-care education program. The purpose of this project was to create a weekly hands-on demonstration class for patient/caregiver participation during hospitalization. The aim was to positively impact infection rates and increase patient satisfaction. BSI route-cause analyses indicated multifactorial issues; however some neutropenia-associated infections at home were observed. Through staff interviews, it was determined some patient dissatisfaction stemmed from teaching TC care on day of discharge with patients/caregivers feeling rushed and unprepared. Therefore, nursing staff developed a class focusing on demonstration of home-care procedures and a review of complications and emergent situations. The one-hour class allows 30 minutes of teaching and 30 minutes of practice on a manikin chest with a TC. These opportunities prepare patients/caregivers for application and review of home-care procedures on day of discharge with the patient's care nurse. A teaching session script was developed to promote consistency. All teachers are hematology-oncology RNs who have demonstrated expertise in class teaching; teachers are assigned responsibilities outside of patient care assignments permitting undivided attention to participants. Over 6 months, 26 classes were presented with 35 patients/caregiver dyads participating; all completed a survey rating teaching effectiveness and their comfort in TC care at home. Nine dyads have participated more than once for increased hands-on TC care. Of those from class, 24 patients were discharged with TC; only one patient was readmitted with a line-related infection since intervention initiation. In addition, a decreasing trend in BSI rate has been observed. Preliminary results indicate positive responses from patients/caregivers with improved satisfaction. Informal nurse surveys also positively reflect improved patient/

caregiver TC home-care skills, knowledge, and satisfaction in the discharge demonstration process. Through a successfully implemented hands-on patient/caregiver-directed TC home-care program, line-related BSI readmissions have decreased, patient RAD and staff satisfaction has increased.

1051203

DURABLE RESPONSES WITH NILOTINIB IN PATIENTS WITH NEWLY DIAGNOSED CHRONIC MYELOID LEUKEMIA IN CHRONIC PHASE (CML-CP): 18-MONTH RESULTS FROM THE ENESTND STUDY. Gerry Gorospe, Heme/HCT, City of Hope, Duarte, CA; Hagop Kantarjian, Department of Leukemia, The University of Texas MD Anderson Cancer Center, Houston, TX; Andreas Hochhaus, Hämatologie und Internistische Onkologie, Universitätsklinikum Jena, Jena, Germany; Richard Larson, Hematologic Malignancies Clinical Research Program, The University of Chicago Medical Center, Chicago, IL; Giuseppe Saglio, Internal Medicine and Haematology, University of Turin, San Luigi Gonzaga Hospital, Orbassano, Turin, Italy; and Timothy Hughes, Division of Haematology, SA Pathology, Royal Adelaide Hospital, Adelaide, South Australia, Australia

Imatinib has been the standard of care for the frontline treatment of CML-CP. However, clinical evidence shows some patients have inadequate response, develop resistance, or develop intolerable side effects with imatinib. Nilotinib is a potent and selective inhibitor of BCR-ABL, the cause of CML, that recently received approval for newly diagnosed CML-CP. ENESTnd (Evaluating Nilotinib Efficacy and Safety in Clinical Trials of Newly Diagnosed Philadelphia chromosome-positive CML patients) is a multicenter, randomized, open-label, controlled phase 3 study comparing the safety and efficacy of frontline nilotinib with imatinib. To report on evolving data impacting standard of care for CML-CP patients. Patients with newly diagnosed CML-CP were randomized to nilotinib 300 mg twice daily (bid, n = 282) or 400 mg bid (n = 281) or imatinib 400 mg once daily (n = 283). Efficacy was determined by major molecular response (MMR, a 3-log reduction in BCR-ABL transcripts), complete cytogenetic response (CCyR), disease progression to advanced phases of disease, and overall survival (OS). The long-term efficacy and safety evaluation of nilotinib is ongoing. With a median follow-up of 18 months, the best overall rates of MMR and CCyR were significantly higher in both nilotinib arms compared with the imatinib arm. Significantly more patients in both the nilotinib 300-mg bid and 400-mg bid arms achieved undetectable BCR-ABL levels than imatinib. The rates of progression to advanced phase and blast crisis were significantly lower for the nilotinib arms versus the imatinib arm. OS was higher for both nilotinib arms versus imatinib. Both nilotinib and imatinib were well-tolerated. Discontinuations due to adverse events were lowest for nilotinib 300 mg bid compared with nilotinib 400 mg bid and imatinib. The results of this longer-term evaluation continue to confirm the superior efficacy of nilotinib to imatinib for treatment of newly diagnosed CML-CP. In this era of healthcare, decreasing cost and improving quality of life are important goals of healthcare providers. With the continuing developments in the treatment of CML, oncology nurses must keep current on new study developments to enhance patient care.

1051352

VIRAL INFECTIONS IN THE SEVERELY IMMUNOCOMPROMISED PATIENTS: WHAT THE ONCOLOGY NURSES NEED TO KNOW. Yazhen Zhong, Stem Cell Transplant and Cellular Therapy, MD Anderson Cancer Center, Houston, TX; and Maria Luzalie Niangar, Stem Cell Transplant and Cellular Therapy, MD Anderson Cancer Center, Houston, TX

Despite advances in current antiviral prophylaxis and treatment, viral infections cause significant morbidity and mortality

in severely immunocompromised patients such as those receiving Stem Cell Transplantation (HSCT). Most oncology nurses are familiar with the Herpes viruses, the most common causes of viral infections, however, it is critical that nurses caring for severely immunocompromised patient be aware of less common infections related to adenoviruses, respiratory viruses, enteroviruses, JC virus (JC was the patient's initials from whom the virus was identified first time) and parvovirus. Certain viral infections may affect multiple organs making the treatment more difficult. The purpose of this presentation is to provide an up-to-date, evidence based review of the types of viruses and associated risks, their association with diseases, such as cytomegalovirus associated pneumonia and colitis, and JC virus associated progressive multifocal leukoencephalopathy. The distinctions between viral infection and disease, appropriate diagnostic tests, current medications, and future directions of treatment will also be discussed. Current literature will be presented to inform the topic. Common and treatable viral infections in HSCT patients such as stomatitis and mucositis associated with herpes simplex viruses will be discussed. In addition, other conditions caused by viral infections that may be more acute or life threatening, including pneumonia, pneumonitis, disseminated infection, hemorrhagic cystitis, colitis, post-transplant lymphoproliferative disease (PTLD), encephalitis, progressive multifocal leukoencephalopathy (PML), and bone marrow suppression or graft failure, will be covered. In relation to immunocompromised patients, after the presentation, participants will be able to: a. list 3 rare types of viruses, b. identify 3 disease conditions associated with viruses. c. discuss the limitations of current antiviral management. d. explore ongoing research for antiviral treatments. Oncology nurses play a vital role in patient care, including assessment, early recognition of infections, and patient and family education. Nurses caring for immunocompromised patients must be knowledgeable about the associations between viruses and diseases, the rationale of specific diagnostic tests, current treatments, to provide evidence-based care and education.

1051430

GEAR UP—A PREPAREDNESS WORKSHOP FOR BREAST CANCER PATIENTS. Susan O'Connor, MSN, RN, OCN®, Breast Center, Anne Arundel Medical Center, Annapolis, MD

During the period between the diagnosis of breast cancer and the definitive surgery can be very stressful and anxiety-producing. The workshop teaches women methods to help reduce anxiety and lower stress levels. The workshop also addresses the causes and prevention of lymphedema and provides pre-operative measurements. Patient education and support for the phase of care between the diagnosis of breast cancer and the definitive surgery. The workshop is held every two weeks. The workshop is opened by a licensed counselor who welcomes the patients and invites them to briefly talk about their diagnosis and how they are coping. The group is then led through a breathing exercise followed by a guided imagery exercise. The concepts of keeping well, in mind and body, through the integrative approaches of exercise, stress reduction and nutrition, are discussed. The lymphedema therapists then introduce the topic of lymphedema, explaining the causes and preventative measures. Pre-surgical lymphedema measurements are taken and documented, and a copy is given to the patient. At the conclusion of the workshop, a question/answer session is held and evaluations of the workshop are submitted by the patients. Fifty per cent of our breast center's newly diagnosed have attended the sessions since its inception in May, 2010. Evaluations are very positive for the benefits of the workshop. The number of post-operative referrals to lymphedema have increased. With increased attention to preventative measures, patients are presenting earlier to see the lymphedema specialists and interventions are more effective. Psychosocial assessments at post-operative appointments, using the NCCN (National Comprehensive Cancer Network) Distress Thermometer, indicate a decrease in distress for those patients attending the workshop.

The program evaluations rate the effectiveness of the speakers and each part of the program. Modifications have been made to allow for more open discussion and the program handouts have been modified to include additional written information and resources. All indications are that the patients benefit physically and emotionally from the workshop, which enhances overall wellness.

1051431

THE EXPERIENCE OF ONCOLOGY NURSES WHO PROVIDE BEREAVEMENT SUPPORT. Vicki Meyouhas, RN, MSn, CON(c), CHPCN(c) CMSN(c), School of Nursing, University of Ottawa, Ottawa, Ontario, Canada; and Susan Brajtman, RN, PhD, School of Nursing, University of Ottawa, Ottawa, Ontario, Canada

Oncology nurses are present in varying degrees in the lives of cancer patients and their families as they journey through the cancer trajectory. When the patient dies, it is common practice to sever the relationship between the nurse and the family, leaving the bereaved without this relationship during this difficult period. Although bereavement has been acknowledged as a period of increased morbidity and overuse of health care system resources, nurse-led bereavement support programs are not commonplace in tertiary care settings. Currently, very little is known of the experience of oncology nurses who provide bereavement support, and scant research exists regarding the needs of nurses who take on bereavement support in addition to their main nursing role. More enhanced knowledge and understanding of the role and experience of oncology nurses who provide bereavement support could impact services provided to bereaved individuals. To explore the benefits and the challenges of providing bereavement support from the perspective of oncology nurses. To understand the support oncology nurses require to carry out the role of bereavement support providers. The primary nursing model of care is the lens used to contextualize the experience of these nurses. Interpretive Description methodology was used to guide data collection and analysis. This method has been defined as "a qualitative inquiry into human health and illness experiences for the purpose of developing nursing knowledge". Interpretive Description yields clinically useful knowledge that can change and enhance practice. Semi-structured interviews were conducted with nine nurses from different oncology settings. The experiences of these oncology nurses were influenced by factors such as: the use of primary nursing, unit culture, workload concerns, and perceived lack of knowledge and skills. The three themes of this study are "Living the benefits of completing the circle of care", "A professionally challenging opportunity" and "Navigating the unknown". These nurses recognize bereavement support as an essential aspect of oncology nursing that allows for closure and for ensuring that the bereaved are coping well. Specific educational and administrative strategies and recommendations for research, education and practice are suggested to enhance oncology nurses' ability to provide service to bereaved individuals.

1051492

OUTCOMES OF EDUCATIONAL INTERVENTIONS TO DECREASE THE INCIDENCE OF CATHETER-RELATED BLOODSTREAM INFECTIONS IN HEMATOLOGY ONCOLOGY INPATIENTS. Susanne Vendlinski, RN, BSN, MSN, AOCN®, CNS, Professional Practice, The James Ohio State Comprehensive Cancer Center, Columbus, OH

Severe sepsis related to CR-BSIs can result in consequences such as increased costs, morbidity/ mortality, and prolonged hospitalization. Therefore, CR-BSI is a nurse-sensitive outcome to address. Inpatient unit CR-BSI rates exceeded comparable comprehensive cancer center benchmarks which prompted observational audits and staff surveys. This process identified gaps, including knowledge deficits and practices inconsistent with institutional

policy. It was hypothesized that central venous catheter (CVC) use was so commonplace that practice was routine and inconsistent rather than intentionally aimed at infection prevention. The purpose of this quality improvement process was to measure efficacy of educational interventions in reducing CR-BSIs, based on the rationale that knowledge and practice gaps were identified. The unit staff development coordinator and clinical nurse specialist developed and facilitated an educational intervention that utilized self-study and hands-on skill performance. Sessions were scheduled on all shifts to promote participation and to provide adequate time for personalized learning. Content was based on institutional policy and current evidence. Nurses and patient care associates (PCAs) completed self-learning packets that addressed their respective roles and responsibilities for CVC care and CR-BSI prevention strategies. The educational components included: pre-test; review of posters, handouts, and competency checklist; return demonstration of CVC dressing change and line care; post-test. Facilitators, present at sessions, provided feedback on competency skills performance and content application. Additionally, signage at the bedside was posted to remind all staff, patients, and visitors of line infection prevention behaviors (proper handwashing, "scrub-the-hub" and access sites, and "tubing-off-the-floor"). Post intervention, an immediate, dramatic decrease in rates of CR-BSIs was observed with an overall sustained downward trend. One unit sustained 107 days of zero CR-BSIs. Patient/family awareness of line care best practice was evident in comments either acknowledging such practice (i.e., hub/access site scrubbing) or reminding staff to perform best practices. Units with signage had sustained, reduced rates of CR-BSIs compared to similar units without posted signage. CR-BSIs in the oncology hematology patient are a high priority concern. Individual staff education with self-learning principles and skill performance demonstrated a positive effect on CR-BSI rates. The phenomenological finding of patient and family involvement in proper CVC care suggests that education of the patient and family may contribute to a sustained decrease and/or prevention of CR-BSIs. Further research is indicated to explore this potential benefit.

1051526

CARING FOR THE MORBIDLY OBESE PATIENT WITH A GYNECOLOGIC MALIGNANCY. Vita Norton, RN, BSN, OCN®, Gynecology Oncology, Massachusetts General Hospital, Boston, MA; and Michelle Howard, RN, BSN, Gynecology Oncology, Massachusetts General Hospital, Boston, MA

Obesity rates have increased significantly, and 2009 statistics suggest that 35.5% of adult American women are obese. In addition to many other diseases, obesity is a major risk factor for endometrial and ovarian cancer, the first and second most common gynecologic malignancies in the United States. The growing number of morbidly obese patients being treated for these malignancies has compounded the challenges for providing quality nursing care for these patients. Use the case study approach to explore effective nursing interventions to meet the special needs of obese patients with gynecologic malignancies. A 60 year-old 500-pound female who had been bedbound for six days was transferred to the gynecology-oncology unit in a bariatric bed. Because of her immobility, the patient had become incontinent of urine which further compromised her already fragile skin integrity. Despite having bariatric equipment available including a bed with an assist-to-stand feature, a heavy-duty transfer lift, a bariatric wheelchair, and a bariatric shuttle chair, staff had concerns about getting the patient out of bed safely. In addition, it took five staff members to assist with re-positioning and perineal care, which was necessary at least every two hours. Working collaboratively, a care plan that focused on her special needs relating to mobility, skin integrity, and elimination was developed. The staff was successful in transferring the patient from her bed to a bariatric wheelchair using the transfer lift. With staff coaching and supervision, she was then able to stand up from there and demonstrated

that her gait and mobility were steady. The patient requested a switch to a standard hospital bed because it was easier for her to move in and out of, and she was able to ambulate herself to the bathroom. Her skin integrity quickly improved, and she was soon discharged to home instead of a rehabilitation center as originally planned. Using bariatric technology is not always the solution. By working collaboratively as a team, being flexible, and thinking critically, the staff helped a patient to overcome some significant barriers for healing, reduce her requirement for acute care, and be discharged home.

1051568

DEVELOPING AN EDUCATIONAL INITIATIVE TO IMPROVE RESPONSE TO HYPERSENSITIVITY AND ACUTE INFUSION REACTION EMERGENCIES IN AN OUTPATIENT ONCOLOGY INFUSION CENTER. Carol Bell, RN, MSN, OCN®, Infusion Treatment Area, Stanford Cancer Center, Stanford, CA; Arturo Beckles, RN, BSN, Infusion Treatment Area, Stanford Cancer Center, Stanford, CA; Yolanda Raquiza, RN, BSN, Infusion Treatment Area, Stanford Cancer Center, Stanford, CA; LaTanya Dean, PharmD, Satellite Oncology Pharmacy, Stanford Comprehensive Cancer Center, Stanford, CA; Gail Moore, RN, BSN, OCN®, Infusion Treatment Area, Stanford Cancer Center, Stanford, CA; and Diane Martinez, RN, BSN, Infusion Treatment Area, Stanford Cancer Center, Stanford, CA

Outpatient infusion treatment areas (ITAs) are the site of most systemic cancer therapy administration. Many antineoplastic drugs including monoclonal antibodies have the potential to cause hypersensitivity reaction (HSR) and acute infusion reaction (cytokine release syndrome). Most reactions are mild, CTCAE grade 1 or 2. Severe reactions are rare, reported in less than 1-5% of common oncologic infusions. Reaction rate is higher for chimeric and lower with humanized monoclonal antibodies. A mild reaction can quickly become a severe reaction leading to respiratory arrest, shock, and death. The Beacon electronic medical record ordering system in use at the Stanford Cancer Center ITA has protocols and standing medication orders for prophylaxis and management of HSR. Traditionally, expert nurses in our unit have taught new practitioners management of HSR based on their knowledge and experience, using existing protocols. When a patient has a reaction the response often involves more staff than necessary, with a tag team approach frequently leading to distress and fear by the patient, their visitors and other patients. Problems we have identified are disorganized response with excessive personnel response and unclear delineation of responsibilities. The purpose of this inservice program is to review HSR with ITA nursing staff to improve preparedness of staff and response by primary nurse, and to manage patient/visitor distress commonly associated with these events. Using current research of published literature we are developing an educational series in three parts. Nursing and pharmacy staff are collaborating to develop the program. The first section will review incidence and pathogenesis of reactions. Clinical manifestations of each body system will be included in this section along review of appropriate nursing management action. The second section will review of the drugs used in the management of HSR associated with commonly prescribed anti-neoplastic therapies. The third section will use a case study approach to review material with post test and competency check. Response to HSR is to be added to unit nursing competencies. We expect to update our protocol and streamline our current response plan. Ideas so far have included reserving an area in the unit for patients who may be expected to react based on the dosing and maintaining readily available emergency kit for use when reaction occurs. It is essential that oncology nurses treating patients with these agents have knowledge of the infusion reaction potential of the drugs they administer as well as expert clinical practice skills to identify and treat signs and symptoms of hypersensitivity immediately.

1051569

NURSE EDUCATION CRITICAL TO IMPROVE BREAST CANCER CONTROL: INTERNATIONAL BREAST CANCER LEADERS CONSENSUS STUDY. Lillie Shockney, RN, BS, MAS Breast Center, Johns Hopkins, Baltimore, MD; John Bridges, PhD, Johns Hopkins Bloomberg School of Public Health, Johns Hopkins, Baltimore, MD; Omalkhair Abulkhair, MD, Department of Oncology, King Saud University for Health Science, Riyadh, Saudi Arabia; Carlos Barrios, MD, Center of Oncology Research, São Lucas Hospital, Porto Alegre, Brazil; Chiun-Sheng Huang, MD, PhD, MPH, Department of Surgery, Breast Center, National Taiwan University Hospital, Taipei, Taiwan; Sung-Bae Kim, MD, PhD, Department of Oncology, Asan Medical Center, Seoul, Democratic People's Republic of Korea; and Barri Blauvelt, MBA, Institute for Global Health, University of Massachusetts, Amherst, MA

Medical advances have greatly reduced breast cancer morbidity and mortality in developed nations, but the majority of the world's women living in low and middle income nations still lack access to prevention, screening and treatment. The purpose of the study was to identify emerging needs and challenges observed by breast cancer thought leaders in diverse international settings representing the majority of women in the developing world and to identify strategies for improving breast cancer control. 225 breast cancer medical, advocacy and policy leaders from 30 countries in Latin America, Asia, the Middle East/North and South Africa, Canada and Australia participated in this study. The study sample was composed of 203 breast cancer specialists, 12 patient advocates and 10 policy makers. While the survey questionnaire was structured, respondents were encouraged to express their thoughts and concerns in an open format. The most salient needs identified by international breast cancer thought leaders were to: (1) train nurses in patient and family care, management, education and clinical research (48%); (2) individualize therapy (47%); and (3) improve understanding of the reasons for apparently higher proportions of younger women presenting with more aggressive tumors among non-Caucasian populations (45%). Analysis of these and other needs identified evolved into 4 key themes to improve overall breast cancer control: Capacity, Research, Advocacy and Access. This study was used to create a taxonomy of key themes and dimensions within each theme that may be useful to governments and societies to better evaluate opportunities to improve breast cancer control. Within the dimensions, the most significant need identified by this study was to improve nurse education in breast cancer patient care, management and clinical research. Most respondents recognized nurses as pivotal to breast cancer patient care and outcomes. However, in addition to an acute shortage of qualified oncology nurses in most countries, those involved in breast cancer care require further education in patient and family member communications and education, in familial and other risk assessment and monitoring, in clinical research, and in multidisciplinary team participation.

1051635

NURSES' KNOWLEDGE, ATTITUDE, AND PRACTICE RELATED TO SEXUALITY IN PATIENTS WITH CANCER: WHAT IS THE EVIDENCE? Lucy Mathew, RN, BSN, MA, MD Anderson Cancer Center, Houston, TX; Silvestina DeCoteau, RN, MSN, NEA, BC, MD Anderson Cancer Center, Houston, TX; and Silvy Ninan, RN, MD Anderson Cancer Center, Houston, TX

Sexuality is an important aspect of human health; however it is often not addressed by nurses and other healthcare providers. Many cancer patients have significant issues related to sexual functioning, body image, and intimacy. Sexual problems often result from the physical and psychological side effects associated with cancer and cancer treatment. It has been shown that attitudes and

beliefs can influence behavior. Nurses' beliefs and attitudes about sexuality can influence their ability and/or willingness to assess and educate their patients. Educating patients about sexuality is not consistently included in the patient's plan of care on this unit. The purpose of this project was to evaluate the evidence from the literature regarding nurses' knowledge, attitude and practice towards sexuality, and to provide education to our unit nurses on how to initiate sexuality discussion with their patients. The Evidenced Based Resource Unit Nurse (EB RUN) team on our unit conducted a literature search related to nurses' knowledge, attitudes, and beliefs on sexuality using the electronic databases CINAHL and Pub Med; search terms used were attitude, belief, patient sexuality, knowledge, and cancer. Nurses reviewed the articles and completed an evidence summary table of the findings. A poster was presented during our institution's Nurse's Week Celebration. A national nurse expert on the topic of sexuality was utilized to provide an educational session to the nurses. Post presentation evaluation was completed by each participant to determine the effectiveness of the educational session. The evidence identified multiple barriers to nurses addressing sexuality issues with their patients. Nurses were in agreement that sexual problems should be a part of the nursing assessment but lacked the necessary knowledge, confidence, and were not comfortable initiating the discussion. Evidence indicated that nurse's attitude can be improved by education. Numerous researches indicate a need for sexuality education beginning in nursing school and continuing throughout the nurses' career. A disparity exists between what nurses identified as important to their care of patients and what is practiced. Oncology patients require nurses who are knowledgeable, competent, and secure in discussing sexuality concerns.

1051730

POSTOPERATIVE ILLNESS-RELATED DEMANDS AND ADAPTATION STATUS IN PATIENTS WITH GASTROINTESTINAL CANCER. Michio Mizuno, RN, PhD, Graduate School of Comprehensive Human Sciences, University of Tsukuba, Tsukuba, Ibaraki, Japan; Aiko Kanakubo, RN, MSN, Graduate School of Comprehensive Human Sciences, University of Tsukuba, Tsukuba, Ibaraki, Japan; Tomomi Sumi, BN, MN, Graduate School of Comprehensive Human Sciences, University of Tsukuba, Tsukuba, Ibaraki, Japan; Masami Sato, RN, MN, Graduate School of Comprehensive Human Sciences, University of Tsukuba, Tsukuba, Ibaraki, Japan; Jun Kataoka, RN, PhD, School of Nursing and Health, Aichi Prefectural University, Nagoya, Aichi, Japan; and Fumiko Oishi, RN, PhD, Graduate School of Medicine, Osaka University, Fukita, Osaka, Japan

After discharge from hospital following an operation, patients may be adapting to the impact of cancer while at the same time dealing with various illness-related demands. It is important to understand the adaptation status of such patients, focusing on illness-related demands. The aim of this study was to examine the characteristics of postoperative illness-related demands among patients with gastrointestinal cancer and the relationship between these demands and patients'; adaptation status. The present study presumed the following factors to be related to patients'; adaptation status: quality of life (QOL), resilience, anxiety, fatigue, attributional questions (e.g., "why me?"), and illness-related demands. Illness-related demands are specific to cancer patients shortly after discharge from hospital and correspond to patients' adaptation status. A questionnaire survey using scales related to cancer patients' adaptation status was administered to patients with gastrointestinal cancer who had undergone surgery. A total of 69 questionnaires (effective response rate, 78.4%) were collected anonymously by mail within 1 week after discharge from hospital and were statistically analysed. The average age of the respondents was 63.1 (SD=11.5) years. Factor analysis identified two factors: "demands for getting on in life after cancer diagnosis" (factor 1); and "demands for dealing with medical information"

(factor 2). The average score of factor 1 was lower than that of factor 2. The factor 2 score was significantly higher among patients with no spouse and no occupation and was moderately correlated with age. On multiple regression analysis, QOL and attributional questions were indicators of demands, whereas anxiety, fatigue, resilience, and attributional questions, but not demands, were indicators of QOL. The present findings suggest that low QOL and attributional questions result in heavy illness-related demands on patients shortly after discharge from hospital. In addition, dealing with medical information results in heavy demands, particularly for patients without a spouse or occupation and those of advanced age. These results indicate that it may be necessary to develop nursing support for patients in order to understand their cancer experience and to help them appropriately deal with medical information.

1051793

PATIENT SAFETY: AN ESSENTIAL PIECE OF THE PUZZLE IN AN EMERGENCY ONCOLOGY SETTING. Janine Kennedy, RN, BSN, MA, OCN®, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; Catherine Licitra, RN, BSN, MSN, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; and Chasity Walters, RN, MSN, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY

The Urgent Care Center (UCC) of a comprehensive cancer center delivers emergency care to pediatric and adult oncology patients. This unit averages 24,000 annual patient visits, ranging from treatment-related side effects to oncologic emergencies. Due to the complexity of the oncology population, UCC nurses need to balance tasks and think critically to provide safe patient care. Through review of events and observations, it was recognized that safety procedures needed to be enhanced to make this critical area safer for patients. Patient safety includes the actions taken by healthcare organizations to prevent patients from being harmed. A review of the literature confirmed that UCC nurses function like other nurses, using workarounds, under-reporting incidents, and failing to engage in closed-loop communication. Analysis of UCC events and near-misses demonstrated a need for review of policies and education regarding high-risk activities. UCC staff participated in a safety culture survey, the results of which identified areas to build upon. This combination of content derived from the literature and UCC-specific areas of concern were used to develop a UCC Patient Safety Day. The UCC Patient Safety Day was developed by a team of staff and leadership to provide education and training needed to foster a culture of safety. The topics addressed were patient safety principles, medication errors, patient identification processes, communication techniques, and patient specific interventions including suicide assessment and precautions, cardiac monitoring, and CMS Never Event prevention. The use of actual clinical examples was discussed whenever possible. The UCC Patient Safety Day resulted in the implementation of red-box communication, which calls for an uninterrupted area for nurse to nurse handoff, inter-shift communication worksheets, and revised patient care policies. Event and near-miss data is monitored with the hope of an increase in reports, demonstrative of a patient safety culture. The safety culture survey will be repeated at six month post-safety day to assess for change in staff perceptions. The UCC Patient Safety Day provided the staff the foundation for cultivating a culture of patient safety in an emergency oncology setting. All of the topics discussed and interventions taken from it are relevant across all oncology settings.

1051812

NURSE-DRIVEN MULTIDISCIPLINARY FLOW SHEETS: FACILITATING TEAM COMMUNICATION AND THE IDENTIFICATION OF COMPLICATIONS ASSOCIATED WITH ALLOGENEIC BONE MARROW TRANSPLANTATION. Kathleen Wiley, MSN, RN, AOCNS®, Hospital of the University

of Pennsylvania, Philadelphia, PA; Jacqueline Smith, MSN, CRNP, AOCNP®, Hospital of the University of Pennsylvania, Philadelphia, PA; Christina Torre, BSN, RN, Hospital of the University of Pennsylvania, Philadelphia, PA; Carrie DeFeo, BSN, RN, Hospital of the University of Pennsylvania, Philadelphia, PA; Ali Garrity, BSN, RN, Hospital of the University of Pennsylvania, Philadelphia, PA; and Teresa Kider, MSN, RN, OCN®, PMHCNS-BC, Hospital of the University of Pennsylvania, Philadelphia, PA

Allogeneic bone marrow transplantation (BMT), an extremely complex medical treatment, requires vigilant nursing assessments to facilitate early diagnosis of complications. Early recognition of clinical changes is optimal in diagnosing BMT complications, including sinusoidal-obstructive syndrome, graft versus host disease, and interstitial pneumonitis. The need to cluster vague signs and symptoms associated with these complications for the nursing staff was identified in order to facilitate identification, diagnosis, and optimal outcomes. A multidisciplinary flow sheet was implemented clustering signs and symptoms of complications and facilitating multidisciplinary communication. The flow sheet ensures all vital laboratory and pathology tests are considered when planning care for transplant patients. Furthermore, it promotes holistic care encompassing physical and psychosocial needs of the patient and family. The form was developed by advanced practice nurses with input from BMT clinical nurses and members of the multidisciplinary team. The information is recorded by both shifts and is incorporated into the day shift nurse's presentation on medical rounds, where concerns about patient needs can be discussed among team members. Additionally, multidisciplinary team members consult the form. The flow serves multiple purposes. It hones the medical and nursing team into components of assessment vital for diagnosing common transplant complications, and it offers a forum to consider nutritional, psychosocial, and physical therapy considerations into the plan of care. While nurses and members of the multidisciplinary team are pleased with the information gathered via the form, clinical practice outcomes remain difficult to measure. Qualitatively, nurses report an increase in organizational structure to their patient's presentation, and state the form offers information vital to their assessments and prioritization of care. We believe continued use of the form will correlate with improved patient outcomes and communication between multidisciplinary teams. Unit analysis revealed 28% nurses with minimal BMT experience, and medical care provided by a teaching service. Such flow sheets facilitate identification of common complications, ensuring vital components of assessment are not overlooked. Nursing-driven flow sheets used to communicate with medical and multidisciplinary staff are easily transferred to populations other than BMT patients, as they may be used in a variety of settings to serve similar purposes.

1051847

FROM CHARGE NURSE TO RESOURCE NURSE: AN EVOLVING LEADERSHIP ROLE FOR THE STAFF NURSE. Tracy Carafeno, RN, BSN, MS, Oncology, Smilow Cancer Hospital at Yale New Haven Hospital, New Haven, CT; Maribeth Landau, RN, BSN, MSN, Oncology, Smilow Cancer Hospital at Yale New Haven Hospital, New Haven, CT; and Sarah Eder, RN, BSN, Oncology, Smilow Cancer Hospital at Yale New Haven Hospital, New Haven, CT

Staff nurse leadership development is a priority of our collaborative governance structure. To that end, nurse managers and staff on the gynecology/oncology inpatient unit recognized that the demands of the current charge nurse role were overwhelming and a major source of dissatisfaction for all staff. The responsibilities of carrying a full assignment coupled with the challenges of managing admissions, staffing, and patient flow were unrealistic role expectations. To evaluate the effect of the Resource Registered Nurse

(RRN) role that replaced the traditional charge nurse role on the gynecology/oncology inpatient unit. Results of focus groups and a staff survey informed development of the RRN job description that ensured a staff nurse leader was available to help meet nurses' daily needs and improve performance on quality metrics. This budget neutral position required all staff to agree to have an additional patient to free the RRN from direct patient care responsibilities. The RRN, jointly selected by managers and staff for clinical excellence, flexibility, approachability, and efficiency, work Monday through Saturday from 6:30 AM to 6:30 PM. Although the RRN role does not provide additional pay, they do have a more regular daytime schedule. RRN responsibilities include early rounding with medical team to help prioritize overall patient needs, assist with verification of chemotherapy orders, maintain efficient patient flow by assisting with admissions and discharges, and mentoring staff to improve quality of care. A baseline staff satisfaction survey was conducted and will be repeated in 6 months. Anecdotal reports reveal that staff is highly satisfied with the RRN role. Improvements were observed in select quality metrics, which will be reported as before and after for: 11 am discharge, documentation related to pressure ulcer prevention and fall prevention, and efficient chemotherapy administration. The RRN role, devised by our collaborative efforts, will be implemented on two additional inpatient oncology units at our hospital and can be easily replicated by other hospitals to meet the needs of their nurses who practice on busy oncology inpatient units.

1051886

PREVENTING CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTIONS: USING EVIDENCE TO CHANGE PRACTICE BEHAVIORS. Lisa Barbarotta, MSN, AOCNS[®], Smilow Cancer Hospital at Yale New Haven, New Haven, CT; and Amy Bush, BSN, OCN[®], Yale School of Nursing, New Haven, CT

Central line associated blood stream infections (CLABSIs) are a significant cause of morbidity, mortality, and increased health-care costs. CLABSIs directly reflect care provided at time of insertion and throughout the lifetime of the central line. The effects of cancer treatment place patients at high risk for CLABSIs. We experienced a high incidence of CLABSIs on our inpatient oncology units over the last year. As CLABSIs are considered preventable, an intervention to reduce the incidence was warranted. Determine the impact of a multi-factorial approach including creative education strategies and performance feedback to reduce CLABSIs. The oncology clinical nurse specialist and a master's nurse practitioner student designed and implemented a project on the inpatient oncology units to evaluate nursing practice based on national guidelines for central line care. First, fifty nurses were given a nineteen item written test to evaluate their knowledge of central line care. Then, we performed over fifty observations using a central line maintenance checklist to determine nurses' adherence to best practices. Although staff performed well on the test, there were deficiencies in observed nursing practice, leading us to conclude that "nurses know the right thing to do, but they don't always do the right thing." The results of these comparisons posed a challenge. These deficits were not cognitive; therefore, general education about CLABSI would not change practice. Our first approach was to share these data with 100% of inpatient nursing staff to reinforce how their poor technique directly contributes to CLABSI. Observed practice deficiencies drove targeted educational interventions. Additionally, to ensure standardization of practice, we revalidated 100% of oncology nursing staff on port technique, revised port kits to facilitate sterile procedure, and provided education to other areas where ports are commonly manipulated, including Interventional Radiology, Diagnostic Imaging, and the Emergency Department. The success of our project will be evaluated by comparing CLABSI incidence data (measured as cases per week) post-intervention to pre-intervention incidence data. Changing behavior is more complex than simply providing education. To prevent CLABSIs, the culture of the unit must be transformed with a commitment to adhering to evidence based standards of care.

1051971

RELATIONSHIP-BASED LEADERSHIP TRAINING: A FUNDAMENTAL COMPONENT IN THE DEVELOPMENT OF THE BEDSIDE NURSE. Barbara Van de Castle, MSN, OCN[®], APRN, BC, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD; Laurie Bryant, BSN, RN, OCN[®], Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD; and Gina Szymanski, MS, RN, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD

At this NCI-designated comprehensive cancer center staff have received role-specific leadership education in charge nurse and preceptor classes. Anecdotal reports from nurse managers and clinical nurse specialists revealed that staff needed additional training in leadership behavior and staff empowerment techniques, in addition to learning the tasks and responsibilities associated with these roles. A relationship-based approach to leadership development provided the framework for a new class where aspiring leaders discover that relationships form the basis of trust, build rapport and positively impact patient care outcomes. To create a training program that prepares the charge/preceptor nurse to approach the work from a relationship-based leadership perspective rather than a role and task-oriented perspective. Staff that met the experience criteria for participating in the new workshop were invited to attend an 8 hour didactic and "role play" session on team empowerment, relationship-based leadership and assessing learning styles. Group size was limited to 10 participants to ensure opportunity for networking and interactive activities. Post session evaluations were completed at the end of each class. A total of 39 staff have participated in this new workshop over the past 24 months. Post session evaluations reveal above average results for session content, presentation, and quality and knowledge of the speakers. Future sessions will include pre-workshop self-assessments of participants' work styles to be used during the session to facilitate discussion and gain appreciation for diverse approaches to work and problem-solving. Additionally, six month post-workshop evaluations will be conducted, measuring the level of integration of relationship-based leadership principles in to practice. Nurses require education and mentoring early in their careers to develop strong leadership ability. Leadership workshops should be founded on a relationship-based management model. The quality of the relationship between leaders and staff influences employee engagement, performance and ultimately organizational outcomes. This leadership workshop was designed to improve leadership training for the bedside nurse in an effort to enhance the quality and effectiveness of charge nurses and preceptors on the units.

1051972

PAVING THE WAY TO ONCOLOGY NURSING PRACTICE: A SUMMER CLINICAL FELLOWSHIP FOR SENIOR NURSING STUDENTS. Elizabeth Johnson, MSN, RN, AOCNS[®], AOCN[®], OCN[®], Gynecologic Oncology, Massachusetts General Hospital, Boston, MA; and Jane D'Addario, BSN, RN, Gynecologic Oncology, Massachusetts General Hospital, Boston, MA

Recognizing that content dedicated to oncology nursing may be limited in undergraduate nursing curricula and that nursing students may be dissuaded for various reasons from selecting oncology for their first job experience, leadership at an academic medical center with a large cancer care program established a summer fellowship to provide two nursing students entering their senior year with a concentrated, hands-on, paid immersion experience in oncology nursing. Of the 20 students who have successfully completed the program since its inception, a number have opted to launch their careers in oncology. To explore the impact of an oncology nursing student fellowship experience on the transition into professional practice. In the summer of 2010,

two new graduate nurses from the previous year's oncology nursing fellowship joined the staff of a gynecology oncology unit at an academic medical center. Through reflective narratives, they shared how their fellowship experiences affected their decisions to launch their professional careers in oncology and impacted their transitions from student to professional. A nursing fellowship program in oncology has provided beneficial intensive experiences for students entering their senior year. The ten-week, full-time fellowship involved mentored practice interspersed with focused observational experiences. Through written narratives and ongoing discussion, two recent graduates provided valuable insights about how their oncology fellowship experiences affected their decision process related to entry-into-oncology-practice and their transitions from the student to the professional role. The narrative reflection, as described by Patricia Benner, is a useful tool to explore the process and meaning of significant experiences and has been used widely to analyze clinical practice. In sharing reflections about their experiences in an oncology nursing fellowship and their ensuing transitions into the work setting, two recent graduates provided invaluable feedback about the fellowship program and its potential impact on professional practice.

1051995

SAFE AND EFFECTIVE ALTERNATIVE TO IV IRON INFUSION.

Fiona McCaughan, RN, BS, MS, MBA, OCN®, Hematology Oncology, Winchester Hospital, Stoughton, MA; Louise Pong, RPh, BS, Hematology Oncology, Winchester Hospital, Stoughton, MA; and Leona Rossetti, RN, OCN®, Hematology Oncology, Winchester Hospital, Stoughton, MA

Intravenous iron therapy is used for chemotherapy-induced anemia, optimizing ESA therapy, and in anemia of chronic renal failure or anemia due to GI blood loss. There is a lack of consensus on which is a better form of IV iron administration in ambulatory setting. Various infusion forms of IV iron are widely used. These require long infusion times, test doses and/or pre-medication. Iron Sucrose products allow IVP administration over 2-5 minutes without test dose or pre-medication. The ease of administration and shortened chair time has led us into adopting this form of administering IV iron in our infusion clinic. Evaluate the safety and efficacy of substituting IVP iron sucrose for infusions of Iron in the ambulatory infusion clinic. Literature search and evidence base practice review to evaluate the IVP form of administering IV iron in ambulatory setting. Educate and inform providers on alternate form of IV iron administration. Develop exclusion criteria. Develop a standard order sheet/order set. Trial with patients over two months. During trial period of two months, no adverse events occurred with the Iron Sucrose. After the trial all providers converted to IVP Iron Sucrose. Currently 90% of doses are administered as IVP, 10% as infusions. Patient Outcomes: No adverse events with the Iron Sucrose infusion reactions. IVP is effective therapy as measured by Iron, Hematocrit and Ferritin levels. Nursing Outcomes: No test dose required. No pre-medication needed. Reduces chair time. Patient Flow/Patient Throughput: Using a 1 hour infusion time (60 minutes) compared to an IVP time (15 minutes), each treatment represents an increase of 45 minutes of chair time availability. Provides a more flexible administrative schedule. Reduces office visits. Decreases in cost of care. Iron repletion has become a part of cancer patients care. Intravenous iron provides a better form than oral iron in oncology patients due to impaired gastrointestinal absorption of iron. Administering iron as an IVP provides a cost effective, time efficient and efficacious well tolerated option.

1051996

FAILURE TO RESCUE (FTR) AND THE UTILIZATION OF HIGH-FIDELITY SIMULATION AS A STRATEGY TO IMPROVE OUTCOMES IN ONCOLOGY PATIENTS. Taletha Askew, MS,

MBA, RN, CNS, The Ohio State University Comprehensive Cancer Center—Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, Columbus, OH; Tanya Trotter, MSN, RN, CNS, The Ohio State University Comprehensive Cancer Center—Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, Columbus, OH; Stacey Vacchiano, MSN, RN, CRNP, The Ohio State University Comprehensive Cancer Center—Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, Columbus, OH; and Paula Garvey, MSN-ED, RN-BC, The Ohio State University Medical Center, Columbus, OH

National Quality Forum selected failure to rescue (FTR) as core measure for evaluating nursing care in acute care hospitals. Review of unit specific quality data identified failure to recognize acute changes in patients' condition often resulting in Code Blue events. Improve RNs recognition of and appropriate responses to acutely decompensating patient. Pre-defined outcome measures are increased number of ERTs (Early Response Team events) and decreased number of Code Blue events for patient population. Use of high-fidelity simulation in clinical education helps to improve self confidence and clinical judgment. It also enhances problem solving abilities, offers opportunities for unlimited practice of rare and critical events in a safe, controlled environment without risk to patients. Education plan was developed utilizing high-fidelity simulation to assess RNs learning needs, develop interventions and evaluate learning outcomes. Phase I consisted of assessment of RNs clinical practice during enactment of simulation scenario created from actual patient's chart. Data was collected via direct observation during simulation exercises on (a) RN's responses to changes in patient's condition; (b) communicating up the medical chain of command; (c) obtaining/implementing orders; (d) correct use of equipment; (e) requesting additional resources as needed (ERT/Code Blue). Phase II consisted of a combination of education on appropriate use of equipment and case studies. Phase III consisted of 8 hour didactic course focusing on FTR and the nursing assessment, respiratory distress and a second simulation exercise to reinforce content. Phase IV consisted of 4 hours of didactic content titled "Thoracic Surgery and the Oncology Patient" and "Cancer Pain: What you need to know". Phase V will commence in approximately 12 months. Monthly outcomes data from January 2010 to present indicate Code Blue events were decreased by an average 300% and ERT events were increased by an average 60%. As part of a comprehensive education plan the use of simulation is helpful for comprehensive assessment to identify unit-specific learning needs, targeted interventions and evaluation. Data can be collected on QI events, near-misses, event reports, and staff feedback. Simulation provides nurses with realistic, hands-on practice with complex patient care conditions or scenarios.

1051999

BREAST CANCER AWARENESS: UNDERSTANDING CULTURAL BARRIERS. Violeta Alvarez, RN, BSN, OCN®, Oncology Department, Mount Auburn Hospital, Cambridge, MA; Mary Hunt Johnson, RN, BSN, OCN®, Community Health, Mount Auburn Hospital, Cambridge, MA; and Janice Maienza, RN, MSN, AOCN®, Oncology Department, Mount Auburn Hospital, Cambridge, MA

Meade (2009) studied women with international -born status and found implications regarding access to screening. Hall (2007) found that Hispanic women benefited from culturally sensitive group education. Focus groups with women in our hospital's surrounding community yielded the following: 1) Women believed "some" of their families and friends knew about breast cancer screening and got annual mammograms. 2) Pain was the #1 sign of breast cancer. 3) Fear was the main reason not to get a mammogram. 4) Access, including insurance was problematic.

To develop immigrant women's capacity to serve as peer breast cancer screening leaders and help our hospital staff plan future community interventions, we created a Learning Community (LC). We sought better understanding of cultural barriers experienced by women from Peru, Haiti, Brazil, and El Salvador. Based on the literature and our own focus groups, the LC content was created with nurses, a social worker, community outreach specialists, mammography technicians and community leaders. Ten immigrant women attended the 12 hour LC. Topics included causes of breast cancer, screening, healthy lifestyle, risk, signs and symptoms, and mammography. Evidence-based teaching tools were developed based on the sessions with attention to the participant's reading level. Cultural barriers were identified by participant's questions, discussions, and evaluations following each session. After the LC, students presented the information to 80 of their peers. Surveys were done to evaluate the total program. Demographic data included age, years in US, spoken languages, countries of origin and insurance status. Barriers identified included breast cancer myths, access to care, discomfort with healthcare providers, language, time constraints, and health insurance coverage. By the end of the sessions, participants were willing to share their learning with peers and felt more comfortable sharing ideas and feelings with health care providers. Navigating the healthcare system is stressful. Immigrant women have added stress as they confront language and economic issues. Myths and homeland experiences also affect their approach to Western medicine. The LC model is a way to understand culture and develop relationships while teaching breast health outside traditional settings.

1052014

PLUS ONE PROGRAM: TRANSITIONING NEW GRADUATES TO ONCOLOGY CERTIFIED NURSES. Cheryl Martin, MSN, ARNP, Nevada Cancer Institute, Las Vegas, NV

As a new cancer center, Nevada Cancer Institute (NVCi) quickly identified the shortage of oncology nurses in Nevada. To build a team of qualified oncology nurses, NVCi received a major grant from the Department of Labor to create an internship program for new registered nurse graduates from a partner community college. The Plus One Program provides didactic oncology training and clinical rotations for these new graduates, positioning them for the Oncology Certified Nurse (OCN[®]) credential. NVCi has formed a unique partnership with the College of Southern Nevada (CSN) and Workforce CONNECTIONS to provide newly graduated nurses with structured training and educational support to attain oncology certification. During their one-year paid internship, nurses spend several weeks engaged in seminar-style learning under the close supervision of a dedicated nurse educator. Modules such as carcinogenesis, diagnosis and staging of cancer, principles of chemotherapy and radiation therapy are studied. The program builds upon the Oncology Nursing Society (ONS) Core Curriculum and provides individual and group learning experiences. Nursing interns develop skills such as administering chemotherapy, symptom management, lymphedema, toxicities, oncologic emergencies and pain management. They "shadow" nurse mentors and, over time, and with direct supervision, they provide patient care. Each skill is supervised and, if needed, corrective coaching is provided by the dedicated nurse educator in concert with the preceptor nurse. Concurrently, interns spend a portion of their time in a learning laboratory where they have access to test preparation materials to help them prepare for examination. To date, weekly sample tests (based on ONS Core Curriculum) indicate passing scores for knowledge acquisition, clinical observations are recording skill attainment and structured interviews and performance evaluations are tracking readiness for oncology nursing. NVCi nursing leadership is interested in hiring interns as they complete the program, and is keenly observing the following: effectiveness of training model to prepare nurses

for certification, cost/benefit analysis of extensive paid training, transition of fulltime employment and the retention of these program participants, as well as the design of a replicable model for use in oncology settings.

1052038

CREATING NURSING EXCELLENCE IN A COMMUNITY BASED OUTPATIENT CANCER CENTER. Sherri Damare, RN, MSN, OCN[®], Clinical Research, Trinitas Comprehensive Cancer Center, Elizabeth, NJ; Carol Blecher, RN, MS, AOCN[®], APNC, Nursing, Trinitas Comprehensive Cancer Center, Elizabeth, NJ; and Jeanette Barefoot, RN, MSSL, OCN[®], Administration, Trinitas Comprehensive Cancer Center, Elizabeth, NJ

Oncology patients are a unique population dealing with significant psychological, physiological, and financial issues that require a specific skill set from nursing. As such, it is imperative that nurses are provided the tools and knowledge necessary to appropriately care for these patients. Previous practice at the Trinitas Comprehensive Cancer Center (TCCC) has been to provide nurses with a basic oncology orientation, but the major focus was on patient flow, forms, and systems which enable them to function efficiently within the outpatient clinic setting. However, this training lacked a patient focused critical thinking skill set. In an attempt to regain the patient focus, an oncology basics course was developed at TCCC. This course is now required of all new nurses entering TCCC and for those who have not yet achieved their OCN certification. The purpose of this program is to provide nursing staff with the tools and knowledge necessary to think critically within the oncology setting. This program utilizes a Constructivist Model learning approach as it enables nurses to build upon existing knowledge to incorporate new concepts and further develop their critical thinking skills as it relates to the care of oncology patients. Interventions include case study discussions and an interactive lecture format. The nurses are also provided with a course syllabus and weekly outlines highlighting important information that will be discussed during weekly study sessions. Additionally, physicians and other OCN certified nurses were incorporated into the program as resources and mentors. Evaluation of the program is currently underway and includes observation of nurse-patient interactions, review of nursing assessments and documentation, examinations and situational mentorship, annual performance evaluations, and passage of the OCN exam. Oncology patients require nurses who are able to think critically within their practice setting. Development of educational programs such as these have the potential of providing nurses who are new to oncology with the basic knowledge and skills necessary to engage in critical thinking, thus improving the patient experience within the outpatient setting.

1052047

PRIORITIZING PATIENT AND FAMILY NEEDS IN AN ACUTE ONCOLOGIC CARE SETTING. Catherine Licitra, RN, MA, UCC, MSKCC, New York, NY; and Janine Kennedy, RN, MA, OCN[®], UCC, MSKCC, New York, NY

The Urgent Care Center (UCC) of a comprehensive cancer center delivers emergency care to pediatric and adult oncology patients. Wait times for physician assessment and bed availability have steadily increased due to the rise in patient volume and acuity. Patient satisfaction scores indicated that patients' needs and concerns were not being addressed in a timely manner. We recognized that patients' needs go beyond their acute oncology issue. We wanted to find a balance between providing complex emergency oncologic care and the personalized needs of patients and caregivers during their encounter in the UCC. In the past year, the UCC staff embraced the Relationship Based Care (RBC) model as the care delivery model for the unit. RBC is defined as a framework to organize patient care delivery in which patients and caregivers are the central focus. It is the caring relationship

between one person and another. The UCC established a pilot concierge program in 2009. Two unit assistants were trained to work as the concierge during this pilot. The UCC concierge communicated with the charge RN and the triage RN regarding patient flow and personal needs. The concierge consistently rounded on all patients. They were responsible for comfort and dietary needs and communicating information regarding admission, pending tests and procedures. The concierge also assisted the caregivers and families with internal and external resources in the Center and surrounding neighborhood. This pilot helped us to establish the needs of the acute oncologic patient in the UCC and to maintain the balance between emergency care and RBC. A survey was conducted post pilot regarding the impact the program had on patients and staff. Positive results lead to the allocation of 2 full time concierge positions for the UCC in 2010. Concierge staff was trained using the RBC model. Ongoing evaluation of this program's impact on the patient experience in the UCC will be determined through patient satisfaction results. The UCC concierge program is an example of how relationship based care can be implemented in the most acute oncologic care setting. This program recognizes and celebrates exemplary care for patients, families, colleagues and self.

1052070

PALLIATIVE CARE FOR ARMED-SERVICES VETERANS: RECOGNITION OF SPIRITUAL DISTRESS AND UNRESOLVED POST-TRAUMATIC STRESS DISORDERS. Elizabeth Delaney, MS, RN, CNS, FNP-BC, OCN®, ACHPN, Nursing Excellence, The Ohio State University, James Cancer Hospital and Solove Research Institute, Columbus, OH; COL Kathy Hayes, MS, RN, BC, CHPN, Hospice and Palliative Care, Dayton VA Medical Center, Dayton, OH; and Jayne Gmeiner, MS, RN, NEA-BC, Nursing Excellence and Palliative Care, Miami Valley Hospital, Dayton, OH

Veterans have complex healthcare needs when facing a terminal illness or end-of-life, including spiritual distress and/or resurgence of post traumatic stress disorder (PTSD). These problems may be evident in combat soldiers and POWs who have previously faced the grim realities of death. Veterans may have witnessed, or caused traumatic deaths that may alter how they come to terms with their own death. Unresolved grief and/or survivor guilt may prevent their journey to a peaceful death. After review of the Ohio Hospice Veteran Partnership recommendations, a Midwest teaching hospital implemented a bedside recognition program to honor Veterans. This ceremony was to provide an opportunity for Veterans to deal with unresolved spirituality and PTSD issues. The purpose of this project was to 1) raise awareness of specific palliative care needs of Veterans, and 2) measure effects of programs and end-of-life issues. Following admission to the palliative care team, Veterans were offered to participate in a bedside recognition ceremony of service to our country. Staff, family, and a Veteran volunteer gathered and acknowledged the Veteran's service to our country. The Veteran volunteer presented the Veteran/patient with a pin. This interaction provided an opportunity for the Veteran to discuss memories. Unresolved spiritual and psychological issues often surfaced. Information learned prompted referral to appropriate resources to address concerns. Verbal and visual cues were observed during these interactions that provided positive feedback from the Veteran, family, and staff. Photos of the ceremonies provided evidence of tearful responses indicating a deeply emotional response to this recognition. The program received overwhelming positive evaluations. One in four Americans facing end-of-life has served our country, and may have been responsible for traumatic events. Such experiences may harbor unresolved spiritual and/or psychological issues that may interfere with a peaceful end-of-life. Based on our program and work with the Ohio Hospice Veteran's Partnership, Veterans nearing end-of-life may benefit from acknowledgement of their

military experiences. Failure to recognize the potential effects of military trauma may result in unresolved issues. We owe our freedom to these American soldiers and must work together to provide the best possible care. It is imperative that healthcare providers become aware of these oft silent challenges and needs of Veterans, especially at the sacred time of end-of-life.

1052100

IMPROVING CHEMOTHERAPY DOCUMENTATION. Colleen O'Leary, RN, MSN, AOCNS®, Oncology Services, Advocate Good Samaritan Hospital, Downers Grove, IL; and Karen Hagemaster, RN, BSN, Oncology Services, Advocate Good Samaritan Hospital, Downers Grove, IL

Errors in chemotherapy administration cause significant harm to patients. Prior to administration, the nurse must review the regimen for side effects, appropriateness for the indication, and that it is evidence based. Confirming drug name, dose, volume, rate, route, expiration, and appearance must also be completed. To assure safe administration of chemotherapy and compliance with hospital policy and regulatory guidelines a specific verification process must be documented as part of the patient record when administering chemotherapy. Although oncology nurses at this hospital were completing a verification, there was no specific documentation of their actions. A process improvement plan was put into place to address this issue. All chemotherapy orders were copied and put into a central chemotherapy orders binder. A verification form that included all aspects of required verification was developed and placed in a verification binder. All nurses were educated regarding use of the new form which included an independent double check prior to administration of all chemotherapy. Audits were performed to verify compliance with the new procedure. From January - March of 2010, prior to implementation of the improvement plan, an average of 54% of chemotherapy administered had appropriate documentation of verification. The percentage increased to 89% in the first month following implementation with a goal of 100%. One identified barrier to reaching goal was with administration of outpatient chemotherapy. The forms were being left in the outpatient chart and sent to medical records. Since the form was not a part of the permanent record, it was discarded and had to be rated as not completed. A checklist for outpatients was developed that included placing the verification form in the binder at completion of administration. As a result the goal of 100% compliance was reached for 29 of the 36 weeks studied or 81% of the weeks. When something was identified as missing, the specific nurses involved were contacted and coached regarding proper documentation. Assuring proper documentation of verification helps to assure that all aspects of the verification process are completed thus providing the safest administration of chemotherapy.

1052131

DAY IN THE LIFE: USING MILITARY STRATEGY TO FACILITATE TRANSITION INTO A NEW CANCER HOSPITAL. Lisa Truini-Pittman, RN, BSN, MPH, OCN®, CPON®, Smilow Cancer Hospital at Yale-New Haven, New Haven, CT

Opening a new cancer hospital, offering a full range of services with 128 beds and 104 ambulatory treatment spaces, required the merger of multiple physician office practices with six inpatient units from twenty different locations and the coordination of operational processes of more than 14 departments. In planning for this merger, we employed "Day in the Life (DIL) exercises" used by the military to simulate and test operational systems before opening military medical environments. The purpose of our project was to ensure operational safety and readiness prior to opening the hospital. The DIL exercises consisted of patient scenarios that involved staff from every discipline performing their role within the scenario. The scenarios, developed by staff volunteers, were timed to the minute and sequenced to run

simultaneously. A “kick-off rally” for all participants was held before each DIL event. Pre- and post-conferences were also held for each scenario. The scenarios were lead by a “director” and an “evaluator” to assure that the scenario was fully played-out. An evaluation tool was used by participants to record observations throughout the scenario and to guide feedback discussions during the post-conference. The DIL event concluded with a high-level debriefing during which the director/evaluator partners reported the most concerning issues to department heads and key stakeholders. Following the DIL event, a summary of findings was created within 24 hours, and an executive report and action plan were finalized and presented to senior administration within 72 hours. Five DIL exercises, held on different dates, were composed of 23 interdepartmental scenarios, and involved 356 staff and 30 patient volunteers. We identified 404 issues that were prioritized and addressed prior to opening the hospital as well as multiple staff training needs. Participants expressed a sense of empowerment related to their contribution toward safeguarding the new environment. DIL provided the opportunity to see into the future and to affect a safer environment for our patients, families, and staff on the first day of occupancy. This strategy can be easily adopted by other organizations planning on opening new cancer services.

1052135

BRIDGING THE INFORMATION GAP: AN HPV EDUCATION PROJECT. Dionne Walker, BSN, RN, The University of Texas M.D. Anderson Cancer Center, Houston, TX; Linda Bracks-Madison, MSN, RN, The University of Texas M.D. Anderson Cancer Center, Houston, TX; and Judith Payne, PhD, RN, AOCN®, The University of Texas M.D. Anderson Cancer Center, Houston, TX

Human Papillomavirus (HPV) is the most common sexually transmitted infection in the United States with approximately 20 million persons currently infected and an estimated 6.2 million additional persons who will become infected every year. By age 50, at least 4 out of every 5 women will have been infected with HPV at one point in their lives. HPV is a virus that is easily spread during sexual intercourse through skin to skin contact. Although the FDA has approved a vaccination to reduce the risk of cervical cancer, it is most effective if administered before the initial sexual experience. Sexually active women are at risk of contracting the virus which increases their risks for cervical cancer. The two-fold purpose of this evidence-based education project was to evaluate the literature on the effect of increased public awareness in reducing the incidence of HPV-related cancers, and to implement a community-based education program. The goal was to educate women regarding general HPV knowledge of high and low-risk HPV strains, risk factors for contracting the virus, availability of HPV genotype testing, necessity for routine and follow-up pap smears, and other treatment options. Nurses must use a more proactive approach when assessing each patient’s sexual health history. Appropriate educational information is needed to increase HPV and cervical cancer prevention for women. An adult learning theory guided the development of this community-based education project. The literature suggests that preventive patient education plays an important role in the reduction of HPV-related cancers. Women need to be educated regarding the risks of contracting the virus as well as the recommended screening and treatment modalities. Preliminary results show that providing educational information can result in women reporting an increased awareness and knowledge regarding HPV. Focusing on the educational needs of women at risk for HPV infection, a pilot program was implemented to increase their knowledge regarding HPV, the risks of contracting the virus and the recommended screening and treatment modalities. Women who are willing to participate in a community-based education project will be more likely to make informed health decisions and will be equipped to participate in shared decision making.

1052158

EDUCATION NEEDS FOR CHEMOTHERAPY’S EFFECTS ON FERTILITY. Amanda Polk, BSN, RN, Brain and Spine Center, MD Anderson Cancer Center, Houston, TX; and Angie Ames, RN, OCN®, Brain and Spine Center, MD Anderson Cancer Center, Houston, TX

The risk of infertility due to cancer treatment in oncology patients is well known, however there is a lack of patient education prior to the start of fertility toxic treatment. In surveys of adult oncology patients, less than 60% of patients recall their healthcare provider discussing the risks of infertility caused by cancer treatment or their options to preserve fertility prior to the initiation of treatment. The effect of cancer treatment on fertility is determined by several factors, including age, gender, diagnosis, radiation and chemotherapy agents and treatment duration. Nurses have an opportunity to advocate for our patients’ access to this information. The purpose of this presentation is to describe improved and structured ways for nurses to advocate for and educate the patient about fertility prior to the initiation of cancer treatment, and to highlight the importance of the topic of fertility to the cancer patient. Within a clinic treating adults with brain cancer at a large comprehensive cancer center, there is no existing standard for education about the effects of cancer treatment on fertility. Data will be gathered within our institution to determine the satisfaction level of patients of child bearing age regarding fertility education prior to initiation of cancer treatment. As a result, patient education will be created to provide to this patient population within this clinic. Follow-up surveys will be conducted. Studies have established the need for structured patient education regarding fertility risks due to chemotherapy. An evaluation will be made through patient surveys to determine the level of patient satisfaction with fertility education received before implementation of standardized patient education compared to after patient education is standardized. Honest and accurate information is of utmost importance when discussing fertility with the cancer patient. Nurses should encourage patients to discuss infertility risks with their physician before treatment begins and provide reliable resources for fertility experts in the area as well internet resources specializing in fertility. Nurses need to create an open and receptive environment to encourage patients to express their concerns.

1052185

SUMMARY OF CARDIAC EFFECTS OF Nilotinib AND Imatinib in Patients Enrolled in ENESTND (Evaluating Nilotinib Efficacy and Safety in Clinical Trials of Newly Diagnosed Philadelphia Chromosome-Positive CML Patients) Trial: Implications for Oncology Nurses. Reynaldo Garcia, Protocol Office, UNC Lineberger Cancer Center, Chapel Hill, NC; Richard Larson, Hematologic Malignancies Clinical Research Program, University of Chicago Medical Center, Chicago, IL; Hagop Kantarjian, Department of Leukemia, University of Texas MD Anderson Cancer Center, Houston, TX; Timothy Hughes, Division of Haematology, SA Pathology, Royal Adelaide Hospital, Adelaide, South Australia, Australia; and Gerry Gorospe, Division of Hematology and Hematopoietic Cell Transplantation, City of Hope, Duarte, CA

In the past decade, three target-specific drugs have emerged for treatment of chronic myeloid leukemia (CML) in chronic phase (CML-CP). Imatinib paved the way for tyrosine kinase inhibitors (TKIs), and this was followed by the newer and more potent BCR-ABL kinase inhibitors nilotinib and dasatinib. Preclinical studies suggested that TKIs may affect cardiac function. The cardiac safety data from early-phase studies showed prolongation of QT intervals in some patients who were imatinib-resistant or -intolerant and received nilotinib. ENESTnd is a phase 3 multicenter, open-label, randomized study comparing the safety and efficacy

of nilotinib with imatinib in the front-line setting. To present the 18-month median follow-up cardiac safety analysis and discuss the implications for oncology nurses. Patients received nilotinib 300 mg twice daily (bid, n = 282), nilotinib 400 mg bid (n = 281), or imatinib 400 mg once daily (n = 283). Patients with baseline QTc <450 msec were eligible. Close monitoring for QT prolongation on ECG and changes in left ventricular ejection fraction (LVEF) were performed at regular intervals throughout the study. No decrease from baseline in LVEF was observed at any time during the study in any treatment arm. Increase from baseline in QTcF >30 msec occurred in 26% of patients in each nilotinib arm and 18% of patients in the imatinib arm. Less than 1% of patients experienced an increase in QTcF >60 msec from baseline. No patient had a QTcF interval >500 msec. Additionally, no patients discontinued their treatment due to QTcF prolongation or change in LVEF. These results suggest that nilotinib has an acceptable cardiac profile that is similar to imatinib in patients with newly diagnosed CML-CP. Oncology nurses play an important role in the optimal management of patients with CML. Having a clear understanding and knowledge of appropriate management of the side effect profile of oral chemotherapy agents will help nurses to provide the best patient care. Information for evaluating early cardiovascular signs and symptoms and prompt management of side effects is essential. Additional patient discussion points, such as drug-drug and drug-food interactions are beneficial.

1052226

PREPARING FOR ONCOLOGY PATIENT NEEDS: BLOOD AND MARROW TRANSPLANT NURSING WORKFORCE SYSTEM CAPACITY INITIATIVE. Elizabeth Murphy, RN, EdD, Patient Services, National Marrow Donor Program, Minneapolis, MN; Kim Schmit-Pokorny, RN, MSN, OCN®, Blood and Marrow Transplantation Program Oncology/Hematology Section, University of Nebraska Medical Center, Omaha, NE; Terry Sylvanus, RN, MSN, ACNS-BC, AOCN®, H. Lee Moffitt Cancer Center and Research Institution, BMT Unit, University of South Florida, Tampa, FL; Alexandra De Kesel Lofthus, MNM, CHTC, Patient Services, National Marrow Donor Program, Minneapolis, MN; Ellen Denzen, MS, Patient Services, National Marrow Donor Program, Minneapolis, MN; and Joyce Neumann, RN, MSN, AOCN®, MD Anderson Cancer Center, University of Texas, Houston, TX

More than 20,000 allogeneic blood and marrow transplants (BMT) are performed in the U.S. each year. This number continues to increase; however, workforce shortages and lack of adequate infrastructure present challenges to the future growth of BMT. The National Marrow Donor Program® (NMDP), with support from the Oncology Nursing Society (ONS) BMT special interest group (SIG) and the American Society for Blood and Marrow Transplantation (ASBMT) Transplant Nursing SIG, sponsored the System Capacity Initiative (SCI), a series of Symposia to assess the ability to meet these future needs. The purpose of the SCI Nursing Workforce workgroup is to identify the benefits and challenges of BMT nursing and to develop recommendations to support BMT nurses and address workforce issues. Primary data was collected via internet survey from July 16 - August 5, 2010. The survey was sent to SIG members of ONS and ASBMT. Participants included nurses in the U.S. who were not advanced practice professionals. Descriptive analysis and weighted rank scoring was performed using SPSS. The survey was sent to > 1,600 BMT nurses with a response rate of 9% (N=148). Respondents were White (81%), female (95%) staff nurses (60%) practicing within BMT for > 10 years (38%). Overall, 62% of respondents were very satisfied or satisfied as a BMT nurse. The following aspects were ranked as most satisfying: Providing physical care (72); Hope/promise that transplant offers (69) and Nurse to patient ratio (69). The top challenges facing BMT nurses included: Work-

ing in an increasingly challenging environment (111); Staying abreast of scientific advances/changes in BMT (63); Recruiting/hiring sufficient number of nurses (59) and Balancing demands of work/personal life (59). More than 70% indicated they plan to advance their nursing degree. The results of this survey will be used to provide recommendations to academic and professional organizations for addressing future workforce challenges and promoting the BMT nursing profession. The final product of the SCI workgroup will contribute to future technology, treatment, and services that drive the field of BMT.

1052264

CHEMOTHERAPY-RELATED COGNITIVE IMPAIRMENT: THE BREAST CANCER EXPERIENCE. Jamie Myers, PhD, RN, AOCN®, School of Nursing, University of Kansas, Edwardsville, KS

Chemotherapy-related cognitive impairment (CRCI) is recognized as a commonly reported sequela of the treatment of breast cancer. Women complain of being uninformed about CRCI and express frustration at lack of validation of the experience. Little has been published about the experience of CRCI and oncology nurses have acknowledged lack of access to pertinent educational materials. Changes in cognitive function have the potential for a significant impact on survivors' quality of life. The purpose of this qualitative descriptive study was to describe the experience of CRCI for women with breast cancer who received chemotherapy, and identify information about CRCI that women would find useful prior to chemotherapy and the onset of cognitive changes. The Revised Conceptual Model of Chemotherapy-Related Changes in Cognitive Function Based on the Theory of Unpleasant Symptoms was used as the theoretical framework for the study. In-depth interviews were conducted with 18 women who reported changes in cognitive function and were within 6-12 months of completing chemotherapy. Qualitative content analysis was used to analyze the data. A focus group was conducted to validate and refine the data analysis. Expert and peer review enhanced the credibility and trustworthiness of the study results. The themes for the study results were Life With Chemobrain, How I Changed, How I Cope, and How to Teach Me. Participants described difficulty with short term memory, focusing, word finding, reading, and driving. Issues with fatigue, balance and/or coordination also were of concern. Coping strategies included writing things down, depending on others, focusing on one task at a time, and giving oneself permission to make mistakes. Participants wanted to receive information about CRCI prior to initiating chemotherapy and desired an individualized approach to education. Specific educational content, reinforcement of education, and on-going assessment for CRCI were recommended. The study results provide support for the impact of CRCI on functional ability and suggest that fatigue may require further evaluation as a potential moderating factor of CRCI. Application of the study results will serve to validate the experience of CRCI for women with breast cancer and contribute to patient satisfaction with the delivery of care.

1052310

ACUTE CARE OF ONCOLOGY PATIENTS ON AN INPATIENT ONCOLOGY NURSE PRACTITIONER UNIT. Jean Treacy, APRN-BC, AOCNP®, Massachusetts General Hospital, Boston, MA; Jeanne Vaughn, APRN-BC, OCN®, Massachusetts General Hospital, Boston, MA; Erin Barry, APRN-BC, Massachusetts General Hospital, Boston, MA; Martha Brezina, APRN-BC, Massachusetts General Hospital, Boston, MA; Eileen Comeau, APRN-BC, Massachusetts General Hospital, Boston, MA; Elizabeth Deiulis, APRN-BC, Massachusetts General Hospital, Boston, MA; John Kane, APRN-BC, Massachusetts General Hospital, Boston, MA; Tracey Lafferty, APRN-BC, AOCNP®, Massachusetts General Hospital, Boston, MA; Michelle Le-

tourneau, APRN-BC, Massachusetts General Hospital, Boston, MA; and Jennifer Logan, APRN-BC, Massachusetts General Hospital, Boston, MA

Due to the changing requirements for medical house staff instituted by the Accreditation Council for Graduate Medical Education, 14 Medical Oncology beds at the Massachusetts General Hospital were to be without house staff coverage as of June of 2010. From prior experience, it was recognized that Nurse Practitioners could provide exceptional, individualized and comprehensive care of oncology patients. Therefore as a solution, the Cancer Center leadership developed an Inpatient Oncology Nurse Practitioner Unit. The purpose of the Inpatient Nurse Practitioner unit is to provide acute care to the oncology patient throughout the trajectory of a cancer diagnosis. The Nurse Practitioner unit is comprised of ten Nurse Practitioners who work 12 hour rotating shifts and provide coverage for up to 14 patients 24 hours a day, seven days a week. Patients are assigned to nurse practitioners with effort made to adhere to a primary nursing model to provide continuity of care. Both verbal and written reports are used to ensure safe handoff between shifts. The assigned Nurse Practitioner is delegated as the «responding clinician» and is responsible for ordering and interpreting labs and diagnostic studies, assessing the patient daily, evaluating any change in status, participating in family meetings, managing medications, consulting and conferring with specialists, and admitting and discharging patients. Daily progress notes are written and the plan of care is reviewed by the attending physician. Presently the success of the unit is evaluated by comparing length of stay to the medical service and by the hospital wide Press Ganey patient satisfaction survey. Since the units' inception, the average length of stay has consistently been 1-3 days shorter than the comparable house staff medical service. The results of the Press Ganey surveys have also demonstrated a high level of patient satisfaction. Oncology Nurse Practitioners have been an invaluable addition to the care of patients with cancer in the outpatient setting and this Inpatient Nurse Practitioner unit strives to provide the same excellence in care. It is our hope to continue to decrease length of stay as well as to develop a more specific tool to measure patient and staff satisfaction.

1052429
PROMOTING EVIDENCE BASED PRACTICE: THE IMPLEMENTATION OF AN AMBULATORY TELEPHONE TRIAGE PROJECT. Mary Elizabeth Davis, RN, MSN, AOCNS®, MSKCC, New York, NY

Symptom assessment and management over the telephone is an important role of the ambulatory oncology nurse. Standardized algorithms can guide assessment of a symptom, identify contributing factors, help determine urgency, and specify nursing interventions. Our institution's telephone triage manual is a pocket sized reference for assessment and management of disease or treatment related symptoms. Initially published in 1995 and based on our standards of care, the manual outlines symptom assessment criteria, predisposing, precipitating, and alleviating factors. A three-tiered triage system is utilized to categorize patients' symptom as emergent, urgent, non-urgent, and specific criteria guide the nurse in determining the priority of the issue and need for intervention. A review of forty-seven common cancer symptoms was undertaken by the Ambulatory Nursing Practice Council. The goal of the review was to confirm the algorithms in our telephone triage manual were based on current evidence to advance nursing practice. A corresponding project to develop an electronic nursing documentation tool that paralleled the standardized algorithms was undertaken. Nurses were educated about evidence based review process including how to perform a literature search and how to critique research. Nurses utilized advanced practice nurses and library resources to provide expertise. An evidence based review on assessment, associated symptoms, precipitating and predisposing factors and interventions for thirty nine symptoms from the existing manual as well as eight

new symptoms was performed. The revised manual underwent review at the hospital clinical council and was approved by the medical board. Following approval, implementation will include educating all ambulatory nurses about the standardized algorithms and the new electronic documentation tool. Data obtained from the electronic documentation tool will help identify trends of care and nursing-sensitive practice outcomes based on the use of our standardized algorithms. Information gathered, such as statistics on the presence of contributing factors for specific symptoms or nursing interventions implemented can cultivate opportunities for nursing research. Use of our telephone triage manual supports both a logical approach to cancer symptom management and adherence to institution approved algorithms of care. Use of the algorithms integrated with oncology knowledge will promote evidence based nursing practice.

1052467
“FACING FORWARD LIVE” . . . STRUCTURE AND OUTCOMES OF A PATIENT SURVIVORSHIP EDUCATION PROGRAM. Patricia O'Reilly, RN, BSN, OCN®, Oncology, Cleveland Clinic Cancer Center at Fairview Hospital, Cleveland, OH; and Jean Ellsworth-Wolk, RN, MS, AOCNS®, Oncology, Cleveland Clinic Cancer Center at Fairview Hospital, Cleveland, OH

Post cancer treatment education is an essential component of oncology survivorship programs. In our practice setting, a multidisciplinary team was formed to evaluate our current practice of supporting cancer patients as they transitioned from active treatment to surveillance. The team included medical oncology nurses, radiation oncology nurses, advanced practice nurses and social workers. One of the goals of this team was to develop an educational session for patients when treatment was completed addressing both physical and psychological needs. The purpose of this project was to improve patient knowledge in the management of late and long term side effects and psychological distress related to cancer treatment in a supportive group environment. An additional goal of the educational program was to develop an increased awareness of the cancer center's wellness initiatives which promote wellness behaviors. A multidisciplinary task force was formed to review relevant literature and current practice trends. A focus group of current cancer survivors completed a needs survey assessment to determine topics to be included in the educational program. A bimonthly educational class was developed and is presented to cancer survivors at completion of treatment. . A process was implemented to schedule all patients in this class as they complete initial treatment. The class presents information on possible long-term side effects of treatment and includes information on ways to improve or maintain a healthy lifestyle. An Oncology Social Worker also presents information on psychosocial issues to reduce the effects of emotional distress. Patient evaluations have been overwhelmingly positive, outcomes have included an increased participation in health promotion programs. Patients may develop a sense of empowerment for regaining a sense of control in their lives and their futures. Meeting the educational needs of cancer survivors is essential in assisting the patient to discover their “ new normal”. The importance of using a multidisciplinary approach to achieve this goal is demonstrated by meeting both the physical and psychosocial needs of the patient. Our program demonstrates a successful strategy to improve long term care in oncology.

1052468
THE PENROSE CANCER CENTER PULMONARY NODULE CLINIC: IMPROVING OUTCOMES FOR LUNG CANCER PATIENTS. Patty O'Connell, RN, MS, OCN®, Penrose Cancer Center, Colorado Springs, CO

Lung cancer is the second leading cause of all deaths in every ethnic group, and kills more people than colon, breast, and pros-

tate cancers combined. When caught early, lung cancer is treatable and curable. Few people present at an early stage, so most lung cancers are found incidentally at a more advanced stage. The Penrose Cancer Center Pulmonary Nodule Clinic (PNC) exists to monitor abnormal imaging in order to diagnose suspicious nodules early and refer for appropriate treatment. The national average for the time of first contact for a patient with a lung nodule to the time of first treatment is 60-90 days. The Penrose PNC is currently following 190 patients referred by PCPs, ER physicians, or patients themselves. ER physicians and radiologists provide the patient with the PNC phone number. Frequency of repeat scanning is determined by age, smoking history, personal history of cancer, family history of lung cancer, and size of nodule. A weekly Thoracic Multidisciplinary Conference (MDC) seeks the opinions of pathologists, radiologists, pulmonologists, oncologists, thoracic surgeons, and the research team to formulate an individual diagnosis and/or treatment plan. The Penrose Cancer Center PNC maintains an average time of 16 days between the first contact with a lung nodule patient to first treatment. The Thoracic Nurse Navigator is currently following 37 lung cancer patients. Twelve patients in the last year have been diagnosed at Stage I lung cancer due to the PNC. Various quality indicators are being followed in order to show improved outcomes for patients followed and diagnosed through the Pulmonary Nodule Clinic. Data from the Penrose Cancer Center PNC show significant improvement over national statistics for the time between first contact to first treatment. Patients are diagnosed at an earlier, treatable stage. In order to track improved patient outcomes, the Penrose Cancer Center monitors other quality indicators such as numbers of patients presented at Multidisciplinary Conference, patients referred for smoking cessation, and patients enrolled in clinical trials.

1052486

ON THE HOUR! ROLE MODELING VIDEO CREATED TO IMPROVE HOURLY ROUNDING BEHAVIORS. Elizabeth Blasiak, RN, MSN, OCN®, Medical Oncology, Smilow Cancer Hospital at Yale New Haven Hospital, New Haven, CT

Hourly rounding is a model of nursing care that emphasizes key nursing behaviors to improve nursing efficiency and promote improvement in nursing-sensitive outcomes (Studer Group, 2007). Despite recent staff education about hourly rounding, compliance with the frequency and use of hourly rounding behaviors remains low. The purpose of this project is to provide an innovative intervention called "On the Hour" aimed at improving hourly rounding behaviors of nursing staff that results in a decrease in call bell use and improvement in select nursing-sensitive outcomes. Oncology nursing leaders (managers, educators, clinical nurse specialist) developed a collaborative action plan that consists of three key elements: 1) education, 2) competency assessment, and 3) monitoring of hourly rounding behaviors that includes staff performance feedback. The staff is required to view a 23-minute video that focuses on the four P's of hourly rounding that includes, Pain, Personal Needs, Positioning, and Placement. The video first demonstrates undesirable behaviors, then models expected behaviors highlighting how rounding can promote nursing organization and efficiency. The leadership group used humor, music, and clinical situations to create the video that engages staff, but most importantly, uses these leaders as actors to role model best nursing practice. A competency checklist will be used and managers and educators will perform staff competencies by direct observation of hourly rounding. Focused patient interviews will also be done to ensure patient understanding and their perception of hourly rounding. Baseline call bell frequency and reason for call will be compared with post-intervention call bell frequency to assess for a decrease in calls. Baseline and post-intervention nursing-sensitive outcomes includes: 1) overall patient satisfaction scores 2) satisfaction with pain management, 3) fall rates, and 4) hospital-acquired pressure ulcer incidence. The practice of hourly rounding provides a proactive approach to organizing nursing care. Although the

video was originally created for the oncology nursing staff, the extremely positive response prompted the Chief Nursing Officer to mandate that all direct care nursing staff and student nurses view the video throughout the organization. We anticipate that staff enthusiasm and improved hourly rounding behaviors will result in improved clinical outcomes for our patients.

1052496

REFEEDING SYNDROME PREVENTION AND MANAGEMENT: USE OF A PATIENT CARE CONFERENCE TO EDUCATE NURSES ON REFEEDING SYNDROME IN AN ONCOLOGY PATIENT.

Kara Wade, RN, BSN, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; and Jayne Wipronick, MS, RD, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY

Refeeding syndrome is a metabolic disturbance that occurs when patients who have lacked adequate nutrition begin to receive nourishment. Select oncology patients are at higher risk because of their disease and iatrogenic effects of treatment. Patients who receive enteral feeds, experience significant weight loss, or have a prolonged NPO status are most at risk. Often underdiagnosed, it can lead to life threatening complications, specifically fluid and electrolyte disorders and multisystem complications. Patient outcomes can be improved if nurses comprehensively understand risk factors, monitoring and preventative strategies, and early manifestations of refeeding syndrome. Having identified an educational need amongst the nursing staff on our inpatient head and neck surgical oncology and gastrointestinal medical oncology unit, a patient care conference was developed in collaboration with the unit based dietitian. Nursing responsibilities such as facilitation of specimen collection, reporting of laboratory values, and titration of enteral feeds were the key points reviewed. The nurse and dietitian conducted a needs assessment, performed a comprehensive literature search, and developed a patient care conference. A patient on the unit undergoing monitoring for the syndrome was identified and highlights of his care were presented including: the patient's nutrition plan, laboratory values, electrolyte supplementations, and nursing implications. An overview of the pathophysiology of refeeding syndrome was provided by the dietitian. By utilizing the patient care conference, the nurse accentuated both successes and weaknesses of this patient's management, therefore presenting a clinically applicable example to peers. Prior to the conference, staff lacked clinical confidence when monitoring at risk medical-surgical oncology patients. Staff was unaware of their role in preventing refeeding syndrome including: timing blood draws, reporting lab values, administering electrolyte supplementation and titrating enteral feeds. After attending the care conference, staff nurses were able to apply their newly acquired knowledge to expertly manage other at risk patients on the unit. This patient care conference provides a model for educational mentorship amongst staff nurses and is a valuable exemplar of senior nurses sharing clinical expertise. As a result, the gained knowledge has enabled our nursing staff to care for our complex oncology patient population with greater expertise and efficiency.

1052503

"ANSWER IS . . .": ENGAGING ANCILLARY STAFF IN EDUCATIONAL INITIATIVES BY INCORPORATING A GAME SHOW FORMAT TO DETERMINE COMPREHENSION OF CONTENT.

Jaine Jewell, RN, OCN®, Nursing, MD Anderson Cancer Center, Houston, TX; Kelly Faltus, RN, MSN, AOCNS®, ACNS-BC, Nursing, MD Anderson Cancer Center, Houston, TX; and Roxy Blackburn, RN, BSN, OCN®, Nursing, MD Anderson Cancer Center, Houston, TX

The vast differences in educational preparation of ancillary staff members can make standardizing unit-specific continuing education a difficult task for staff educators. In clinical areas where complex or cutting-edge treatments are the norm it is beneficial for

all staff members to have a basic understanding of the processes in use. The challenge for the educator is to ensure the material is engaging for staff from a variety of educational and professional backgrounds while ensuring comprehension of the educational content. The purpose of this project was to engage nearly 50 ancillary staff members at a large NCI-designated cancer center, including nursing assistants, unit clerks and administrative assistants, in content related to the stem cell transplant patient population on their home unit. The nursing leadership team on a stem cell transplantation (SCT) unit developed a six part educational series of modules applicable to the SCT patient population. The topics were: An Overview of Cancer, Stem Cell Transplant (SCT) Pathophysiology and Purpose, SCT Modalities, SCT Pharmacology, SCT Complications, and The Role of the Ancillary Staff Member in the Care of the SCT Patient. Each module was presented in a forty minute power point presentation, using both bulleted points and colorful graphics, and concluded with a humorous quiz in a Jeopardy-style format. The modules were presented in sequence, approximately two weeks apart, and attendance by the ancillary staff was mandatory. During each Jeopardy style quiz at the conclusion of each presentation dollar amounts were associated with each correct answer, and even though no money was actually awarded, the opportunity to have the highest dollar score among their peers encouraged each participant to pay close attention to the content of each presentation. At the conclusion of all six modules, an evaluation form was distributed to all participants. Although the evaluation did not specifically ask about the quiz format, each of the thirty-seven respondents gave very positive evaluations of the educational content and structure of delivery. Engaging ancillary staff in unit-specific educational initiatives provides an ongoing challenge for unit educators in developing engaging learning opportunities while ensuring comprehension of often complex subject content. Incorporating light-hearted or humorous aspects into the curriculum can be key to increasing staff participation and satisfaction with the initiative.

1052526

SYMPTOM MANAGEMENT EXCELLENCE (SME) INITIATIVE: PROMOTING EVIDENCE-BASED ONCOLOGY NURSING PRACTICE. Donna Berry, PhD, RN, AOCN®, FAAN, Phyllis F. Cantor Center, Dana-Farber Cancer Institute, Boston, MA; Jean Boucher, PhD, RN, ANP, Phyllis F. Cantor Center, Dana-Farber Cancer Institute, Boston, MA; Meghan Underhill, RN, FNP, Phyllis F. Cantor Center, Dana-Farber Cancer Institute, Boston, MA; Kristin Roper, RN, Phyllis F. Cantor Center, Dana-Farber Cancer Institute, Boston, MA; and Toni-Anne Saunders, MPH, Phyllis F. Cantor Center, Dana-Farber Cancer Institute, Boston, MA

Having the best evidence at hand with which to intervene for cancer symptoms is pre-requisite for nursing excellence in oncology patient care. However, the infrastructure and approach are not often developed or implemented to make this a practice reality. The purpose of the Symptom Management Excellence (SME) initiative is to use institutional structure and process to create standard approaches to cancer symptom control by carefully testing the feasibility of clinical implementation of efficacious interventions to treat common and distressing symptoms. The Dana-Farber Cancer Institute (DFCI) received foundation sponsorship to implement a new approach for reducing adverse symptomatology in ambulatory care patients with cancer. We first identified the highest incident symptoms self-reported by patients from throughout the Institute. Secondly, we surveyed direct-care nurses with regard to the three most common, severe and important-to-manage symptoms encountered in their clinical practice. Using the Science and Practice Aligned Within Nursing approach, we identified direct nurses interested in the topic. Finally, literature reviews were conducted and expert investigators were invited to present research findings and consult with our interdisciplinary team. From March 2009-May 2010, 330 patients

in medical and radiation oncology completed the Symptom Distress Scale while enrolled in a clinical trial. The highest incident, moderate to severe symptoms were fatigue, fear & worry, impact on sexuality, insomnia and appetite problems. The survey results from 163 DFCI nurses identified fatigue as most common (71%), most severe (52%), and second most important-to-manage (25%). Anxiety and anorexia were identified as other common, severe and important symptoms. Triangulation of these data with an evaluation of research literature revealed that symptoms with best available evidence included anorexia, anxiety and fatigue. The SME-Fatigue team convened and now includes clinic nurses, a nutritionist, an exercise physiologist, and doctorally-prepared nurse facilitators; all DFCI employees. Three outside investigators participated in a one-day workshop with the team and contributed to developing the practice change to address cancer-related fatigue. The implementation feasibility testing will begin in early 2011. The SME initiative has successfully utilized patient-reported data, direct-care nurse input, evidence for efficacious interventions and expert consultation to systematically address a cancer symptom management issue.

1052543

BEYOND ONCOLOGY . . . CARING FOR THE HEARTS OF OUR PATIENT POPULATION. Kathleen Schardien, RN, MSN, AOCN®, Memorial Sloan Kettering Cancer Center, New York, NY; Patricia McTague Allen, RN, MSN, FNP-BC, Memorial Sloan Kettering Cancer Center, New York, NY; and Kevin Browne, RN, MS, CCRN, Memorial Sloan Kettering Cancer Center, New York, NY

As hospitalized oncology patients become more acutely ill and increasingly require expert cardiac care to support them through oncologic therapies, a need existed at our comprehensive cancer center to develop a cardiac intermediate care unit (CICU). This innovative program is housed in twelve beds of a forty-two bed medical/surgical oncology and telemetry unit. The program manages patients with active cardiac disease which supersedes their oncology diagnosis and care for patients with cardiac toxicity associated with cancer treatment. Patients most commonly requiring focused management include those with chemotherapy toxicity, uncontrolled hypertension, congestive heart failure and symptomatic atrial fibrillation. Patients are admitted directly to the cardiology oncology service and unit based mid-level practitioners allow for rapid management of clinical scenarios. Criteria for admission to the CICU are based on nationally recognized guidelines for patients requiring more advanced cardiac care or monitoring. Bedside monitors allow for immediate rhythm interpretation at the point of care and enhance the current telemetry monitoring system. Order sets were developed to provide standardized management of atrial fibrillation and congestive heart failure. Care is escalated to a collaborating cardiac center with invasive capabilities. To prepare our oncology nurses to administer complex cardiac medication regimens and treatment modalities staff achieved ACLS certification and attended a customized dynamic didactic training program. An additional individualized interactive inservice was provided to each nurse on the new bedside monitor. Multidisciplinary daily rounds and ongoing inservicing supplement staff knowledge. Enhanced nursing and medical services now provided include bedside monitoring, transesophageal echo, cardioversion and cardiac medication infusions. Managing this higher level of acuity on the unit has resulted in decreased intensive care unit transfers and timely escalation of care to collaborating cardiac care facilities. Ultimately, patients return to their primary service for continued oncologic management. The launch of this program has helped our institution meet current standards for best practice in cardio-oncology care. Oncology nurses have mastered a broadened skill set and experience heightened morale after successfully implementing a valuable program. The unit provides an exemplar for other institutions attempting to improve cardiac management of their oncology patient population.

1052587

OVERCOMING BARRIERS TO EFFECTIVE CHEMOTHERAPY EDUCATION. Chris Tucker, RN, BSN, OCN®, Stanford Cancer Center, Stanford Hospital and Clinics, Stanford, CA; Margaret Hawn, RN, BSN, OCN®, Stanford Cancer Center, Stanford Hospital and Clinics, Stanford, CA; Denise Giarrappa, RN, BSN, OCN®, Stanford Cancer Center, Stanford Hospital and Clinics, Stanford, CA; and Hollice Gautier, RN, BSN, Stanford Cancer Center, Stanford Hospital and Clinics, Stanford, CA

Education prior to chemotherapy treatment is essential to ensure patient safety, positive outcomes and the best experience for patients. Providing effective patient education within a busy clinic, private practice or an infusion treatment area is a challenge. Nurses need to be proactive in creating the best possible learning opportunities that promote patient education and satisfaction prior to chemotherapy. Oncology nurses at our academic medical center developed a first time chemotherapy course to educate and orient patients/families and demystify the experience prior to start of treatment. The class includes what is cancer, cancer treatment modalities, chemotherapy & biotherapy mechanism of action, side effects, managing side effects, what to anticipate and ways to cope during treatment for patients and family members, a focus on stress management and emotional support and a tour and orientation to the treatment area including what to expect on treatment days. After 5 years of offering the course 4-8 times/month, it remained underutilized. Recent patient satisfaction scores reflected insufficient education prior to treatment. A quality improvement project was instituted. Identified barriers to class attendance included: providers unaware of class schedule, ineffective word of mouth system for scheduling patients and long travel distance to attend the course. Utilizing the electronic medical record, a referral order for «chemo class» was created. The order flows to a designated e-mail box. A nurse checks the box daily, calls to schedule the patient for a class and reiterates the value of participation. A pilot program was initiated with a select patient population, building this referral into the actual chemotherapy plan order set. This approach allowed the provider to check a box thus ordering the class during development of the chemotherapy order/plan. Within four months of creating the referral order, class attendance increased from 3-5 to 33 per month. Next steps are to build the chemotherapy class referral order into every chemotherapy plan order set, offer the class via web access, and develop outcomes measures to capture the effectiveness of the education.

1052667

ADVOCACY: USING ONE VOICE TO SPEAK FOR THE NEEDS OF MANY. Mary Vecchio, RN, MSN, APN, OCN®, Community Education and Outreach, Hunterdon Regional Cancer Center, Flemington, NJ

Nurses accept responsibility for patient advocacy. Through words and actions they relay the needs and concerns of patients to others, positioned to make a difference. Nurses have the opportunity to raise the awareness about the needs and concerns of all cancer patients to those who are positioned to enact change, elected legislative officials. The current political climate, on the state and federal level, threatens the limited funding available for programs and research. Oncology nurses can provide justification for the continued support of these efforts. The purpose of this activity is to motivate members of the community, both health care professionals and lay public, to engage in advocacy activities ensuring that cancer care issues remain a priority on local, state, and federal political agendas. The principles of community organization provide the framework for identification of concerns, mobilization of resources, and development of strategies to achieve the desired goal. A key staff member from Hunterdon Regional Cancer Center has been selected as the advocacy chairperson for the Hunterdon County Cancer Coalition (HCCC). This individual has membership in ONStat, and the American Cancer Society

Cancer Action Network (ACS CAN). As chairperson, she has the responsibility of recruiting individuals to assist in “making their voices heard”. She will provide a presentation to members of the local ONS CHIP on the value of joining ONStat. She will educate coalition members, and selected community groups, about ACS CAN and their potential role of participation. Local membership enrollment in the aforementioned national advocacy organizations and the HCCC advocacy committee will be monitored. Through the efforts of these members it is hoped that a productive relationship can be formed with elected representatives on a local, state and federal level. Local members will receive guidance and instruction from the advocacy chairperson to support the development of a productive relationship with elected officials on a local, state and federal level. Oncology nurses are skilled in applying informational content and experience. Political advocacy is not a standard part of many curriculums but essential to today’s health care environment. Providing education locally is the essential starting point to build political change relationships.

1052685

WE GRIEVE TOO: ONE INPATIENT ONCOLOGY UNIT’S STRATEGIES TO RECOGNIZE AND MANAGE COMPASSION FATIGUE. Katrina Fetter, RN, BSN, OCN®, Lancaster General Hospital, Lancaster, PA; and Betsy Collins, RN, MSN, AOCN®, Lancaster General Hospital, Lancaster, PA

Oncology nurses are consistently exposed to death and dying. On this inpatient unit that exposure can be difficult when the patients are so close to the staff that it is like losing a family member. Unfortunately compassion fatigue as caregivers is an issue our unit has struggled with. It is also a struggle to provide the quiet time, space, and materials that may benefit these patients and families. The purpose of this initiative is to provide the interdisciplinary team with a method to combat compassion fatigue. It is also to bring awareness to the patients who are receiving end-of-life care. Interventions to help identify these patients include a dove magnet that is placed on the outside of the door of an end-of-life patient’s room and a bereavement package that the unit has compiled. The dove signifies to all staff to allow quiet and privacy. The package contains things like cds, bibles, journals, a cd player, and a picture frame to help support the patient and family during their stay. Interventions for the staff include a remembrance tree that holds the names and obituaries of recently lost patients. Lastly, for patients that the unit was especially close to there are blank journals that the staff write thoughts and memories in and send to the loved ones of the patient. An evaluation of the interventions was completed via a staff survey in February of 2010. Twenty five surveys were received and all of them were positive responses about all of the interventions. Comments included “a 100% amazing idea”, “we love it”, and “it keeps us informed”. Since the start, staff has also verbalized an improved ability to talk about their thoughts and feelings about patient deaths. There is always exposure to the process of dying on an oncology unit so it is important to find ways to support staff. Further ideas may be needed for support during exceptionally rough times of loss and follow-up will continue. Overall, the staff does feel well supported and a better experience for the patient and families makes for a better experience for the staff.

1052722

YOUR SAFETY IS IN YOUR HANDS: UNIT BASED SAFETY COUNCIL STRIVES TO INCREASE PATIENT PARTICIPATION IN FALLS PREVENTION IN THE INPATIENT ONCOLOGY SETTING. Jennifer Fox, RN, BSN, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; and Claire Carmody, RN, BSN, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY

With the diagnosis of cancer, patients often struggle with sudden declines in functional status and subsequent loss of indepen-

dence. As a result, patients become vulnerable to safety issues, in particular falls, which in turn become a significant safety dilemma in the inpatient oncology setting. A nurse's role is to identify risks, implement interventions, and promote compliance through patient participation. At this comprehensive cancer center, a unit based safety council was developed for nurses to activate these important strategies with objectives including staff education, patient awareness, and development of assessment and evaluation tools. Collected and analyzed data regarding frequency and nature of patient falls resulted in improving our current falls prevention program. Using a Relationship Based Care nursing model, in accordance with Joint Commission National Patient Safety Goals, we sought to increase patient participation in falls prevention through the development of a unit based safety council. Council members conducted staff educational conferences to illustrate actual fall events. These conferences encouraged discussions that fostered new strategies for improved safety with the goal to eradicate unassisted falls as well as focusing on overall prevention strategies. Safety was communicated as a priority and patients came to understand their individualized risk and need for assistance. A post-fall assessment tool was instituted to evaluate the effectiveness of nurse-patient conversations and patients' awareness of individualized risk factors. Staff interest and participation is evident through admission audits and a posted ongoing tally of days without a fall. The council is currently implementing a written safety contract to be signed by each individual patient upon admission. In review, awareness to challenges include respecting patient autonomy while simultaneously fostering understanding and participation with falls precautions. Through discussions and intervention, we continue to engage our patients in maintaining their safety. This clinical council utilizes innovative approaches to manage the safety of acutely ill oncology patients and to provide a model for other institutions attempting to take a fresh look at patient falls in the oncology population.

1052727

INVESTIGATING AND SUPPORTING THE EXPERIENCE OF NURSE GRIEF IN THE AMBULATORY ONCOLOGY SETTING: CONNECTING WITH THE DISCONNECT. Karen Gleason, RN, BSN, OCN®, North Shore LIJ HealthSystem Monter Cancer Center, Lake Success, NY; Kathi Morse, LCSW, ACSW, North Shore LIJ HealthSystem Monter Cancer Center, Lake Success, NY; Robin Brenner, RN, OCN®, North Shore LIJ HealthSystem Monter Cancer Center, Lake Success, NY; and Kathleen Pelc, RN, BSN, OCN®, North Shore LIJ HealthSystem Monter Cancer Center, Lake Success, NY

Monter Cancer Center is a suburban ambulatory center that serves adult oncology patients. The faculty practice and treatment center experience an average of 3,900 patient visits monthly, and employ 180 staff including professional and support staff. There have been 300 patient deaths thus far in 2010 due to disease. The ambulatory setting emphasizes the disconnect staff feels, patients who are often known for years to the staff, die in locations other than the place of medical care. There is inconsistent notification of death of patients, and no formal staff bereavement opportunities. A literature review revealed few studies that report research of staff grief in the ambulatory oncology setting. The literature addressed the professional caregiver experience in settings other than ambulatory, and themes included: 1) need for increased support from supervisors, 2) need for bereavement related education, and 3) obstacles to grief expression of patient loss. Death of patients can result in significant personal stress that may be reflected in behavior changes, and possible burnout. Leadership's project was to assist professional staff in the identification of solutions to address death notification, and to support staff grief. Desired outcomes included the provision of identified bereavement tools, and an environment conducive to expression of grief. A formal survey weighted by a Likert scale was utilized to draw insight

from the ambulatory oncology nurse's grief experience. Analysis resulted in a multidisciplinary interventional approach to support the staff. Interventions included: 1) educational presentations on professional grief led by a social worker 2) development of an "Expressive Bereavement Group"; 3) implementation of a formal patient memorial book, and 4) a journal club meeting dedicated to staff grief. Included pre and post intervention surveys, and informal staff interviews with project participants. This project addressed the impact of patient death on staff, particularly nurses who spend a great deal of time with patients in the ambulatory setting. Resultant interventions based on survey were well received by those who chose to participate in support measures. Staff were encouraged to self govern need identification, and participate in activities available to address grief and bereavement in the work setting.

1052735

ASSESSMENT OF GENETIC PREDISPOSITION TO SECONDARY LYMPHEDEMA AS A POTENTIAL TOOL IN EDUCATION FOR RISK REDUCTION AND INDIVIDUALIZING CANCER TREATMENT: A PILOT STUDY. Jane M. Armer, RN, PhD, FAAN, School of Nursing, University of Missouri, Columbia, MO; and Bob R. Stewart, EdD, School of Nursing, University of Missouri, Columbia, MO

Limited information exists regarding risk factors for developing secondary lymphedema (LE), a chronic and often debilitating condition that may affect 40-60% of breast cancer survivors. Secondary LE presents in a phenotypically-similar way to the less common primary LE, which is not precipitated by an event such as cancer treatment. While studies have discovered associations between primary LE and certain autosomal recessive and autosomal dominant genetic mutations and variations, these and other genetic relationships have yet to be rigorously explored and confirmed in secondary LE. This study is a pilot for a larger-scale genetics study with primary aims to: (1) examine associations among specific candidate genes and human growth factors known to be associated with primary LE in a cohort of breast cancer patients with secondary LE, and (2) seek to identify novel genetic mutations associated with LE risk through Genome Wide Association Study (GWAS) analysis. Existing publicly-accessible previously-GWAS'd data sets lack the rigorously-phenotyped LE data required to elucidate genetic associations with secondary LE following breast cancer treatment, data provided in this proposed study. The study is based on Armer's Biopsychosocial Model of Post-Breast Cancer Lymphedema in which genetic predisposition is hypothesized to be an individual predisposing factor for the development of LE. Pilot funding was obtained for a GWAS-design feasibility study with 192 breast cancer survivors with/without LE (96/96). Genetic material (buccal swabs/saliva), limb volume (perometry/circumferences), and self-reported LE-related symptoms were collected in one lab appointment. The Illumina HumanOmni1-Quad BeadChip microarray was used for GWAS analysis. Ninety-five percent of survivors consented to participate in the genetic pilot. In the first wave of data collection, buccal swabs provided adequate yield for DNA extraction (concentration average 174.94 ng/ul). In the second wave of data collection, saliva is being collected as the DNA source for comparison of quantity and quality of DNA extracted. Pilot data support our ability to obtain samples and conduct GWAS, but a larger sample is needed to achieve sufficient power to identify risk loci. These pilot findings form the basis for a larger multi-site study aimed at examining genetic predisposition to secondary LE, leading to the design and timing of subsequent interventions aimed at reducing LE risk and improving overall survivorship quality of life. Additionally, findings concerning interactions among breast cancer treatments and LE genetic predisposition will have the potential to guide the selection of cancer treatment to minimize these complications when survival outcomes are equivalent across competing treatment approaches.

1052744

MANAGEMENT OF HYPERTENSION DURING TIVOZANIB THERAPY: RESULTS FROM A PHASE 2 RANDOMIZED DISCONTINUATION TRIAL. Brooke Esteves, BSN, RN, AVEO Pharmaceuticals, Inc., Cambridge, MA; A. Strahs, PhD, AVEO Pharmaceuticals, Inc., Cambridge, MA; W. Slichenmyer, MD, ScM, AVEO Pharmaceuticals, Inc., Cambridge, MA; P. Bhargava, MD, AVEO Pharmaceuticals, Inc., Cambridge, MA; E.M. Regan, RN, OCN®, Dana Farber Cancer Institute, Boston, MA; and P.M. Fischer, RN, MSN, OCN®, Memorial Sloan Kettering Cancer Center, New York, NY

Tivozanib is a potent and selective inhibitor of all 3 vascular endothelial growth factor receptor (VEGFR) kinases. Therapies that inhibit the VEGF pathway disrupt tumor angiogenesis, which is critical for tumor growth. Hypertension is an established target-related side effect of VEGFR inhibitors. The objectives of this study were to determine the activity of tivozanib in renal cell carcinoma (RCC) and evaluate its safety and tolerability, including management of observed toxicities. 272 patients with locally advanced or metastatic RCC (any histology) and no prior VEGF-targeted therapy were enrolled in a phase 2 randomized discontinuation trial and received 1.5 mg/day tivozanib (3 weeks on, 1 week off = 1 cycle). Response was evaluated by independent radiology reviewers using standard RECIST criteria. Blood pressure (BP) was measured in the clinic on Days 1 and 15 of the first 4 cycles, and on Day 1 of subsequent cycles. Hypertension (systolic BP >140 mm Hg and/or diastolic BP >90 mm Hg) was managed by study oncologists using a treatment algorithm involving standard anti-hypertensives and/or reduction/interruption of study medication. Tivozanib treatment resulted in a median progression-free survival (PFS) of 11.8 months in all patients and 14.8 months in patients with clear cell histology and prior nephrectomy. Hypertension was the most common treatment-related adverse event (50%); the most common grade ≥ 3 treatment-related adverse events were hypertension (9%), asthenia (2%), diarrhea (1%), and fatigue (1%). Although hypertension was commonly observed, it was readily managed per the study algorithm. Presence of hypertension was associated with significantly longer PFS compared with patients without hypertension (diastolic BP, 17.6 vs 8.3 months, respectively; systolic BP 14.8 vs 8.9 months, respectively; $P = 0.01$ for both). Tivozanib was effective and well tolerated. Because hypertension is a common and manageable side effect of VEGFR inhibitors, patients should be educated before beginning tivozanib treatment. Home BP monitors and a treatment algorithm may be used by physicians and nursing staff for managing hypertension. The efficacy and acceptable tolerability observed with tivozanib monotherapy has led to evaluation of tivozanib in combination with temsirolimus (RCC), FOLFOX6 (colorectal cancer), paclitaxel (breast cancer), everolimus (colorectal cancer), and capecitabine (solid tumors).

1052755

THE IMPACT OF A CAREPARTNER PROGRAM ON TWO INPATIENT ONCOLOGY UNITS. Crista Creedle, RN, BSN, OCN®, UNC Hospitals, Chapel Hill, NC

Oncology nurses often serve as primary educators for patients and their families. Providing standardized education can alleviate the burden felt by the caregiver and improve health outcomes for both the patient and caregiver. Four disease groups were included in this study that represent a significantly longer hospital stay than other cancers: Acute Myelogenous Leukemia (AML), Acute Lymphoblastic Leukemia (ALL), Lymphoma or those undergoing Blood Marrow Transplant (BMT). The complexity of care is significantly higher, necessitating greater caregiver burden following hospitalization. Eligible patients and their caregivers received post-hospitalization care education through an Oncology CarePartner Program addressing the patient's physical and emotional needs. This education included central line care, infection and bleeding precautions, nutritional needs, and ways

to manage fatigue. The impact of the CarePartners program on caregiver burden was evaluated by the Oberst Caregiving Burden Scale (OCBS) and Bakas Caregiving Outcomes Scale (BCOS) on 2 oncology units (medical/oncology (n=17) and blood marrow transplant (n=21) at three times: within 5 days of admission (T1), patient discharge from the hospital (T2), and 30-days post discharge (T3). Guided by the social cognitive theory, we focused on interrelationships between behavior, personal, and environmental factors of the CarePartner and his/her ability to understand and complete the educational skills. Eligible patients admitted to the Oncology service between February-November 2010 were able to participate in the CarePartner Program. Changes in scores from T1-T2, T1-T3, and T2-T3 for both the OCBS and BCOS were evaluated using Wilcoxon Signed Rank tests. Carepartners (n=38) were most often spouses (68%) or mothers (16%), Caucasian (79%), female (74%), full-time employees (47%) or retired (21%), and without other caregiving responsibilities (84%). Median age for carepartners/patients was 57/56, and patients' median length of stay was 28 (medical/oncology) and 22.5 (BMT) days. Significant increases from T1-T2 (median=4, $p=0.0007$) and T1-T3 were seen (median=5.5, $p=0.003$) in the BCOS. No significant changes in OCBS (time or difficulty) were seen. Standardized patient education helped improve caregivers' overall well-being, but failed to impact the time spent in caregiving or difficulty with caregiving tasks. Educational changes to address these specific areas or evaluation by different scales are both worth further investigation.

1052799

DEVELOPMENT AND IMPLEMENTATION OF A MULTI-DISCIPLINARY CARE COORDINATION PROCESS FOR PATIENTS TREATED WITH PROVENGE® (SIPULEUCEL-T).

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Provenge® (sipuleucel-T), approved by the U.S. Food and Drug Administration in April, 2010, is an autologous cellular immunotherapy indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Care coordination required to provide this new therapy is complex and involves multiple disciplines. A well-defined care coordination process and clear policies and procedures are imperative for successful management of patients receiving this novel therapy. The purpose of this project was to develop and implement a standardized care coordination process and clear policies and procedures for handling and administration of Provenge® (sipuleucel-T). Following FDA approval of Provenge® (sipuleucel-T), education sessions were presented by representatives of Dendreon, the manufacturers of Provenge® (sipuleucel-T). These sessions highlighted the complex care coordination that would be required to successfully manage this new therapy. A multidisciplinary task force led by nurses was formed. A care coordination checklist was developed that included all required steps and aspects of care coordination by the oncology clinic nurse. Provenge® (sipuleucel-T) handling and administration policies and procedures were developed for pharmacy staff and infusion room nursing staff. Patient education materials were developed. The first patient infusion of Provenge® (sipuleucel-T) occurred early in June, 2010. Data was collected in July, 2010 quantifying time required by clinic staff for care coordination. Using a continuous quality improvement model, the care coordination checklist and policies and procedures were revised by the multidisciplinary task force over a six month period from July to December, 2010. To date,

more than 70 patients have been screened for possible Provenge® (sipuleucel-T) treatment, 14 patients have been treated, with a total of 38 infusions of Provenge® (sipuleucel-T) completed. In addition to establishing a standardized care coordination process, the work of our multidisciplinary task force streamlined the time required for care coordination, enhanced continuity of care, teamwork, and collaboration between clinic areas. Oncology nurses are in a unique position to establish standards of care for patients receiving new cancer therapies. This nurse-led, multidisciplinary approach to managing patients treated with Provenge® (sipuleucel-T) could be adapted for use by other oncology centers implementing this novel treatment.

1052849

FEASIBILITY PILOT ON MEDICATION ADHERENCE AND KNOWLEDGE IN AMBULATORY PATIENTS WITH GASTROINTESTINAL CANCERS. Robin Sommers, DNP, ANP-BC, AOCNP®, Medical Oncology, Dana Farber Cancer Institute, Boston, MA; Donna Berry, PhD, RN, AOCN®, FAAN, Phyllis F. Cantor Center for Research in Nursing and Patient Care Services, Dana Farber Cancer Institute, Boston, MA; and Kathleen Miller, EdD, ACNP-BC, FAANP, Graduate School of Nursing, University of Massachusetts, Worcester, MA

The increase in approved new oral cancer therapies has introduced new challenges including a shift in responsibility for self-administering and managing side effects from clinicians to patients and families. There is evidence for nursing support of these patients using education and monitoring prior to and during home administration. This evidence-based project evaluated the feasibility of an oncology nurse-led verbal and written education protocol within an ambulatory, gastrointestinal (GI) cancer practice setting to support patients' self-medication adherence and knowledge of oral chemotherapy and side-effects. Structured teaching sessions and monitoring were developed, including a follow-up nursing telephone call within 72 hours and the use of paper drug diaries to document any problems taking the oral agents and subsequent side effects. The Morisky Medication Adherence Scale-8 (MMAS) was adapted to fit the oral chemotherapy scenario and administered as a self-report outcome measure about 4 weeks later, following the first cycle of therapy. MMAS-8 scores can range from 0-8, with 8 indicating highest adherence. Thirty adult GI patients with cancer in the outpatient setting participated. The GI clinic nurses were able to reach 25 patients by telephone within 72 hours of initiation of treatment. A majority of patients (24/30) received both verbal and written education by their medical provider and 23 completed drug diaries correctly. Seventeen participants documented side-effects within the first 72 hours of initiation of treatment, and of those, 8 were unable to discuss how to manage the side-effects on the follow up phone call. At the end of the first cycle of therapy, MMAS-8 scores were high, mean of 7.89 (SD=.55). We demonstrated the feasibility of an educational and monitoring protocol for GI patients taking oral chemotherapy. Daily monitoring was important as side-effects were documented and addressed when patients were unclear how to self-manage the side-effects. The adapted MMAS-8 was a feasible adherence measure. Consistent with other pilot studies, these findings suggest that educational support delivered both in clinic and over the phone combined with patient-reported monitoring was not only feasible, but resulted in highly adherent self-care behavior.

1052874

INCREASING RECRUITMENT OF UNDERREPRESENTED POPULATIONS THROUGH TRIAL SELECTION AND RELATIONSHIP BUILDING. Nicholas Shuman, MSN, RN, Cancer Institute, New York University, New York, NY; Stephanie Lauro, BSN, RN, Cancer Institute, New York University, New

York, NY; and Louise Lynch, RN, Cancer Institute, New York University, New York, NY

An academic cancer institute affiliated with a public hospital provides historically underrepresented populations increased access to cutting-edge treatments through clinical trials (CT). Due to increased complexity of available trials, limited staff, and a historically difficult to reach population, CT accruals at the affiliate site have been low. Increasing affiliate hospital staff buy-in, appropriate trial selection, and development of strategic relationships with key personnel have resulted in increased CT recruitment. Evaluate CT accrual through increased staff buy-in, appropriate trial selection, and relationship building among key personnel at an affiliate hospital site. In August 2009, a clinical trial nurse (CTN) was placed in the affiliate site to identify and enroll CT patients. CTN is used as a resource by staff for all clinical trial activities. Study initiation meetings were conducted with affiliate hospital staff-infusion nurses and pharmacists. Study specific information was reviewed-medication, indication, mechanism of action, and required study procedures. Key personnel, deemed to be influential in CT implementation within the public hospital, were identified. Monthly meetings involving all key personnel were established to discuss upcoming trials, patient population, trial selection and issues relevant to increasing patient accruals. With increased interaction among CTN and affiliate hospital staff, issues related to investigational agent administration have decreased and staff buy-in has increased. Continued guidance and education provided by the CTN, resulted in more investigational agents- including Phase I agents-being administered by the infusion nurses. Protocols for target populations-hepatocellular carcinoma, stage IV lung, and metastatic breast cancer-were given priority in submission and approval. Appropriate trial selection resulted in increased efficiency of trial openings. Monthly meetings with identified key personnel enabled studies related to these target populations to be expedited through the approval process. The ability to build strategic relationships across the institutions has increased the availability of appropriate protocols. This coupled with increased staff buy-in and appropriate trial selection, has resulted in an overall increase in CT accrual of underrepresented populations (60 in 2010 vs. 38 in 2009) while opening less CTs per year (18 in 2009 compared to 10 in 2010).

1052880

A "DRAMATIC" APPROACH TO SCHWARTZ CENTER ROUNDS. Carol Tringali, MS, RN, AOCNS®, Penn State Hershey Medical Center, Hershey, PA

Stress is a recognized aspect of today's fast-paced society that often leads to a decreased ability to convey compassion to those around us. Professional caregivers frequently face difficult emotional and social issues during interactions with patients and families. Self-awareness of the impact of these issues on performance, as well as opportunity for discussion and supportive feedback, is limited by demands of the hectic workday. Schwartz Center Rounds is a program sponsored by the Kenneth B Schwartz Center to support and advance compassionate health care in which caregivers, patients and their families relate to one another in a way that provides hope to the patient, support to caregivers and sustenance to the healing process (www.theschwartzcenter.org). This multidisciplinary forum provides opportunity for caregivers to discuss difficult emotional and social issues that arise in caring for patients. Participants share experiences, thoughts, and feelings on a pre-selected topic through interactive discussion. In this Oncology Nursing Society "Year of Psychosocial Care", it is important to take care of ourselves so we can generously give of ourselves to patients and colleagues. Schwartz Center Rounds provide a safe, comfortable environment for honest discussion about emotions surrounding our efforts to provide quality care in the face of difficult psychosocial patient issues. Staged dramatic readings by The Kienle Center Players-a medical theater group sponsored by the Doctors Kienle Center for Humanistic Medicine at Penn State

Hershey Medical Center and composed of faculty, students, and medical center staff-replaced our usual panelist presentation twice during each of the last two consecutive years of monthly Schwartz Center Rounds. The situations portrayed in the dramatic reading "Cancer Tales" by Nell Dunn, and general audience responses, will be described. The performance of this dramatic reading was enlightening, perceptive, and poignant. This presentation, and discussion that followed, received "Exceptional" scores on evaluations returned from participants. Innovative approaches to presentation of Schwartz Center Rounds content can effectively stir introspection and stimulate beneficial discussion related to patients' perception of how we address, or fail to address, their needs. Understanding how patients and families define empathic care will improve communication between health professionals and patients.

1052916

QUALITY OF LIFE DURING REHABILITATION: RECTAL CANCER PARTNER EXPERIENCES WITH ALTERED BOWEL FUNCTION. Jean Boucher, PhD, RN, ANP, GSN, UMass Worcester, Worcester, MA; Debra Lundquist, MS, RN, NP, GSN, UMass Worcester, Worcester, MA; Bilal Piperdi, MD, Cancer Center, UMass Memorial Medical Center, Worcester, MA; and Janet McDade, MS, RN, NP, Colorectal Surgery, UMass Memorial Medical Center, Worcester, MA

Rectal cancer affects over 153,760 in both men and women in the United States. Newer advances in treatment for rectal cancer patients include neoadjuvant chemoradiotherapy followed by surgery then post surgical adjuvant chemotherapy that improves five-year survival. Current gaps exist for rectal cancer survivors regarding the effects of current treatment practices on long-term altered bowel function and health-related quality of life (HR-QOL) concerns including partners' perspectives both individually and together. The purpose of this study was therefore to: 1) Describe the experiences of adult rectal cancer patients and their partners during rehabilitation from cancer treatment, including long term considerations; and, 2) Examine health-related quality of life (HR-QOL) issues for rectal cancer patients and their partners including well-being and coping during their rehabilitation and in follow-up care. The City of Hope Quality of Life (COH-QOL) framework was used to help guide this study. This framework includes four QOL domains: Physical well-being, psychological well-being, social well-being, and spiritual well-being as used in studies with breast cancer, ostomy patients, family distress, and cancer survivorship. A qualitative design of 20 adult rectal cancer patients, stage II/III, and their partners have been recruited to participate in face to face semi-structured interviews. Qualitative descriptive design allowed for use of purposive with maximum variation in sampling techniques to include broad information on the rectal cancer survivor and partners' perspectives on altered bowel function experiences and HRQOL concerns. Qualitative content analysis revealed emerging common themes with verification through trustworthiness of data to manage data analysis to inductively derive themes. Analysis of similarities versus differences for patients, partners, gender, and other socio demographics was also included. Themes include unknown expectations regarding chronic bowel function, symptom unpredictability, anxiety, and rehabilitation for lifestyle alterations including role, social isolation, intimacy, work and financial concerns. Results indicate the need for long-term follow-up, education and management to help patients and their partners adapt to their new «normalcy» including support during this transition and as survivors. Targeted interventions are needed to address behavioral needs and dyadic adjustment through coping strategies and ongoing clinical monitoring.

1052926

WHAT ONCOLOGY NURSES MAY NOT KNOW ABOUT CANCER-RELATED LYMPHEDEMA. Jane M. Armer, RN, PhD, FAAN,

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It is estimated that 22%-66% of breast cancer survivors are at risk of developing lymphedema (LE), a failure of the lymphatic system due to treatment procedures resulting in distressing and debilitating limb swelling. Further, a recent systematic review reports LE occurrence averages 15% among non-breast cancer patients; survivors of cancers such as melanoma (30% in lower extremity) and genitourinary (13%) cancers develop LE as well. Chronic in nature, symptom management by trained LE therapists is critical to improving quality of life during cancer survivorship. However, precise information regarding therapists' practices and management is not well understood. The goal of this research was to collect information about LE treatment and management in the US as reported by LE therapists. Orem's self-care deficit nursing theory provides the study framework. The findings from this study will be used to assist nurses in developing specific approaches for support and education about LE risk-reduction and management among cancer survivors. An online survey was developed by the American Lymphedema Framework Project (ALFP) executive and research committees for administration in November 2009. Invitations to complete the online survey were sent to existing databases of LE therapists, LE educators, and industry members for further dissemination. Descriptive statistics were conducted. The preliminary analysis included data submitted by 415 therapists from 46 states. The practice settings included hospital-based outpatient clinic (65%), private practice (26%), and hospital-based inpatient service (13%). Most patients had secondary LE (78%); 22% had primary LE. Of those treated for secondary LE, 65% were oncology patients, and the balance had LE related to primary causes, trauma, or obesity-related problems. Most therapists provided treatment of the upper extremities (59%), followed by lower extremities (30%), trunk (16%), head and neck (6%), and genitals (4%). Nearly all therapists (97%) offered comprehensive decongestive therapy (CDT) for LE treatment. Other treatment modalities included skin care (80%), risk reduction education (85%), exercise/movement (85%), and soft tissue mobilization (68%). These preliminary findings provide evidence that oncology patients with LE constitute a majority of those seen for treatment by LE therapists. Patients reportedly receive treatment for this chronic condition from a trained group of therapists in a variety of practice settings which include treatment for oncology-related LE, as well as other lymphatic system disorders. Data suggest that the bundled intervention of CDT, the standard in the field, is individualized for patients based on need. These findings provide guidance for oncology nurses providing support and education for survivors with and at risk of LE.

1052950

USING AN INNOVATIVE APPROACH TO DEFINE A STANDARD FOR RESPONDING TO MEDICAL EMERGENCIES ACROSS HOSPITAL-AFFILIATED OUTPATIENT FACILITIES. Rori Salvaggio, MS, RN, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; Chasity Walters, MSN, RN, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; and Maryellen O'Sullivan, MA, RN, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY

Medical practice in the United States continues to shift from inpatient to outpatient facilities. As both the volume and acuity of

patients seen in the ambulatory care setting continues to increase, facilities must be prepared to respond to medical emergencies in a consistent and routine manner. This NCI-designated comprehensive cancer center is a 470 bed tertiary care facility. A significant portion of its outpatient services are provided in freestanding facilities across geographically distant locations. Patient care services vary by site and include screening, diagnostic radiology and oncologic care and treatment. When the need for policy and procedure changes regarding the management of medical emergencies was identified at one facility, it became apparent that a standardized approach across sites was advantageous. A multidisciplinary committee was then formed to define a standard for responding to medical emergencies across all of the freestanding ambulatory care facilities. The rarity of true medical emergencies precluded use of traditional retrospective approaches to quality improvement. The committee therefore used a variation of the healthcare failure mode and effects analysis (HFMEA) developed by the VA National Center for Patient Safety to evaluate each facility. The HFMEA process included defining the type of services provided at each site, listing all potential medical emergencies associated with these services and, based on their potential effect, determining a hazard score. Also included was an analysis of clinical personnel, equipment and medical emergency data describing number of events, type and severity. A standard for responding to medical emergencies across facilities was developed and is pending Medical Board approval. Upon approval, high-fidelity simulation exercises will be conducted in situ to ensure staff competence. Monitoring of emergency event data is ongoing. The Joint Commission requires that an equivalent level of care be provided across all areas of an organization. Hospital-affiliated ambulatory care facilities must have a system for prompt and efficient response to medical emergencies. HFMEA provides a proactive strategy for assessing risk and guiding the design of a safer healthcare system.

1052980

COPING TO ENHANCE CARING: A HEALING WORKSHOP FOR NURSES. Patricia McTague, MSN, RN, FNP-BC, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; Maureen Laffey, BSN, RN, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; Melody Rosamilia, BSN, RN, OCN®, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; and Marcia Katz, BSN, RN, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY

A medical oncology service including Melanoma and Sarcoma patients was added to our existing high acuity medical, surgical oncology unit. Caring for this patient population created palpable stress amongst the nursing staff as many of these patients often are young and terminal. The heightened emotional intensity from interacting with these patients created increased compassion fatigue amongst nursing caregivers. Nursing leadership identified a need to address compassion fatigue and sought to develop a program to enhance self care nurturance and promote effective coping strategies. Based on the Relationship-Based Care nursing model this program was designed to sustain caring relationships and devise lasting solutions for deepening and healing relationships with self, colleagues and patients and families. A restorative workshop focusing on self care and strategies to promote work life balance was offered to nursing staff. Representatives from the multidisciplinary team led interactive sessions discussing challenging patient interactions, ethical dilemmas and effective coping strategies. Therapeutic role playing exercises to foster effective communication surrounding end of life discussions were facilitated by experts from palliative care. Patients and family members previously treated on our unit shared testimonials about their hospital experience. These stories poignantly highlighted the value of the caring moment in developing relationships. Integrative medicine therapies including music, massage and movement activities enhanced the experience while offering outlets for

promoting wellness. Self reflection and spiritual renewal were appreciated during an interfaith blessing of the hands ceremony to close the day. Prior to our program nurses reported distress when caring for patients with terminal diagnoses. This workshop provided staff with a skill set to reduce compassion fatigue and achieve optimal health and wellness. Post program evaluations demonstrated overwhelmingly positive responses from all who attended. Participants and presenters were equally inspired and rejuvenated from this initiative. There is inherent compassion fatigue in caring for terminal oncology patients. Promoting self care strategies nurtures oncology nurses and allows them to thrive in their clinical practice area. Due to its success, elements of this program have been added into ongoing Relationship Based Care workshops and nursing orientation curriculum.

1052995

“GROWING” YOUR NUMBER OF ONCOLOGY CERTIFIED NURSES: A MULTISTAGED APPROACH. Karen Roesser, RN, MS, AOCN®, Oncology, CJW Medical Center, Richmond, VA

Attaining certification in oncology nursing (OCN®) indicates that a nurse has achieved a level of knowledge and expertise to be able to competently care for patients with a diagnosis of cancer. Given the choice of having a certified nurse vs. a non-certified nurse who provides care, it would seem to be a non-issue that any patient, physician, or fellow nurse would prefer the oncology certified nurse who possesses an increased knowledge base thereby lending to better patient care-related decisions. All institutions strive to improve the quality of care which is provided to their patients. This describes the efforts of a comprehensive community cancer hospital to increase the number of nurses certified in oncology nursing and to improve the level of care to their patients. A multifaceted program aimed at several points of entry provided a focus for these efforts. This included: 1)Planting the seed regarding certification when a nurse is interviewed for a job; 2) Focusing on the potential accomplishments expected; 3)Showing a simple, but specific plan for studying/achieving a passing score; 4)Inspiring a nurse to want to achieve a higher level; 5)Continuing to accentuate the positives you see and what you know someone is capable of; 6)Making discussion of certification part of each evaluation and; 7)Recognizing those nurses who have achieved certification. This recognition includes acknowledging each nurse through a formal oncology recognition ceremony and each nurse is shown with his/her accomplishments on a revolving power point presentation on a television monitor in our cancer hospital lobby. In the past eight years, we have enhanced our percentage of certified nurses from 26% to 54% of our cancer hospital. In addition, our hospital has been chosen to be the provider of choice for the oncologists who now only admit patients to our institution. Growing our numbers of oncology certified nurses has resulted in a win-win situation for our patients and our physicians as well as a great sense of achievement and pride for our certified nurses. In addition, our annual recognition program has become such a positive event that all of the nurses want to attend and be recognized.

1053047

“NEEDS ASSESSMENT”: ITS ROLE IN THE DEVELOPMENT AND IMPLEMENTATION OF A SUCCESSFUL ONCOLOGY STAFF EDUCATION PROGRAM. Nikki Brooksbank, BSN, RN, OCN®, Inpatient Oncology, Duke University Health System, Durham, NC; Giselle Boward, BSN, RN, OCN®, Inpatient Oncology, Duke University Health System, Durham, NC; Deborah Allen, MSN, RN, CNS, FNP-BC, AOCNP®, Inpatient Oncology, Duke University Health System, Durham, NC; and Katrina Green, MSN, RN, CNE, Inpatient Oncology, Duke University Health System, Durham, NC

Staff education to assure safe practices is the goal for most programs. However, in a large academic medical center, two inpatient

adult oncology units had unique needs for a very experienced staff with fewer novice nurses. Thus finding methods to meet the varied needs of these staff would benefit staff mentorship, advance practice, and improve patient care. The aim was to assess and evaluate the varied needs of the staff, prioritize educational needs, and implement a comprehensive educational program through multiple formats. The inpatient clinical nurse specialist (CNS) and staff representing varied experience levels created a Needs Assessment web-based tool permitting multiple answers and write-in additions. The survey was administered as part of annual competencies to facilitate participation. Survey analyses were performed with filters applied for variances in age, years of experience, clinical ladder advances, and oncology certification. A staff education committee involving the CNS, unit-based educators, and cancer center oncology clinical nurse educator set unit-based priorities from these results. Formats for educational delivery were decided and staff nurses known to be interested in educational projects were approached for assistance or clinical ladder project development. All programs were evaluated for content and staff satisfaction. The Needs Assessment covered 7 targeted categories with an average of 7 subtopics; staff evaluated their comfort with the topic and their desire to receive basic or advanced education within each area. Both units had 100% staff completion of the survey. Five primary areas were targeted for each unit; four of these areas overlapped for both units. Through 20 educational offerings over the course of one year, all targeted areas were addressed. On average, 75% of staff participated. In addition, 13 secondary areas had educational offerings for a total of 27 additional events. Evaluations have been positive with staff enjoying the educational offerings and implementing appropriate evidence-based practices into daily nursing care activities. Development of the Needs Assessment tool aided in assessment, evaluation, and prioritization of educational programs for two inpatient adult oncology units. Staff have increased knowledge, advanced nursing practice, and improved patient care through participation in educational events that were prioritized by their needs.

1053065

DELINEATION OF HEMATOPOEITIC CELL TRANSPLANT (HCT) NURSE COORDINATOR ROLE AND IMPROVEMENT OF NURSE COORDINATOR PRACTICAL ORIENTATION PROCESS IN THE HCT CLINICAL PROGRAM: DEVELOPMENT OF SKILLS COMPETENCE INVENTORY. Jody Reyes, RN, OCN®, Hem/HCT and Medical Oncology, City of Hope, Duarte, CA; Kathy Patane, RN, Hem/HCT and Medical Oncology, City of Hope, Duarte, CA; Susan Paskar, RN, Hem/HCT and Medical Oncology, City of Hope, Duarte, CA; Shirley Johnson, RN, Hem/HCT and Medical Oncology, City of Hope, Duarte, CA; and Jody Seerup, RN, Hem/HCT and Medical Oncology, City of Hope, Duarte, CA

The role of the HCT Nurse Coordinator is a developing role in the field of nursing. There are select cancer centers that perform HCT. The role of the HCT nurse coordinator is unique, complex and highly specialized, organizing all aspects of care provided to patients prior to transplant. The nurse coordinator provides patient education, coordinates diagnostic testing, clinical trial participation and follow-up care in collaboration with a multidisciplinary team. City of Hope is recognized in the field of hematopoietic cell transplantation (HCT) as one of the largest and most successful bone marrow and stem cell transplant centers. The increased number of patients, reaching the milestone of 10,000 transplants performed, and the complexity of HCT regimen warranted re-evaluation of the HCT nurse coordinator orientation and to develop this role in order to provide the best pre-transplant care and coordination. To define the HCT Nurse Coordinator Role and develop an HCT Nurse Coordinator specific orientation. Nursing administration, nurse coordinators, preceptor, professional practice leaders and a nursing consultant evaluated the current

orientation process in HCT program. We defined HCT nurse coordinator, developed a role specific detailed skills inventory list and modified existing competence evaluation form and selected experienced coordinator as preceptor to a new coordinator. As a result of the pilot, a new orientation process was adopted. Development of a clinical orientation inventory form provides information on an individual's progress and a timeline for completion of orientation. The orientation inventory documents achievements and accomplishments required to practice independently and the ability to make professional decisions. HCT is a rapidly-changing field, with exciting new discoveries being made. Nursing is an integral member of the multidisciplinary team who cares for the HCT patient. The nurse coordinator is knowledgeable to manage early complications, provide education & support to the patient and family. The nurse coordinator role will need to continue to evolve as the field of HCT itself develops, but a practical orientation to the HCT program for the nurse coordinator provides a solid foundation to their new role.

1053071

JAPANESE-US CONNECTION: NURSES' ROLE IN MULTIDISCIPLINARY ONCOLOGY TEAM INITIATIVE. Joyce Neumann, RN, MS, AOCN®, MD Anderson Cancer Center, Houston, TX; Nicholas Szewczyk, RN, MSN, NP-C, MD Anderson Cancer Center, Houston, TX; Tomoko Izawa, RN, CNS, MD Anderson Cancer Center, Houston, TX; Hiroko Komatsu, RN, PhD, School of Nursing, Keio University, Tokyo, Japan; and Naoto Ueno, MD, PhD, MD Anderson Cancer Center, Houston, TX

Multidisciplinary oncology care has been practiced and a part of healthcare in the US for many decades while Japan has maintained a time honored more paternalistic style of leadership and cancer care. Even the word multidisciplinary is not easily translated to Japanese. To provide a forum for an exchange of information between oncology care teams in US and Japan and an opportunity for Japanese physicians, nurses, and pharmacists to experience a multidisciplinary approaches to cancer treatment. Ten years ago a major educational initiative was started by a Japanese-American physician and a team of nurses, physicians and pharmacists from a major US cancer center. This has evolved into two major transpacific programs. The Japanese Team Oncology Program (J-TOP), a annual 3 day symposium for oncology physicians, nurses and pharmacist from all parts of Japan, is taught by US and Japanese mentors. The focus is communication, leadership, expanded role, and evidenced based practice. The Japanese Medical Exchange (JME) is program at the US cancer center aimed at further development of leadership and communication to promote multidisciplinary care in Japan. Two nurses, physicians and pharmacists are selected from the J-TOP program to participate in this 5 week program. More than 140 Japanese oncology nurses (420 health care professionals) have participated in the J-TOP and over 15 have come to the US to participate in JME. Multidisciplinary care has become a common practice in Japan. Japanese legislators have passed the Cancer Act which includes professional funding for promoting multidisciplinary cancer care in Japan. Nurses are looking at expanded roles including nurse practitioner. Nursing has been integral in the development of these programs. Nurse members have consistently served as mentors, on the executive committee of the program, and have been a resource for further delineation of expanded nursing roles in Japan.

1053083

A NEW LOOK AT THE IMPORTANCE OF PLANS OF CARE. Giselle Boward, RN, BSN, OCN®, Inpatient Oncology Nursing, Duke University Health System, Durham, NC; Michelle Kasprzak, RN, BSN, OCN®, Inpatient Oncology Nursing, Duke University Health System, Durham, NC; Lindsey Alexander, RN, BSN, OCN®, Inpatient Oncology Nursing, Duke University Health System, Durham, NC; Deborah Allen, RN, MSN,

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It is essential to provide a framework for documenting evidenced-based nursing-sensitive patient outcomes. On an adult medical oncology inpatient unit in a large academic medical center existing care plans contained outdated practices, overlapped foci, and created nursing confusion regarding prioritization and care plan adherence. Thus, there was an opportunity for our unit-based CPC to use evidence-based practices for streamlining and updating relevant oncology care plans. Our unit-based CPC includes staff nurses, nurse manager, and clinical nurse specialist. The goal was to develop evidenced-based care plans with nursing-sensitive outcomes. An additional aim was to decrease the number and the overlap of care plans. We surveyed all adult inpatient nursing units to examine care plans currently in use; 45 different care plans were identified throughout the facility. We systematically reviewed all care plans for redundancy, evidence-based interventions, nursing appropriate interventions, and measurable outcomes. This process was guided by current evidenced-based resources from ONS and NANDA to update interventions and outcomes. In keeping with The Joint Commission recommendations, the care plan templates were updated, increasing the ability of the nurse to individualize the care plan. These changes were approved by unit-based leadership and the hospital's Oncology CPC. Up to 40 care plans were utilized pre-intervention. Through this evidence-based process, this has been streamlined for oncology to 14. The average number of care plans implemented per patient prior to intervention was 3.5; 35% of patients had at least two overlapping care plans. Documentation adherence to care plans pre-intervention was approaching 50%. Preliminary analyses at one-month post-intervention indicate that care plan use per patient has decreased to 3 with improving documentation adherence, currently greater than 70%. Analyses remain ongoing for care plan utilization, documentation adherence, and resolution; these will be available at time of presentation. By using evidenced-based nursing-sensitive patient outcomes to update and streamline existing care plans, we have successfully eliminated redundancy and outdated practices, diminished average patient care plan numbers, improved care plan documentation adherence, and nursing satisfaction with a quick easy to use format.

1053091

SICKLE CELL PAIN MANAGEMENT: A SURVEY OF CLINICIANS' PERCEIVED BARRIERS, KNOWLEDGE AND SATISFACTION. Patricia Palmer, RN, MS, AOCNS®, Patient Care Administration, University of California, Davis, Sacramento, CA; Helen Rice, RN, MSN, OCN®, UC Davis Cancer Center, UC Davis Health System, Sacramento, CA; Nicole Mahr, RN, BSN, OCN®, Patient Care Administration, University of California, Davis, Sacramento, CA; Marcie Crandall, RN, PhD, Patient Care Administration, University of California, Davis, Sacramento, CA; and Theodore Wun, MD, Patient Care Administration, University of California, Davis, Sacramento, CA

Sickle Cell Disease (SCD) is an inherited blood disorder highly variable in clinical manifestations. The most common complication requiring medical attention is the painful episode. Management often falls to oncology clinicians and can be difficult due to lack of objective signs, mistrust, and misinformation regarding the nature of SCD. The aim of this descriptive survey research was to explore clinicians' perceptions regarding barriers, beliefs and satisfaction with the care of adult SCD patients. The ONS oncology focused research agenda doesn't directly recognize the challenges faced by oncology clinicians caring for chronic hematologic disorders. Understanding clinicians' perceptions provides an intervention framework to improve both patient outcomes and clinician satisfaction. One-hundred fifty-one clinicians from hematology/oncology, internal and emergency medicine were recruited

to participate via the web-based Survey Monkey. Expert nurses and physicians developed a survey based on relevant research. The survey included demographics and questions exploring clinician's perceptions of barriers to pain management, knowledge and satisfaction with caring for SCD patients. Forty-three Likert scale, multiple choice and open ended questions were used. Data analysis utilized descriptive statistics and thematic analysis. Caucasian (64.3%) nurses (77.4%) with either an emergency room (31.5%) or inpatient oncology (33.1%) background comprised the majority of respondents. Participants' primary goal in treating SCD was pain relief (80.2%). They believed the patient was the most accurate judge of their pain (92.1%), yet disbelief of patient reports of pain was cited as a barrier (69.3%). Other barriers identified were lack of time/resources (80%), drug seeking behavior (78.1%), potential for addiction (69.3%) and inadequate knowledge (60.6%). Four themes emerged from the narrative responses; clinician dissatisfaction, need for education, consistent approaches and appropriate resource utilization. This survey laid the foundation for an educational intervention to improve clinician satisfaction when caring for patients with SCD. Standardized order sets were developed. A repeat survey will be done six months after the education and order set implementation. Results from this survey validates findings in the literature that misinformed beliefs are barriers to effectiveness and satisfaction in the care of patients with SCD and highlights the dilemmas that oncology clinicians often face when caring for them.

1053108

NURSING INTERVENTIONS TO CONTROL A NOROVIRUS OUTBREAK DURING AN EXTERNAL DISASTER ON AN INPATIENT BONE MARROW TRANSPLANT UNIT. Nicole Wahlhaupt, RN, BSN, University of Maryland Medical Center, Baltimore, MD; and Amanda Choflet, RN, BSN, OCN®, University of Maryland Medical Center, Baltimore, MD

Disaster preparedness and infection control are two vital topics in healthcare management. Successful containment of an infectious disease outbreak, especially during a disaster, has been extremely challenging for healthcare institutions in the past. Norovirus, a highly contagious virus known for causing acute gastroenteritis, infected numerous health care workers and patients on the Bone Marrow Transplant Unit during an external disaster (blizzard). The goal of this project was to control the Norovirus outbreak on the inpatient BMT unit. At the onset of the outbreak, a multidisciplinary approach was utilized, involving Nursing, Infection Control, Infectious Disease, Environmental Services, Nutrition Services, Risk Management, and the hospital's internal Disaster Control team. The team instituted strict infection-control procedures, including surveillance measures for all patients housed on the unit, strict isolation techniques, restriction of patient flow through the unit, and modifications to the care environment. With the aid of Infection Control and through the strict adherence to identified nursing interventions, the outbreak was well controlled, even in the midst of a blizzard that prevented staff and patients from leaving the hospital environment. Through a collaborative effort, a model for intervention was developed and successfully applied. This model can be applied to similar situations if they arise and should be made available to other institutions faced with infection control challenges and for those who are involved in disaster management preparation. Due to the fact that Norovirus infection mimics several symptoms of the normal stem cell transplant course, differentiating between an acute infectious process and expected symptoms was difficult. Also, testing for Norovirus was done off-site, with an average turn-around time of seven days. All patients on the nursing unit were isolated until surveillance cultures were returned negative. Any patient with a new onset of diarrhea was also pan-cultured and placed on presumptive isolation. Given the challenges to containment presented in this case, successful control of the outbreak was a testament to the power of collaboration.

1053142

“WHEN THE CHEMOTHERAPY NURSE LEAVES”: USING PROCESS IMPROVEMENT TO IMPLEMENT AN EDUCATIONAL PROGRAM TO REGISTERED NURSES ON NON-ONCOLOGY UNITS. Jamilah Purvis, RN, BSN, OCN®, Inpatient Oncology, Duke University Health System, Durham, NC; and Nikki Brooksbank, RN, BSN, OCN®, Inpatient Oncology, Duke University Health System, Durham, NC

In our large academic medical center, adult inpatient chemotherapy is administered by chemotherapy-competent (CC) nurses (RNs) working on oncology-based units. However, oncology patients may be admitted to a non-oncology unit for management of other health-related issues and require chemotherapy. In addition, chemotherapy agents used for non-oncology purposes also require CC-RN administration per policy. As previously reported, a process to streamline chemotherapy administration on non-oncology units was successfully implemented and educational staff in-services were provided to targeted unit staff. Subsequent follow-up identified the need for additional staff education on patient monitoring, side effect management after initiation of the chemotherapy infusion, and safe-handling of chemotherapeutic agents. A process improvement plan was developed to address these needs. The purpose was to improve patient care through prompt side effect recognition and management for patients receiving chemotherapy on non-oncology units and promote safe drug handling of non-oncology RNs. Chemotherapy administration and CC-RN utilization data for non-oncology units were reviewed to identify which units may benefit from implementation of an educational intervention based on their commonly ordered agents. Using ONS guidelines, evidence-based chemotherapy-specific information sheets describing chemotherapy indications, monitoring parameters, side effect identification, and management of adverse reactions were developed. Staff in-services were provided to the identified non-oncology units over a three-month duration covering multiple shifts. In-services included a review of the chemotherapy process, safe handling of chemotherapy, and education on agents they typically encounter emphasizing the newly developed chemotherapy information sheets. Data collection is ongoing with analysis expected to be completed prior to presentation. Preliminary analyses indicate staff satisfaction and utilization of the chemotherapy-specific information sheets. Staff report increased knowledge and perceive improvements in patient monitoring, side effect identification and management, and patient satisfaction of nursing care. Process development requires monitoring to see potential opportunities for continuous improvement. Through process improvement, non-oncology staff education targeting specific agents has improved nursing knowledge, patient care, and staff and patient satisfaction.

1053146

ALL TOGETHER NOW: A MULTIDISCIPLINARY APPROACH TO BREAST CANCER CARE. Ann Brinkerhoff, RN, BSN, Huntsman Cancer Institute, Salt Lake City, UT; Vicki Rosser, RN, OCN®, CBCN®, Huntsman Cancer Institute, Salt Lake City, UT; Leslie Roberts-Frieman, RN, BSN, MBA, Huntsman Cancer Institute, Salt Lake City, UT; and Marsha Mills, RN, BSN, Huntsman Cancer Institute, Salt Lake City, UT

The ability to coordinate complicated medical care, patient education, multiple provider appointments, mental health and pharmaceutical issues for cancer patients in an outpatient setting can be optimized by a multidisciplinary approach to patient care. Breast cancer patients move readily between surgical, medical, radiological and radiation services. Cancer patients receive better care when their multiple providers are working together to provide services. Patients receive better care when nursing support is available at all levels. Prior to our Breast Team integration there was a hit and miss approach to nursing care, patient education,

social work services and patient care coordination. Pharmaceutical support came from practitioners on the other side of the building. Patient concern calls were handled by a variety of medical and non-medical personnel. The goal of this project was to improve patient care across the cancer care spectrum for breast cancer patients. Interventions included developing a nurse practice model that included full nursing support for all breast team providers and patients; integrating patient education materials into a consistent teaching regimen; active nursing involvement in multidisciplinary treatment planning conferences; increased Registered Nurse and Nurse Practitioner FTE; full integration of pharmacy and social work support; relocation of medical oncology, surgical oncology, and plastic surgery services to a common work space. Evaluation of the success of this project was based on positive improvement in patient and employee satisfaction scores and employee turnover rates. The breast cancer multidisciplinary team integration has resulted in increased input from nursing staff in patient care; increased ability to solve multi provider patient problems and coordinate care; reinforced patient education and the ability to monitor patients as they move back and forth between surgical, oncologic and radiation treatments. Nursing care was the driving force of this project. Education was also a key factor in patient satisfaction and optimal care. Patient education has improved significantly with the development of this model. We have found that physical proximity was essential to the success of team building and to facilitate communication and continuity.

1053185

INNOVATIVE IN-SERVICE EDUCATION PLAN FOR AN INPATIENT ONCOLOGY/BONE MARROW TRANSPLANT UNIT. Mary Tegen, RN, BSN, OCN®, Oncology/Bone Marrow Transplant, University of California Davis, Sacramento, CA; Lauri Brunton, RN, OCN®, Oncology/Bone Marrow Transplant, University of California Davis, Sacramento, CA; Barbara Hedrick, RN, Oncology/Bone Marrow Transplant, University of California Davis, Sacramento, CA; Wilson Yen, RN, BSN, Oncology/Bone Marrow Transplant, University of California Davis, Sacramento, CA; and Patricia Palmer, RN, MS, AOCNS®, Oncology/Bone Marrow Transplant, University of California Davis, Sacramento, CA

Scheduling in-services in the middle of a shift created obstacles. This resulted in lower attendance, distracted participants and poor retention of the material presented. To develop a plan that would enable RNs to attend a 30 minute in-service in an environment that would foster learning. The Clinical Resource Nurses met and developed a list of topics to present. We scheduled 2 dates per month; one for each shift. The in-service took place at the end of a shift for the off going staff, where there was a 30 minute overlap of shifts. Flyers were posted and emails were sent, notifying both shifts of the upcoming in-services. The Charge RN reminded the off going shift to complete their tasks in preparation for the shift change. The off going staff prepared their written patient reports and the patient care was up to date. To ensure patient safety, the oncoming shift took over patient care while the off going shift attended the in-service. Our initial format included 20 minutes of theory presented by the Clinical Nurse Specialist and 10 minutes of bedside implementation by our clinical resource nurses. After the in-service was presented for the month, it was compiled into an email and sent to all staff. Subjects presented included Chemotherapy Infusion Reactions, Tumor Lysis Syndrome, Sepsis, Neutropenic Fever, High Dose Methotrexate and Patient's Perceptions of Nurse's Knowledge About Cancer and Its Treatment. Attendance improved with this plan, but staff often arrived 5-7 minutes late, so we adjusted the time frame to 20 minutes; 15 minutes of theory and 5 minutes of bedside care. This greatly improved our attendance. Experiences were shared relating to the topics discussed. RNs are asking more questions and are better prepared to care for our patient population with the skills

they have acquired. The post shift in-services have allowed us to provide important clinical information to our staff in a concise and compact delivery with nearly 100% participation. An increase in communication between the novice RN and expert RN staff has been a positive outcome from these in-services.

1053209

SKIN CARE PROTOCOL AND ALGORITHM FOR ONCOLOGY PATIENTS UNDERGOING RADIATION THERAPY. Carla Grieshop, MS, RN, Radiation Therapy, The Ohio State University, Columbus, OH; and Kelli Bergstrom, RN, BSN, CWOCN, Radiation therapy, The Ohio State University, Columbus, OH

Skin reactions are common side effects of cancer radiation treatment. Radiation damages and destroys the basal cell layer of the skin, results in decreased cell proliferation and maturation, and leads to weakened skin integrity. It is an adverse effect that can occur to skin exposed to radiation, particularly where skin is thin and smooth. The severity of reaction varies greatly among individuals, depending on pre-existing health conditions, lifestyle choices, age, nutritional status, type and total dose of radiation, and adjunctive chemotherapy. Reactions usually occur 1-4 weeks after start of treatment and can persist following treatment completion. The severity of skin reactions can range from no reaction to moist, painful ulcerations, and even necrosis. Chronic skin changes can persist for a lifetime with a negative effect on cancer survivorship. The skin care protocol and algorithm were written to provide guidelines in the management of skin reactions secondary to radiation therapy, and throughout the cancer trajectory. This algorithm will allow for future study of (1) nurse-directed patient outcomes and (2) prevention of severe skin-related changes secondary to radiation therapy. Interventions and product recommendations were based on the evidence, best practice, ONS Classification System for Radiated Skin, and enterostomal therapy nursing specialty knowledge of the physiologic processes related to moist wound healing. The aims of the skin care protocol and algorithm included promotion of skin integrity, provision of comfort, maintenance of cleanliness, reduction of pain, protection from trauma, prevention of infection, and supportive care in wound healing. Access to products via internet vendors was considered to allow for general use of the recommendations in all geographic settings. The enterostomal therapists have instituted the algorithm in the treatment of radiation-induced skin changes with improved patient outcomes, ease of treatment decision-making options, and provision of skin products in the institution's boutique. Full institutional adoption of the protocol and algorithm are in process. Radiation therapy is a common treatment modality for the local control of multiple cancers, and a palliative intervention for cancer-related symptoms. A comprehensive guide to the care of radiated skin is not found in the literature. The implementation of the radiation skin care protocol and algorithm will allow for evidence-based care and provide evidence for research studies related to outcome measures. A potential improvement in improved quality of life for oncology patients receiving radiation therapy may occur by decreasing irritation, discomfort, pain, burning, or itching at the radiation site(s), which can negatively affect activities of daily living and lead to possible treatment interruptions.

1053248

IMPACT OF BODY MASS INDEX AND WEIGHT GAIN ON LYMPHEDEMA RISK IN WOMEN WITH BREAST CANCER.

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Hospital, Boston, MA; Alphonse Taghian, MD, PhD, Cancer Center, Massachusetts General Hospital, Boston, MA; Bob R. Stewart, PhD, School of Nursing, University of Missouri, Columbia, MO; and Jane M. Armer, PhD, RN, School of Nursing, University of Missouri, Columbia, MO

Secondary lymphedema (LE) is a complication of breast cancer treatment that significantly impacts the quality of life of breast cancer survivors. The incidence is widely variable and can occur any time after treatment. Several studies have suggested that body mass index (BMI) and weight gain may play a role in LE risk. Given emerging data on the role of weight management in reducing breast cancer recurrence, there is a growing need to explore interventions related to lifestyle modification that may reduce both morbidity and mortality from breast cancer. The purpose of this study is to evaluate the impact of BMI on the incidence of LE in a cohort of patients. The research question is 'Do women with high BMI have a higher probability of developing LE than women with normal BMI?' The influence of BMI and weight gain on LE risk is not well understood. As part of a screening trial for early LE, data was collected to evaluate natural history, risk factors, arm functionality and quality of life. The current analysis represents an interim analysis of the relationship of BMI to risk of lymphedema, controlling for influence of other treatment related factors, such as axillary node sampling, radiation and medical therapies. Data were available for 399 subjects from a large urban comprehensive cancer center, during the period of 2005-2009 with at least 12 months of follow-up measures. Descriptive, univariate and multivariate analyses are reported. BMI \geq 25 was defined as overweight. Threshold for lymphedema was set at RVC (relative volume change) of 5%, measured by perometry. By univariate analysis, both BMI $>$ 25 at baseline and ALND dissection were significantly correlated with incidence of LE (OR=1.89 and 2.90 respectively); additional clinical factors were not significantly correlated with LE risk by univariate analysis. Multivariate analysis was completed by logistical regression. After controlling for ALND and radiation to axillary lymph nodes, BMI $>$ 25 increased the OR for LE incidence by 2.09 ($p < 0.001$ for regression model). Weight control may have significant implications for risk reduction and management of LE in breast cancer survivors.

1053269

EVALUATION OF BCR-ABL MONITORING IN CHRONIC MYELOID LEUKEMIA (CML) IN CLINICAL PRACTICE. Edie Romvari, Bone Marrow Transplant and Leukemia Service, Washington University, Saint Louis, MO; Vamsi Bollu, Health Economics and Outcomes Research, Novartis Pharmaceuticals Corporation, East Hanover, NJ; Robert Morlock, i3 Innovus, Eden Prairie, MN; April Teitelbaum, i3 Research, San Diego, CA; Henry Henk, PhD, i3 Innovus, Eden Prairie, MN; and Reynaldo Garcia, Lineberger Comprehensive Cancer Center-Protocol Office, University of North Carolina at Chapel Hill, Chapel Hill, NC

CML is caused by translocation of the ABL gene on chromosome 9 and the BCR gene on chromosome 22, resulting in a mutated BCR-ABL gene leading to unregulated tyrosine kinase activity. Response to tyrosine kinase inhibitor (TKI) therapy is assessed by quantification of BCR-ABL levels, which can predict long-term outcomes in CML patients. BCR-ABL is measured by quantitative polymerase chain reaction (q-PCR) or fluorescence in situ hybridization (FISH); q-PCR is the most sensitive and can detect minimal residual disease. Although samples for BCR-ABL quantification can be obtained from bone marrow, follow-up testing using peripheral blood is more convenient and less painful. The National Cancer Comprehensive Network (NCCN) Version 2.2011 recommends measuring q-PCR BCR-ABL levels before initiating TKI therapy and every 3 months thereafter. To evaluate the frequency of BCR-ABL testing in a real-world setting and to

discuss implications for oncology nurses. A retrospective claims analysis was conducted from a 14 million member commercial health plan in the United States. Eligible patients were diagnosed with CML, receiving imatinib therapy and enrolled in the health plan for 12 months. Of the 617 patients identified, 43% had no BCR-ABL testing and only 28% had the guideline recommended number of BCR-ABL tests during the 12 months following imatinib initiation. Frequency of BCR-ABL testing increased over the study; however, the proportion of untested and undertested patients was high across the study period. According to this analysis, the guidelines for q-PCR BCR-ABL testing are not followed by the majority of clinicians in this real-world setting. Oncology nurses should monitor the frequency of q-PCR BCR-ABL testing to ensure that it is being conducted as recommended and prompt for testing when needed. Adherence to NCCN guidelines is important for measuring treatment response and optimizing outcomes. Although levels fluctuate, increasing BCR-ABL levels are an indication to evaluate patients for nonadherence, drug-drug or drug-food interactions, and relapse. Important aspects of patient management include education regarding q-PCR BCR-ABL testing, interpretation of results over time, and the use of test results as a tool to encourage patient adherence to therapy.

1053291

LONG-TERM OUTCOMES OF AN ONCOLOGY NURSE INTERNSHIP PROGRAM. Susan Childress, RN, MN, OCN®, Huntsman Cancer Hospital, Salt Lake City, UT; Mary Jean Austria, BSN, OCN®, Huntsman Cancer Hospital, Salt Lake City, UT; and Sandra Kelly, MS, RN-BC, OCN®, Huntsman Cancer Hospital, Salt Lake City, UT

A wide variety of nurse internship programs have proven to attract applicants and reduce RN turnover rates. This organization has found that the long-term outcomes are just as significant. Along with continued cost savings, there has been increased employee satisfaction, patient satisfaction, improved quality of care, and increased professional and leadership development. Build a strong, dynamic oncology nursing foundation to sustain a cancer hospital through growth, economic changes, and health policy evolution. As an ONS 2006 LDI project proposal, the goal was to decrease the cost of nursing vacancies and increase retention by implementing a four month classroom and clinical based internship. Nursing interns were oriented to all three oncology inpatient units and were guaranteed a position on one of the units upon graduation. The fellows' signed a contract to remain at this institution for two years. Long-term evaluation of this program has shown expected and unexpected results. A cost analysis, employee satisfaction, patient satisfaction, quality measures, obtaining certifications, and leadership development will all be shared in this presentation. As a result of the internship program and the economic downturn, this organization now has very little turnover. It would be easy to put a hold on this costly program. The impressive outcomes of this program, after four years of implementation, supports the need to continue.

1053296

ASSESSING HEALTH LITERACY OF ELDERLY CANCER PATIENTS IN CLINICAL PRACTICE: WHAT CLINICIANS NEED TO KNOW. Ellen Mullen, RN, BSN, MSN, Lymphoma/Myeloma, MD Anderson Cancer Center, Houston, TX; and Daniel Mullen, RN, BSN, Lymphoma/Myeloma, MD Anderson Cancer Center, Houston, TX

Health literacy is defined as the degree in which a person has the ability to obtain, process, and understand health information needed to make appropriate health decisions. The most recent survey conducted by the National Assessment of Adult Literacy (NAAL) in 2003 revealed 36% of American adults overall have limited health literacy. Most notable is the rate among the elderly

(people >65 years old), with 59% scoring at the basic or below-basic levels. Studies have shown that people with limited health literacy have less health knowledge, increased hospitalizations, ER visits, medication errors, and higher healthcare costs than individuals with adequate health literacy. Several instruments are available to screen for health literacy but they are underutilized. Clinicians routinely underestimate the prevalence of limited health literacy among their patients and frequently overestimate their ability to understand the information they provide to their patients. This poster will discuss the health consequences of inadequate health literacy, the strengths and limitations of the two widely used reliable and valid screening instruments, the Rapid Estimate of Adult Literacy in Medicine (REALM) and Test of Functional Health Literacy in Adults (TOFHLA), and offer ways on how to utilize them effectively. The REALM and TOFHLA were developed to assess individuals' health literacy level. These tools should be administered at the initial visit. Upon determining the patient's literacy level, communication methods, either oral or written, should be tailored to match the patient's level of understanding. These tests are easy to administer, do not cause any undue burden for patients to complete, and can provide vital information to develop a treatment plan. At the end of the presentation, the audience will be able to gain understanding of the consequences of inadequate health literacy, discuss the strengths and limitations of the two instruments, and able to use these instruments in their practice setting. Clinicians should assess for health literacy to learn the prevalence of limited health literacy, especially, among the elderly since they access the health care system the most due to chronic illnesses. Being aware of patients' health literacy level will improve communication and ultimately improve health outcomes.

1053304

UNMET INFORMATION NEEDS AND QUALITY OF LIFE IN YOUNG BREAST CANCER SURVIVORS IN JAPAN. Mika Miyashita, RN, PhD, Hiroshima University, Hiroshima, Japan; Akemi Kataoka, MD, Breast Surgery Clinic, Tokyo, Japan; Shinji Ohno, MD, National Kyushu Cancer Center, Fukuoka, Japan; Hidetoshi Kawaguchi, MD, National Kyushu Cancer Center, Fukuoka, Japan; Junko Nishimura, MD, National Kyushu Cancer Center, Fukuoka, Japan; Shiguro Murakami, MD, Hiroshima City Asa Hospital, Hiroshima, Japan; Shinji Ozaki, MD, Hiroshima University Hospital, Hiroshima, Japan; Mayumi Yamaguchi, RN, Hiroshima University Hospital, Hiroshima, Japan; and Miyako Takahashi, MD, PhD, Dokkyo Medical University, Tsuga-Gun, Japan

Breast cancer is the most common cancer among Japanese women. In 2005, 13.5% of all cases were in under age 45. Breast tumors in young breast cancer patients tend to be more aggressive, and have a greater effect negatively on quality of life. The purpose of this study are to describe unmet information needs and quality of life in young breast cancer survivors in Japan, and to examine relationships between satisfaction with information and quality of life. According to Stress and Coping Theory, information is a resource that aids adjustment, and therefore, unmet information needs can affect patients' quality of life. This study use WHO definition of quality of life, which is multidimensional construct composed of four domains: physical, psychological, social, and environmental. Participants who were diagnosed breast cancer at 45 year-old and under 45 year-old were recruited. After signing consent form, participants completed the information needs questionnaire containing 50 items, WHOQOL26, and demographic and medical information questionnaire. Descriptive statistics and t test were used to analyze data. To assess the relationship between satisfaction with information and QOL, mean scores of WHOQOL26 were compared between the patients with satisfied and unsatisfied with the information. 202 (65.6%) patients with a mean age of 45.3±6.7 years completed

the questionnaire. The highest unmet information need, which was perceived as unsatisfied by 28.2% of respondents, was identified overall communication with physician. The information of menopause caused by chemotherapy or hormonal therapy which was specific information in young patients was perceived as unsatisfied by 13.9%-16.3% of respondents. The mean scores of total QOL and QOL subscales were deemed to be modestly high, ranged from 3.40 to 3.57. As to the items of the information needs questionnaire with moderate high rate of unsatisfied respondents, the results of t test on satisfied patients compared to unsatisfied patients with the information showed significant differences in the mean scores of total QOL or QOL subscales. This study suggested that oncology nurses should teach patients communication skills, and provide adequate information to meet the unmet needs in order to enhance quality of life in young breast cancer survivors.

1053330

A SURVEY TO DETERMINE ATTITUDES AND FEELINGS ABOUT DEPRESSION/SUICIDE RISK SCREENING. Joanne Lester, PhD, CRNP, AOCN®, Nursing Excellence, The Ohio State University, Grove City, OH; Majorie Anderson, MS, PMHCNS, Nursing Excellence, The Ohio State University, Grove City, OH; Nanacy Treece, MS, PMHCNS, Nursing Excellence, The Ohio State University, Grove City, OH; Angela Chesser, MS, PMHCNS, Nursing Excellence, The Ohio State University, Grove City, OH; Barbara Warren, PhD, RN, The Ohio State University, Columbus, OH; Kathleen Moore, BS, College of Nursing, The Ohio State University, Columbus, OH; and Steven Naber, PhD, Statistics, The Ohio State University, Columbus, OH

Suicide is a leading cause of mortality in adults, with elderly males at greatest risk. The literature suggests that 45-66% of persons who commit suicide may have been seen by a primary care provider in the month prior to their death. Therefore, appropriate and timely screening for suicide risk by all health care professionals is prudent. The nursing literature has identified potential barriers to implementing depression and suicide screening. These barriers include fears about causing patients distress, discomfort with screening questions and with administering the screen in the presence of family members or caregivers, problems in communicating with patients' physician about a positive screen, and perceived paperwork burden required by screening. However, suicide screening is not typically included in routine assessments; therefore, adequate preparation must occur in order to adequately meet screening requirements, including those requirements by the Joint Commission on Accreditation of Healthcare Organizations. Depression and suicide risk assessment screening is prudent in oncology patients who are considered at increased risk due to a life-threatening and/or chronic illnesses. Lacking in the literature is data that answers the questions related to barriers and beliefs of oncology caregivers to appropriate screening. The purpose of this research study was to characterize current feelings and attitudes among health care professionals about depression and suicide risk screening. The study also sought to explore possible correlations between specific demographic factors that characterize health care professionals to associated feelings and attitudes about depression and suicide risk. Benner's theory of novice to expert nurse was used to examine concepts related to depression and suicide risk screening and observed deficits. This study was a descriptive, observational study of healthcare providers at a mid-west academic medical center with a free-standing comprehensive cancer center. An electronic survey was conducted in summer 2010 (n=1601). Descriptive statistics were used to describe the sample of respondents; Cross-tabulation with Chi-square statistics were used to examine differences between various sub-groups of respondents and the impact of demographic factors on the survey items. Results demonstrated significant differences between fol-

lowing variables: professional years of experience, age, workplace setting, and educational level. Oncology health care providers were more likely to perform depression and suicide risk prevention assessments than age-matched professionals at the general medical center, although demonstrated similar gaps as related to age and years of experience. These results imply the need for further education and learning for the professional community.

1053331

DEVELOPMENT OF A PILOT MENTOR-TO-MENTOR PROGRAM FOR BREAST BRACHYTHERAPY PATIENTS AT UC SAN DIEGO MOORES CANCER CENTER. Eva Bariuan, MPH, RN-BC, OCN®, Radiation Oncology Department, UCSD Moores Cancer Center, La Jolla, CA; and Catheryn Yashar, MD, Radiation Oncology Department, UCSD Moores Cancer Center, La Jolla, CA

Breast Brachytherapy is an alternative treatment to external beam radiotherapy for early stage breast cancer. Generally, Breast Brachytherapy is a five-day course of radiotherapy, delivering radiation to the breast where cancer is most likely to recur. Among the advantages of this treatment is reduced radiation exposure to patient's skin, heart, and lungs. Treatment is delivered through a brachytherapy device that is inserted to the breast through a small incision to the lumpectomy cavity. The treatment schedule is 34 Gy delivered in 10 fractions twice a day with a minimum of six hours between fractions. The radiation source is removed after each treatment although the device is left in place until the five-day treatment is done. Based on our patients' survey, many have requested supportive resources to help them through the treatment process, expressing particular interest and the need to talk with others who have been through similar experiences. This pilot project develops a Mentor Training Program, led by an oncology nurse, to train volunteer mentors who have gone through early stage breast cancer brachytherapy treatment. These Mentors will provide resources and support to women who will be undergoing similar treatment experiences. The Mentor Training Program provides volunteer training, so that the volunteers can provide supportive resources to patients before, during, and after treatment. The Program includes an educational training checklist, which guides Mentors with content about treatment and about how to give supportive educational information to new patients. Then prior to their treatment, new patients are provided the names and contact information of the trained Mentors. Based on patients' feedback about their experience with their Mentors, the Mentor Training Program has been effective. Patients report that the information and support provided by Mentors helped alleviate their anxiety, thereby increasing the patients' confidence in their choice of treatment. The Mentors also helped patients cope with problems in managing symptoms and the challenges of living with breast cancer. The Mentor Training Program has shown to be effective in providing mentor-to-mentor support to early stage breast cancer patients, who are being treated with Breast Brachytherapy.

1053334

DEVELOPMENT AND LAUNCH OF A YOUTUBE-BASED E-JOURNAL CLUB FOR ONCOLOGY NURSES: NURSING RESEARCH NEWS YOU CAN USE (NRNYCU). Ellen Carr, RN, MSN, AOCN®, Moores UCSD Cancer Center, La Jolla, CA; Caroline Brown, DEd, CNS, WHNP, UC San Diego Health System, San Diego, CA; Mario Quitorian, BS, MSN, RN, PHN, UC San Diego Health System, San Diego, CA; and Mary Wickline, MLIS, MEd, UC San Diego Health System, San Diego, CA

Integrating the latest research-based evidence into practice remains challenging for clinical nurses. With the internet and other digital information sources regularly providing a daily avalanche of filtered and unfiltered clinical information, keeping up-to-date

on relevant nursing research is daunting. As a universally adopted digital-era technology, YouTube has emerged as an accessible platform for education and clinical updates. To establish a YouTube platform to post periodically-produced videos as a form of an e-journal club for oncology nurses. This platform can serve as a robust digital-era method to update oncology nurses about clinical evidence-based practice (EBP) information and nursing research. The platform also enables nurses to access information from a trusted colleague, a frequently-used, information-seeking method of learning. A project team developed the Nursing Research News You Can Use (NRNYCU) YouTube platform, targeting oncology nurses. Development established (1) video production values and optimal video length, (2) a production operation to produce videos at minimal cost, (3) success at video posting via a YouTube channel, and (4) a marketing plan to launch the platform. In January 2011, the pilot video of NRNYCU launched on the YouTube University of California San Diego's (UCSD) channel. The three initial NRNYCU videos produced focused on these oncology nursing practice issues: Patient Education, Post-Treatment & Exercise, and Pain Management. Pre-launch focus groups (n = 32) informed the project and marketing launch plans. After NRNYCU launched, UC San Diego oncology nurses were surveyed. Responses revealed that the NRNYCU platform is an effective method to update oncology nurses about clinical EBP information and nursing research. Responses measured: (a) ease of access, (b) interest in content presented, (c) application to practice of content presented, and (d) likelihood to continue to access/view NRNYCU content. The experience of developing and launching the NRNYCU platform via a YouTube channel serves as a boilerplate plan to promote and integrate nursing research evidence into clinical practice. Refinement of the platform continues so that regular production of YouTube accessible videos is a skill set that could be easily adopted by other cancer care facilities or nursing specialties.

1053338

NEW GRADUATE ONCOLOGY NURSES FROM A COMPREHENSIVE CANCER CENTER JOIN A COLLABORATIVE MULTISITE ONE YEAR NURSE RESIDENCY PROGRAM.

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According to the ONS position on the national nursing shortage, nurses entering the workforce will decrease as the number of oncology patients increases. This anticipated mismatch in supply and demand for nursing services creates a dire need to attract and retain new graduate nurses. However, new graduate nurses experience an unprecedented learning curve as they care for increasingly complex patient workloads. Historically, the new graduate nurse experiences reality shock with entrance into practice. Additionally, new graduate nurses report a dip in self confidence and decrease in job satisfaction within the first year of practice which leads to high rates of workplace attrition. New graduate nurses who enter oncology nursing have the added challenge of specialty practice. Transition programs, like a nurse residency, offer unique opportunities to support the development of new nurses from the student to independent professional nurse role in oncology. Similar programs have shown improvement in retention and job satisfaction of new graduate nurses across specialties. To help nurses practice to the full extent of their education, the IOM (2010) has called for an increase in transition programs in specialty areas. The purpose of this project is to determine the relationship of transition program participation and workplace retention, professional satisfaction, and the transition experience in specialty practice. The plan includes the comprehensive cancer center 12 week nursing orientation including classroom and clinical

time with a preceptor. Additionally, the new graduates select a mentor who has been in practice less than 3 years. Each month, new graduates attend educational events with a cohort of new graduates from seven other hospitals involved in the transition program. The monthly programs include debriefing, didactic, games and simulation. Each monthly program includes a written evaluation. A larger research component is comparing the experience of the nurse residency cohort with new graduates not involved in the program. The new graduates are midway through the transition program. The most recent monthly event topic was self care. The group identified that this program was much needed at this point. A constant is their recognition that they are not alone in their stressful transition experience.

1053366

ONCOLOGY NURSES TAKE OWNERSHIP FOR MODEL OF CARE AND STAFFING.

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On a 48 bed inpatient oncology unit, patient assignments were frequently being changed throughout the day. With the current staffing matrix, the unit had higher acuity patients, increased patient fall rates, and declining patient satisfaction scores. Having the right staff mix and staffing ratios is essential to providing quality patient care. Adequate staffing results in a safer environment for patients and increased patient and staff satisfaction. Oncology nurses play an essential role in evaluating their patient care delivery model and staffing to ensure the best possible care for their patients. The purpose of this project was to evaluate the current staffing and patient care delivery model and make changes to improve patient care, as well as increase patient and staff satisfaction. A patient acuity audit was conducted. Patient satisfaction scores were reviewed. A comparative analysis of staffing ratios of local and national hospitals was completed. Unit admission, discharge and transfer volume was assessed. Hospital Benchmarking was analyzed. As a result, changes were made in the patient care model. Schedules were changed for various positions including nurse assistant, nurse technician and unit secretary, and a proposal was presented to hospital administration for the addition of registered nurse staff. Education was provided to nursing staff on the changes to the patient care model. A post-implementation nursing satisfaction survey will be administered. Patient satisfaction could not be assessed during the model of care change because the hospital was transitioning to a different patient satisfaction survey tool. Fall rates will continue to be monitored. Oncology nurses can evaluate their patient care delivery model and implement changes to improve patient care and patient and staff satisfaction. Implications for oncology nursing practice include nurses taking ownership for their practice. The new patient care model, scheduling changes and proposal to increase RN staff were presented to the nursing leadership as an example of how staff can collaborate with nursing management to improve patient care outcomes. This initiative was shared throughout the corporation and may be utilized by other health care institutions to evaluate their own patient care model and staffing ratios.

1053370

MYCOSIS FUNGOIDES: THE UNIQUE NURSING CHALLENGES ASSOCIATED WITH THIS RARE FORM OF NON-HODGKIN'S LYMPHOMA.

Medora Zimmerman-Crumbaugh, RN, BSN, JHH, Baltimore, MD; and MiKaela Olsen, RN, MS, OCN®, JHH, Baltimore, MD

Cutaneous T-cell Lymphoma (CTCL) is a rare form of non-Hodgkin's lymphoma that is characterized by the accumulation of

neoplastic T-cells in the skin. CTCL accounts for approximately 5% of non-Hodgkin's lymphomas. Mycosis fungoides, being the most common form of CTCL, generally presents two ways: as raised lesions, once likened to mushrooms, hence the name "fungoides", or as plaque-like lesions. These lesions create numerous problems for patients, including increased risk of infection, increased risk for mortality, and psychosocial and body-image issues. Mycoid lesions also present unique challenges for nursing care with regard to wound management and skin care. The purpose of this presentation is to educate nurses about mycosis fungoides. The presentation includes pathophysiology, clinical presentation, and key nursing care considerations for patients with mycosis fungoides. Case studies will be used to illustrate these nursing considerations. Wound care guidelines and a "fast facts" flow sheet for the care of patients with mycosis fungoides were developed and implemented in this comprehensive cancer center to assist nurses with the care of these complex patients. Information on wound management and CTCL has been integrated into nursing education for new and experienced Oncology nurses. The goal of this presentation is to increase nurses' understanding of mycosis fungoides. Increased knowledge will enhance nurses' ability to manage these patients' complex skin and wound care needs, assist in infection prevention and treatment, and provide psychosocial support. Mortality for most patients with mycosis fungoides is related to infection or sepsis, rather than the primary disease. Interventions provided by nurses, through skin and wound care, can assist in the prevention and management of potentially fatal infections. Skin care routines can enhance skin appearance and suppleness, improve body mechanics and increase quality of life for these patients. Through this presentation we will share experiences and case studies, and provide guidelines for caring for patients with mycosis fungoides.

1053378

DEVELOPING AND GROWING A COMMUNITY HOSPITAL BASED PALLIATIVE CARE PROGRAM. Susanne Fessick, RN, FNP, OCN®, Palliative Care, CJW Medical Center, Richmond, VA

Medical decision making in the setting of life-threatening diseases can be complicated and time-consuming for the practitioner while trying to promote an integrated approach to palliative care in our patients with cancer. With 56% of our patients dying in the hospital setting and only 43% of hospitals reporting to offer palliative care services (The Robert Wood Johnson Foundation). The need for palliative care services appears to exist and needs to be improved upon. The purpose of this is to outline how we were able to start a palliative care service, immediately raise the awareness and education level of nurses, physicians and staff, and double our number of inpatient consults in one year. The inception of our Palliative Care Program began in 2002 as a committee whose primary goal was coordinating an annual palliative care conference. In 2005, a study conducted at our hospital supported the need to recruit a palliative care physician champion. In 2008, a board certified geriatrician and palliative physician began the Inpatient Palliative Care Consultation Service offering in-services and educating medical staff about the new service. At the end of 2009, a board certified family nurse practitioner was added to complement the growing service. In 2010, forty bi-monthly unit in-services and poster sessions were offered to all nursing units. In August 2010, a clinical social worker was added to our growing team with the ability to meet one on one with patients and families in crisis. There were 219 reported consults for calendar year 2008, 343 in 2009 and 650 for 2010. Our largest referral base is the Hospitalist service at over 50% of the total number of consults seen with the Oncologists coming in as second at 17%. Through the use of grass roots unit by unit education and building strong communication efforts with each referring physician, this has enabled us to increase the number of patients receiving palliative care two fold in one year. As the program is better understood, we will continue to reach more patients in need. In addition, new specialties are beginning to request palliative services more often.

1053389

STANDARDIZING PATIENT EDUCATION FOR SAFE HANDLING OF CHEMOTHERAPY AT HOME. Bernadette Lore, RN, BSN, OCN®, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; and Beth Boseski, RN, MSN, OCN®, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY

Advancements in science and technology enable patients to receive chemotherapy in home-based settings. Patients and care givers benefit from the convenience of home administration; however, the absence of an oncology nurse may pose a potential safety risk. Patients must be educated about safe handling and administration of intravenous and oral chemotherapy in the home. In 2008, The American Society of Clinical Oncology (ASCO) and the Oncology Nursing Society (ONS) published chemotherapy administration standards to maintain patient safety during chemotherapy administration. Nurses play an important role in educating patients regarding safety standards for chemotherapy administration at home. At this center, we did not have consistent information in an easy to read format on safe handling of chemotherapeutic agents to prevent inadvertent drug exposure in the home. The chemotherapy practice committee identified the need to provide patients with instructions on safe handling of cytotoxic drugs in the home. The ASCO & ONS chemotherapy administration standards provided the framework for a standard patient education tool. To meet the challenge of standardizing patient education on safe handling, a task force was organized consisting of representatives from the departments of medicine, pharmacy, nursing, safety and patient education. A literature search was conducted and guidelines from other hospitals were researched. Safety recommendations from the National Institute of Health on Handling Hazardous Drugs Safely and this center's standard operating procedures for safe handling of cytotoxic drugs were identified. Utilizing the best available evidence, a patient education fact card was created. The information provided on the patient education fact card applies to all age populations. The card was reviewed by nursing leadership, the chemotherapy practice council and the Department of Patient Education for approval. Following implementation, surveys will be conducted to reflect how useful this patient education fact card is for the nurse providing patient instruction and for patients using the fact card. Results of these surveys will be discussed during this presentation. Oncology nurses will use this fact card to educate patients regarding the nature and risk of handling cytotoxic drugs and necessary precautions patients and care providers must take to prevent unintended exposure in the home.

1053399

DO YOU SEE WHAT I SEE? IMPROVING SHIFT TO SHIFT HANDOFF ON THE ONCOLOGY UNIT. Jane Willis, RN, BSHA, OCN®, Inpatient Oncology and Outpatient Infusion, CJW Medical Center, Richmond, VA

Several organizations recognize that communication may be a source for errors. The Nursing Executive Center recommends bedside reporting and a "patient focused report" as an effective method for increasing efficiency and quality. The Joint Commission recognizes that miscommunication between caregivers is responsible for approximately 80 percent of serious preventable adverse events. The goal of this project was to improve nurse to nurse shift handoff with a focus on including the patient in this communication. The Kaizen methodology, a team approach to improve processes by looking at content, sequence, timing, and location, was used to define, standardize and implement shift report. The first step was to evaluate the current report. Observations over several days revealed many issues. More time was wasted than was spent giving report or with the patient. The next step was to eliminate waste. It was discovered that staff wasted time looking for someone to give report to, trying to find a tape recorder that worked, or by listening to the wrong report. A writ-

ten report was developed which incorporated specific oncology-related information. A process for walking rounds between the oncoming and the off going nurse was developed. It included introducing the oncoming nurse and focusing on the plan of care, safety checks [i.e. tracing intravenous (IV) lines] and assuring that the patient is safely positioned in bed and has no immediate needs. Benefits from the implementation of walking rounds have been: reduced time spent from assessing the first patient at 40 minutes to meeting and receiving report on all assigned patients in 30 minutes, decreased calls for assistance during shift change, increased satisfaction of float nurses in familiarity with the unit and their patients, and a decline in falls during shift change. Two types of written report sheets were trialed and abandoned. The staff felt they resulted in wasted time away from the patient. Verbal report and walking rounds have continued to be utilized. Although there may be challenges with this process (multiple nurses to receive report from or if patients are sleeping) overall, this new process is viewed as an improvement in the handoff technique.

1053422

THE IMPACT OF LUNG CANCER SCREENING ON SMOKING BEHAVIORS: INTEGRATIVE LITERATURE REVIEW. Hermine Poghosyan, BSN, MPH, The College of Nursing and Health Sciences, University of Massachusetts Boston, Boston, MA; Lisa K. Sheldon, PhD, APRN, BC, The College of Nursing and Health Sciences, University of Massachusetts Boston, Boston, MA; and Mary Cooley, PhD, RN, Nursing and Patient Care, Dana-Farber Cancer Institute, Boston, MA

Helical Computed Tomography (CT) has emerged as a potential screening test for lung cancer. Identification of effective screening test for those at high risk of developing lung cancer would enable earlier diagnosis and the potential for curative treatment. An important component of care surrounding the use of CT is the impact of screening on decisions surrounding smoking cessation. The aim of this review is to synthesize the evidence regarding the impact of lung cancer screening with CT on smoking behaviors of current and former smokers. Ganong's framework Computerized databases were used to identify articles. Inclusion criteria for studies were: empirical studies, English language, smoking behavior change after CT screening for lung cancer, and published before September 2010. Ten studies met inclusion criteria. Data related to smoking behaviors, motivation to quit smoking, type of cessation interventions used and interest in cessation were extracted from the articles. Content analysis was used to synthesize the results of the studies. Studies were mixed about the impact of CT screening on smoking quit rates. The quit rate among participants ranged from 6.6% to 42% after screening. Among current-smokers, smoking abstinence was associated with older age, worse pulmonary function, and having multiple abnormal CT findings. Motivation to quit smoking, within the next 30 days, ranged from 14% to 35%. Factors associated with increased motivation were older age, lower nicotine addiction, and higher self-efficacy. Relapse rates among former smokers were 10% after CT results. All studies used minimal smoking cessation interventions. Interest in receiving smoking cessation interventions as part of CT screening ranged from 54-86%. CT screening for lung cancer appears to be a teachable moment to address smoking cessation. Interest in receiving smoking cessation interventions as part of CT screening was high. More intensive interventions may enhance cessation rates. Further research is needed to better understand the impact of technology on decisions surrounding smoking cessation and the efficacy of cessation treatment. Nurses play a key role in leading tobacco control efforts among those at high risk for lung cancer.

1053425

APPROACH TO PATIENT EDUCATION AND MANAGEMENT OF TOXICITIES ASSOCIATED WITH IPILIMUMAB. Dana

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Ipilimumab is a fully human monoclonal antibody that blocks cytotoxic T-lymphocyte antigen-4 to potentiate an antitumor response, and is the first agent to show statistically significant improvement in overall survival in previously treated patients with advanced melanoma. Oncology nurses play a pivotal role in ensuring the successful use of ipilimumab in the clinic. Ipilimumab is associated with a characteristic set of common side effects, including gastrointestinal, skin, and liver toxicities, and nurses are ideally placed to monitor for these occurrences. The side effects can be serious, but most are manageable if the patient knows to report symptoms promptly and if management guidelines are followed. It is very important for nurses to familiarize themselves with ipilimumab administration, side effect symptoms and management, and to communicate key points clearly to patients to ensure appropriate treatment. Recommendations exist to manage side effects associated with ipilimumab. Most Grade 1 and 2 side effects can be managed with over-the-counter and dietary interventions, or in the case of diarrhea/colitis of Grade 2 severity, low-dose oral corticosteroids (budesonide). For most Grade 3/4 side effects, ipilimumab may be interrupted and steroids are required to prevent more serious or life-threatening outcomes. A nurse checklist with specific points to review with patients is suggested. In addition, many patients with advanced melanoma have been previously treated with other therapeutics and will require education on the differences between side effect symptoms associated with ipilimumab and those agents. A sample chart comparing the two may be a useful tool for nurses to use while educating patients and caregivers. In some cases, side effects can be life-threatening and treatment-limiting, but most patients can continue on or resume treatment as long as symptoms associated with Grade 1/2 toxicity are reported and treated as soon as they arise. The nurse-patient partnership is a critical factor in achieving this goal and ensuring that patients can remain on ipilimumab treatment long enough to benefit from it.

1053434

RADIATION THERAPY PATIENT/FAMILY TEACHING SESSIONS: PERSONAL TOUCH IN A HIGH TECH SETTING. Carol Koehler, RN, OCN[®], Radiation Oncology, University Hospital, Orange Village, OH; and Joan Kolb, RN, BSN, OCN[®], Radiation Oncology, University Hospital, Cleveland, OH

How can nurses prepare patients to be actively involved in their radiation therapy treatment? It is well known that patients who are prepared for the treatment experience and potential side effects are more likely to tolerate chemotherapy. However, little has been done addressing the impact of preparing patients for the radiation therapy experience and potential side effects despite the fact that over 60% of cancer patients receive radiation at some point during the disease trajectory. Radiation oncology nurses at a large Midwestern cancer center identified a need to develop a semi-structured psycho-educational radiation therapy class modeled after the cancer center's successful chemotherapy classes. This poster describes the development of the psycho-educational program, course content, quantitative and qualitative evaluative data, lessons learned, and tips on how to implement a successful educational program in a radiation oncology department. All patients starting radiation therapy receive information about the class in their initial consultation and they also receive a personal invitation from the radiation oncology nurse and radiation therapists at the time of their first marking visit appointment. Classes are offered twice a month for about one hour. The class contains a power-point slide presentation that discusses what radiation therapy is, who is on the radiation team and their disciplines, how radiation affects cancer cells, pictures of the radiation therapy rooms and machines, and an intensive section on side effects, skin care, nutrition, and coping strategies. Additional printed materials are given to reinforce teaching. Since patients and family members

are part of the team, the nurse discusses what to expect from the team and patient responsibilities for self-management are woven throughout the session. The radiation therapy class has been in existence since July 2009 and evaluative outcome data has been tracked for nearly 17 months. The number of participants at each class has ranged from one family to ten patients and family members. Since the class is not mandatory, refusals to participate are also tracked. Responses from patients who have attended the class have been overwhelmingly positive. This intensive nursing educational session personalizes oncology care in a very high technology department.

1053437

PERCEIVED PROVIDERS' SUPPORT AND LYMPHEDEMA RISK REDUCTION. Mei R. Fu (Qiu), PhD, RN, ACNS-BC, New York University, New York, NY; Amer Guth, MD, FASC, Surgery, NYU School of Medicine, New York, NY; Judith Haber, PhD, RN, APRN-BC, FAAN, College of Nursing, New York University, New York, NY; and Deborah Axelrod, MD, FASC, Surgery, NYU School of Medicine, New York, NY

Despite advances in treatment, many breast cancer survivors still face permanent disruption of their lymphatic system which predisposes them to the risk for lymphedema. Lymphedema has changed the triumph over breast cancer with distressing and life-changing impacts on survivors' quality of life. For decades, the salient issue influencing the impact of lymphedema on breast cancer survivors is survivors' perception of lack of support from healthcare providers. The purpose of this study was to explore the effects of survivors' perceived healthcare provider support on lymphedema risk reduction in terms of perceived competence, motivation, cognitive, and behavior outcomes. Based on the Self-Regulation theory and the Information-Motivation-Behavioral Model, the conceptual framework for the study emphasizes the need for patients to have adequate information to gain understanding of lymphedema risk, make decisions about risk reduction, and implement risk reduction behaviors. The framework proposes that perceived provider support is key to patients' motivation, competence, cognitive and behavior outcomes. Data was collected from 133 breast cancer survivors using a Demographic and Medical Information, a Scale for Lymphedema Risk Reduction Competence, and Motivation, a Scale for Perceived Support from Healthcare Providers, a Knowledge Test, and the Lymphedema Risk Reduction Behavior Checklist. Data analysis included descriptive statistics, multiple linear regression models, and assessment of moderation and mediation. Model fit was evaluated through the R2 for the overall model and incremental change in R2. Cognitive outcome was a significant predictor for survivors' competence, motivation, and behavior outcome. A model was created and evaluated with final model fit indices suggested a good fit to the sample data ($X^2(3, N=133) = 3.94$ ($p = .268$); CFI = .99; RMSEA = .05 (0 to .16); AIC = 29.94; $X^2(\text{diff}) = .181$, $p = .913$). This model supports that provider support directly associated with participants' competence and motivation which are directly related to behavior outcome. Nurses and other healthcare professionals should take the initiative to provide survivors with accurate lymphedema information to insure survivors' cognitive outcome. Healthcare providers should be trained and encouraged to increase survivors' perceptions of provider support, in turn, this will help to promote competence and motivation, resulting in a positive impact on behavior outcome.

1053457

DEVELOPMENT OF STAFF EDUCATION ON STEROID INDUCED HYPERGLYCEMIA IN ONCOLOGY PATIENTS. Danielle Pohlen, RN, BSN, Inpatient Hematology Oncology, Duke University Medical Center, Durham, NC; Holly Smith, RN, BSN, Inpatient General Medicine, New Hanover Hos-

pital, Wilmington, NC; Ellen Davis, RN, MSN, CDE, FADE, Advanced Practice Nursing, Duke University Medical Center, Durham, NC; and Leigh Burgess, MHA, Med, Quality, Outcomes, and Patient Centered Care, Duke University Medical Center, Durham, NC

Hyperglycemia is a complication that oncology patients face, particularly when placed on steroid therapy as part of their chemotherapy regimen. Time used for monitoring, managing, and teaching self-care can be overwhelming for staff of an inpatient unit in a large academic medical center where 75% of hematology-oncology adult patients receiving induction or consolidation therapy are receiving steroids. Furthermore, inconsistencies in staff practices and delivery of patient education warranted promotion of evidence-based practice (EBP) guidelines. In an effort to increase staff knowledge on the development of steroid-induced hyperglycemia (SIH), promote implementation of evidence-based practices, and expand SIH patient education materials, a multi-formatted educational program was presented to staff. To examine staff knowledge and practices, a pre-survey was completed by 50% of staff and served to guide the educational program. Staff in-services were held to present current EBP guidelines for hyperglycemia management, discuss staff survey responses, delineate areas for improvement, and address mechanisms to engage patients and families in self-care of hyperglycemia for home management. A bulletin board placed in a staff-prominent viewing area displayed an EBP Plan of Care on SIH. A Diabetes & SIH educational folder with other unit-specific educational documents was created. The patient education brochure addresses commonly asked questions and care guidelines. A post-survey was administered to evaluate changes in staff knowledge and practices. Results were reviewed with staff in Lunch and Learn sessions. Post-intervention, staff increased knowledge, more consistently perform EBP guidelines, better address patient questions, and exhibit trends towards improvements for early initiation of hyperglycemia care plan and promoting patient engagement for self-care earlier in their hospitalization. Subsequent to these analyses, recurring in-services have been necessary to reinforce practice guidelines, "Key Hyperglycemia Points" were placed at each nursing station, and a hyperglycemia care plan template was developed. Staff and patient responses are ongoing. By identifying areas of educational need among staff, we were able to streamline our educational focus to provide a comprehensive program to promote staff and patient engagement in understanding SIH. Upcoming plans include SIH-careplan initiation and patient education for impact of care.

1053464

LONG-TERM SAFETY AND TOLERABILITY OF FENTANYL PECTIN NASAL SPRAY IN THE TREATMENT OF BREAKTHROUGH CANCER PAIN. Deborah Thorpe, PhD, APRN, AOCNS®, ACHPN, Huntsman Cancer Institute, University of Utah, Salt Lake City, UT; Sharon Weinstein, MD, Huntsman Cancer Institute, University of Utah, Salt Lake City, UT; Mark Wallace, MD, Center for Pain Medicine, University of California at San Diego, San Diego, CA; Allen Burton, MD, MD Anderson Cancer Center, University of Texas, Houston, TX; John Ellershaw, MD, Marie Curie Palliative Care Institute, Liverpool, United Kingdom; and Russell K. Portenoy, MD, Beth Israel Medical Center, New York, NY

Controlled trials with fentanyl pectin nasal spray (FPNS) have confirmed that, compared with placebo or immediate-release morphine sulfate, FPNS produces onset of analgesia at 5 minutes and clinically meaningful pain relief by 10 minutes after a dose for the treatment of breakthrough cancer pain (BTCP). Adverse events in these short-term studies were opioid related; nasal toxicity was not observed. Assess the long-term safety and tolerability of FPNS in opioid-tolerant patients with cancer. Phase III, long-term safety, open-label study. Patients (newly titrated or rolled over from

earlier controlled studies) with cancer-related pain experiencing 1-4 BTCP episodes/day while taking ≥ 60 mg/day oral morphine (or equivalent) were eligible to enter an open-label 16-week safety study. FPNS was used to treat up to 4 BTCP episodes/day. Safety was assessed by adverse events (AEs) and by withdrawal from the study because of AEs. Nasal tolerability was assessed based on clinician findings (nasal obstruction, inflammation, discharge, mucosal color). Subjective nasal assessments were performed by the patient before the first use of study drug; 1 hour after each dose of study drug for the first week only; and at weeks 4, 8, 12, and 16 to assess stuffy/blocked nose, runny nose, itching/sneezing, nose crusting/dryness, burning/discomfort, bleeding, cough, postnasal drip, sore throat, and taste disturbance using a 4-point scale (0=absent, 3=severe). Four hundred three patients were included in the analysis; 110 patients completed the 16-week study. Overall, 24.6% of reported AEs were treatment related. AEs were typical of opioids, generally mild to moderate, unrelated to dose, and led to study discontinuation in 0.9% of patients during titration and 4.5% during established treatment. Treatment-emergent AEs were attributed either to disease progression (13.9%) or to events usually associated with opioids; 1 of 80 deaths was possibly related to FPNS (constipation, intestinal perforation, peritonitis); 15.1% of patients had nonfatal serious AEs. Objective assessments by clinicians and subjective nasal assessments by patients showed no clinically significant effects. Implications for nursing practice include appropriate selection of patients who are opioid tolerant with BTCP and who can follow instructions for medication use. Patients should also have intact nasal mucosa.

1053472

ONLINE COMPREHENSIVE ONCOLOGY COURSE FOR NOVICE ONCOLOGY NURSE PREPARATION. Annette Welch, MS, RN, OCN[®], Nursing Education, Huntsman Cancer Hospital, Salt Lake City, UT; and Mary-Jean Austria, RN, OCN[®], Nursing Education, Huntsman Cancer Hospital, Salt Lake City, UT

Huntsman Cancer Hospital (HCH) is a 50 bed inpatient oncology hospital in Salt Lake City, Utah. An expansion to 100 beds will be completed in the fall of 2011. This creates the need to hire and immerse nurses into an oncology setting. Meeting this challenge has been a strategic goal of the HCH nursing education department. Taking into account current economic trends, the challenge facing the HCH Nursing Education Department was to utilize current advancements in information technology to create and maintain an on-line interactive course that will aid in the foundational preparation of oncology nurses. Nine oncology foundation modules were developed over eight months. Two HCH educators created, illustrated, animated, and voice recorded these modules using Adobe[®] Captivate[®] e-Learning software. The principles of adult learning that were incorporated into the module design included concepts of interactive learning, self-directed knowledge acquisition, and autonomy. Learners accessed the modules using Blackboard[®], an educational technology web site. This site allows flexible asynchronous progression through the course, interaction capability with peers and course instructor and immediate feedback to exams. Instructors have the ability to assign modules separately or as a whole, provide individual clarification and tutoring to learners through discussion boards and confidential contact, track the progression of learners, and solicit anonymous evaluation for each module. Course content, design, level of understanding, and effectiveness of presentation were evaluated throughout the development process using feedback from student volunteers, new graduates, in-house oncology experts, and education specialists. Following completion of each module, an evaluation is required of the learner. This includes relevancy of learning objectives, ease of completion, ability to meet overall goals of the course, and relevancy of content to clinical oncology practice. The outcome of these evaluations is pending. Oncology nurse educators must be leaders in developing sustainable instruction that provides learners

with innovative methods to increase skills and knowledge base. Measurements of quality and high levels of student engagement must be evident in these enterprises. Innovation in oncology education comes from using solid education foundations combined with the interactive potential of on-line modules, dissemination abilities, and up-to-date learning modalities.

1053483

MULTIDISCIPLINARY CARE MODEL FOR CANCER SURVIVORSHIP CARE. Fran Zandstra, RN, MBA, OCN[®], Cancer Survivorship, MD Anderson Cancer Center, Houston, TX; Guadalupe Palos, RN, LMSW, DrPH, Cancer Survivorship, MD Anderson Cancer Center, Houston, TX; Maria Rodriguez, MD, Cancer Survivorship, MD Anderson Cancer Center, Houston, TX; Terri Wheeler, RN, MSN, WHNP-BC, Gynecologic Oncology, MD Anderson Cancer Center, Houston, TX; Kathleen Denton, PhD, Cancer Survivorship, MD Anderson Cancer Center, Houston, TX; and Charles Levenback, MD, Gynecologic Oncology, MD Anderson Cancer Center, Houston, TX

According to the National Cancer Institute (NCI) nearly 12 million people are living with a history of cancer compared to three million in 1971. A key recommendation proposed in the Institute of Medicine's From Cancer Patient to Cancer Survivor: Lost in Transition report was to establish cancer survivorship as a distinct phase of care and ensure the delivery of appropriate survivorship care. To describe an innovative multidisciplinary model of care used to provide services to survivors of gynecological cancers. Patients diagnosed with gynecological (gyn) cancers receiving care post-treatment care in an outpatient clinic of a major comprehensive cancer center were eligible for transition to the Survivorship Clinic. Three major steps in the initial phase were used to develop the Multidisciplinary Care model. They were: 1) engage leaders and experts; gynecologic oncologist, radiation oncologist, bone health specialist, nurses, social workers, nutrition, psychologist, librarian and administrators 2) conduct an extensive literature review of surveillance, treatment late effects, cancer prevention and screening, quality of life 3) develop an electronic summary of care. Practice algorithms were developed in four major domains of care: surveillance of primary malignancy; cancer prevention and screening; monitoring of late effects; and assessment of psychosocial functioning. Survivors were transitioned and seen by a nurse practitioner or gynecologic oncologist. A disease specific algorithm guided the visit and a Passport Plan for Health was personalized to the survivor's needs. To gather preliminary data on the pilot's effectiveness, we collected data from clinical activity and patient satisfaction surveys. From September 2008-March 2010 a total of 221 Gyn cancer patients were transitioned to the Gynecological Survivorship Clinic. 163 patients received survivorship services, and 163 individualized passports were developed and reviewed with survivors. 97% of survivors were appropriately referred for mammograms, 93% for bone density screening and 80% for colorectal screening. Data from the survivor satisfaction indicated that 100% were satisfied with services. Nurses are key in educating survivors and building collaborations with providers to deliver coordinated evidence based survivorship care.

1053500

ATYPICAL CLINICAL RESPONSES TO IMMUNOTHERAPY IN PATIENTS WITH ADVANCED MELANOMA. Blanca Ledezma, MSN, NP, LA Pain and Wellness Institute, Los Angeles, CA

Using immunotherapeutic agents such as interleukin-2 or ipilimumab in patients with advanced melanoma can lead to atypical response patterns not necessarily captured by standard response criteria and can be a source of anxiety for patients accustomed to the responses observed with chemotherapy. The multiple response patterns are likely secondary to the agent's mechanism of action and reflect of the time required for the immune system to mount

an effective antitumor response. An understanding of these novel response patterns by oncology nurses is critical to successfully educate patients. Providing education on response patterns and time to response can decrease patient and caregiver psychological stress. To provide the oncology nurse with recommendations on patient education designed to reduce patient anxiety and case examples resulting from our center's immunotherapy experience. In order to reduce psychological distress, patients were educated prior to starting the therapy and at every point of contact. If the patient was still anxious, patient-friendly literature was provided. Basic information on immune function and mechanism of action were described in a simplified format by using the break and gas pedal analogy. Patients were told that the response patterns can include apparent progression (enlarging lesions), but many patients still continue to have clinical benefit. The mechanism of action of ipilimumab was also used to explain why the first scanning period is not until week 12, unlike chemotherapy. Patients were asked to verbalize education received, such as the response patterns or how the treatment differed from chemotherapy. A decrease in patient and caregiver questions and phone calls was observed following implementation of the educational initiatives. This type of educational program is highly applicable to oncology nurses because treatment regimens in general are moving away from cytotoxics and moving toward targeted and immunotherapeutic agents. Patients receiving ipilimumab may have different response patterns relative to chemotherapy; in some cases response may take weeks or months. Nurses are often the first and most frequent point of contact for the patient and are uniquely situated to provide education that can manage expectation and prevent or alleviate psychological stress.

1053504

STERIOD INDUCED HYPERGLYCEMIA IN THE CANCER PATIENT: THE AMBULATORY NURSING IMPERATIVE. Mary Ellen Beitel, BS, BSN, RN, OCN®, Ambulatory Medical Oncology, Memorial Sloan Kettering Cancer Center, New York, NY

The use of steroid medication is a common component of therapy in patients being treated for cancer. Prolonged use of steroids can lead to hyperglycemia - a condition with significant adverse effects, such as vascular complications, renal compromise, and infection. There is no definitive standard of care for the cancer patient with steroid-induced diabetes. This presentation will discuss the mechanisms of steroid induced diabetes and describe the intrinsic physiological processes of insulin resistance in order to advance the nurses' ability to anticipate, recognize, and manage steroid induced diabetes as it develops. Educating the patient in self-care measures related to new onset steroid-induced diabetes is an oncology nursing challenge. It is clear, however, that when patients understand the dynamics of physiologic glucose and insulin metabolism, they are less likely to be deterred by the complexity of insulin therapy. In caring for patients, nurses must use a variety of teaching tools such as personalized insulin regimens with blood glucose parameters. Education sessions must include insulin delivery devices and compatible accessories which patients can manipulate while gaining confidence. Visual aids related to hyper and hypoglycemia are used so patients will readily recognize symptoms in themselves and intervene. Laboratory studies related to preserving and evaluating critical organ function are simplified for the patient's understanding and to promote adherence to the treatment plan. Improved blood glucose control, as demonstrated by HbA1c within an acceptable range for the duration of steroid therapy, will decrease risk of adverse events. At this NCI designated cancer center, patients who were educated, as described above, demonstrated improved compliance and decreased values of HbA1c within pre-set limits. Steroid induced diabetes is predictable and manageable. Ambulatory oncology nurses are in a position to proactively consider the cumulative effects of steroids on patients. Future initiatives should cultivate nurse's awareness, knowledge and clinical skills related to diabetes management in order to promote the patient's ability for self care.

1053510

FENTANYL PECTIN NASAL SPRAY AND PATIENT ACCEPTABILITY: LONG-TERM CONSISTENT AND RELIABLE EFFECTS IN THE TREATMENT OF BREAKTHROUGH CANCER PAIN.

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Fentanyl pectin nasal spray (FPNS) has been developed to avoid "run-off" and to optimize fentanyl absorption consistent with a typical breakthrough cancer pain (BTCP) time course. Previous controlled trials have confirmed its efficacy and rapid onset of effect compared with placebo and immediate-release morphine sulfate. Examine patient acceptability, consistency, and reliability of effect with FPNS up to 16 weeks. Phase III, long-term safety, open-label study. Eligible patients, who experienced 1-4 BTCP episodes/day while taking ≥ 60 mg/day oral morphine (or equivalent) for cancer-related pain, entered the trial directly and were initially titrated to an effective dose or entered the trial after participation in a previous controlled study. Open-label FPNS could be used to treat ≤ 4 BTCP episodes/day during a 16-week assessment period. Acceptability measures (4-point scale: 1 = not satisfied; 4 = very satisfied) included overall satisfaction and speed of pain relief after each treated episode, ease of use, and reliability and convenience at the end of weeks 1, 4, 8, and 12. Use of rescue medication was also recorded. 356 patients entered the open-label treatment phase of the study; 123 patients (24,012 episodes) had completed at least 12 weeks of therapy and were included in the acceptability analysis. A high satisfaction score (3 or 4) was reported in 89.7% of treated episodes for overall treatment satisfaction and in 90.2% for speed of relief. Between 89% and 98% of patients consistently reported being satisfied with the ease of use, convenience, and reliability of FPNS. Mean acceptability scores (by patient) for ease of use, reliability, and convenience either were maintained or improved through week 16. No patient reported nonsatisfaction. Levels of satisfaction and acceptability were unrelated to dose. Across the whole study, of 42,227 FPNS-treated episodes (N = 356), 94% required no rescue medication. Of 205 patients who completed the open-label treatment phase (up to 16 weeks), 146 (72%) elected to continue treatment with FPNS in the ensuing extension period. Offering an intranasal pain medication may alleviate concerns for patients that have oral complications associated with cancer or cancer-related treatments. Oncology nurses should be aware of these new fentanyl formulations in development.

1053535

OPENING PANDORA'S BOX: DISCUSSING SEXUALITY ISSUES WITH ONCOLOGY STAFF AND SURVIVORS. Carol Blecher, RN, MS, AOCN®, APNC, Nursing, Trinitas Comprehensive Cancer Center, Elizabeth, NJ; and Grisela Hidalgo, LCSW, Social Services, Trinitas Comprehensive Cancer Center, Elizabeth, NJ

Quality of Life issues have been highlighted as important topics for discussion in cancer survivorship. Sexuality is a vital element of our functioning as human beings. Due to the nature of, and the taboos surrounding sexuality, it is often very difficult for both patients and the health care team to discuss these issues openly. The literature contains information regarding sexuality, how to open a discussion and the importance of performing assessments. Despite these facts, the sexual risks related to a diagnosis of cancer

and cancer treatment are rarely discussed, though greater than 50% of cancer survivors report issues related to sexual function. The purpose of this project was to develop programs for both staff and patients regarding sexuality. They were designed to provide a forum for discussion, to overcome barriers regarding discussions of sexuality. Staff education included in-services regarding sexuality presented by the APN. The slides and notes were placed on the shared drive, to be reviewed at any time. Articles regarding sexuality were distributed and discussed in Journal Club. A speaker program on Sexuality was presented. Patient centered programs included a slide presentation followed by discussion at Survivorship Support Group meetings. Sexuality was also included in our Prostate and Breast Cancer Support Groups. Information regarding sexuality was included during initial patient education and in QoL issues during survivorship discussions. Evaluation of presentations was performed using standard course evaluation forms for all of the programs. Patients were also given a questionnaire which contained queries regarding their satisfaction with discussion of sexual issues and function. During discussions with the health care providers we will explore feelings and personal barriers regarding sexuality and identify those individuals who are most comfortable with discussions regarding sexuality. If a member of the staff is uncomfortable they can call on these people to step in and assist. Through education regarding sexuality and the taboos surrounding this subject we are attempting to alleviate some of the discomfort felt by both patients and health care professionals and facilitate open discussion. Sexuality assessment will become standard of care improving quality of care for our patients.

1053536

A NEW TREATMENT OPTION FOR CHEMORADIATION-INDUCED ORAL MUCOSITIS AFTER AMIFOSTINE FAILURE.

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Nasopharyngeal carcinoma (NPC) is a cancer originating in the nasopharynx where the nasal passages and auditory tubes join the remainder of the upper respiratory tract. The standard practice of treating patients with advanced nasopharyngeal carcinoma using radiation and chemotherapy is used to reduce cancer deaths but non-cancer related deaths and toxicity problems have been shown to increase with concomitant chemoradiation therapy. An 18-year old male patient was diagnosed with nasopharyngeal carcinoma (stage IV, bilateral midline mass) at a cancer treatment center in Alabama. The patient received cisplatin with 5-fluorouracil as a continuous infusion and intensity-modulated radiation therapy (IMRT). The patient was given amifostine at the start of therapy over a month to prevent the onset of mucositis. Amifostine was discontinued after one month due to transient hypotension and a pronounced drop in systolic blood pressure. Consistent with chemoradiotherapy, the severity of mucositis was aggravated as the patient's treatment continued and amifostine was discontinued. Signs and symptoms of mucositis included swollen gums, mouth sores, pain and difficulty in swallowing and talking. The patient experienced significant amounts of whitish patches of pus in the mouth and on the tongue. The patient was given NeutraSal, a new product indicated to relieve the discomfort of oral mucositis in patients undergoing radiation and/or high dose chemotherapy for cancer. NeutraSal®, a supersaturated calcium phosphate rinse (Invado Pharmaceuticals, USA) is a powder dissolved in water before use that forms an electrolyte solution resembling human saliva containing high levels sodium, calcium, phosphate and bicarbonate. With two days of NeutraSal treatment at four doses per day, the patient's mouth completely cleared of pus, inflammation and ulcerations. Oral examination of the oral mucosa showed no signs of bacterial or fungal infections. The patient's pain and nausea and vomiting were controlled on by oral medications. The patient did not experience severe xerostomia during his chemoradiation regimen. Oral mucositis remains a challenge for

healthcare providers and patients undergoing chemoradiation in head and neck cancer, especially with patients that cannot tolerate amifostine. NeutraSal, an electrolyte mouthrinse containing high concentrations of sodium, calcium, phosphate and bicarbonate may be a new option to relieve oral mucositis.

1053546

CHINESE AMERICAN BREAST CANCER SURVIVORS' EXPERIENCES OF MANAGING LYMPHEDEMA.

Mei R. Fu (Qiu), PhD, RN, ACNS-BC, New York University, New York, NY

More than 40% of breast cancer survivors in the US have developed lymphedema, a chronic syndrome of abnormal swelling and multiple distressing symptoms. Daily and lifelong interventions are required to managing swelling and symptoms to prevent cellulitis and systemic infections. The incidence and severity of lymphedema and symptoms have been reported to be much higher among non-white ethnic minority survivors. Lack of culturally and linguistically appropriate patient care is a major factor impeding effective provision of health care, including lymphedema care. It is unknown how ethnic minority survivors manage lymphedema in their daily lives. To describe Chinese American breast cancer survivors' experience of managing lymphedema with special attention to cultural factors that may promote or impede daily lymphedema management. A Husserlian descriptive phenomenology was used as a guide for developing a bracket, gathering data, and analyzing data. A qualitative research design with a descriptive phenomenological method was used. A sample of 13 Chinese American survivors with chronic lymphedema were recruited in eastern US. Three in-depth interviews were conducted with each participant, a total of 39 interviews were completed, audiotaped, and transcribed. Data were the women's perceptions, actions, and intentions pertaining to their experience of managing lymphedema. Data were analyzed to identify the essential structures of the experience using a descriptive data analysis. Facing the life-long commitment to lymphedema, Chinese women initiated and continued their efforts to manage lymphedema even when health disparity limited their access to information and standard lymphedema treatment. Six essential structures that constitute the experience were identified, discussed with participants, and compared to the relevant literature: (a) facing lymphedema reality, (b) seeking for mainstream treatment, (c) experimenting Chinese medicine (acupuncture, acupressure, wax massage, elevation, or herbs), (d) seeking out Chinese diet or food that help fluid flow, (e) focusing on daily exercises (walking, Chinese folk dancing, tai chi, Chinese martial arts), and (f) sustaining myself emotionally. Chinese American women needed interventions to provide linguistically appropriate information regarding lymphedema treatment and management and geographically and financially accessible treatment facilities. Future research should target on testing some unconventional approaches used by the women that may promote effective lymphedema management.

1053550

HEALTH POLICY ADVOCACY BEGINS IN UNDERGRADUATE NURSING SCHOOL.

Patricia Poirier, PhD, RN, AOCN®, School of Nursing, University of Maine, Orono, ME

Health policy is a major concern throughout the world. According to Mary Wakefield registered nurse and current administrator of the Health Resources and Services Administration "a nurse's voice can be one of the most powerful heard, when that voice is used." Current estimates place the number of registered nurses in the US at 2.6 million. That represents many powerful voices! Nurses are often hesitant to become involved in health policy for many reasons including being intimidated by the process. Nursing school is an ideal place to begin to involve nurses in health policy advocacy. Many schools of nursing have a health policy course as part of their undergraduate curriculum. In our school a stand-alone course is not currently feasible. Therefore

health policy advocacy is integrated throughout the program of study. ONS provides many resources that can be utilized to teach health policy to undergraduate nursing students including Health Policy "Train the Trainer" and the on-line course Advocacy 101. In the sophomore fundamentals of nursing course students are introduced to the process of health policy advocacy beginning with "Civics 101" an overview of the political process at both the national and state levels. Students are assigned to complete the on-line Advocacy 101 course through ONS. Important health policy issues are identified in class through an open discussion format. Students suggest ways that they as nurses can take action and then write to their elected or appointed policymakers about a health policy issue, identifying what action they wish the official to take. Students receive a grade on their letter with extra credit given if they actually send the letter to the appropriate policymaker. Issues pertinent to oncology nurses that students have identified include the nursing workforce shortage and increasing costs of prescription drugs. Several students have been invited to meet with policymakers at the state and national levels in their district offices. Students have presented their ideas at boards of directors of local health agencies. This feedback reinforces to students that yes, their voices are heard.

1053552

EFFICACY OF FENTANYL PECTIN NASAL SPRAY COMPARED WITH IMMEDIATE-RELEASE MORPHINE SULFATE IN BREAKTHROUGH CANCER PAIN EVALUATED IN A RANDOMIZED DOUBLE-BLIND, DOUBLE-DUMMY CROSSOVER STUDY.

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The typical breakthrough cancer pain (BTCP) episode is rapid in onset (~3 minutes) and has a median duration of 30 minutes. Although oral immediate-release morphine sulfate (IRMS) usually takes more than 30 minutes to become effective, this remains the mainstay of BTCP treatment. It has been reported that fentanyl pectin nasal spray (FPNS) rapidly provides significant pain relief compared with placebo. Compare the efficacy of FPNS with that of IRMS in opioid-tolerant cancer patients with BTCP. Randomized double-blind, double-dummy crossover study. Patients (N=110) experiencing 1-4 BTCP episodes/day while taking ≥ 60 mg/day oral morphine (or equivalent) for background pain entered a double-blind, double-dummy (DB/DD), multiple-crossover study. Those who completed an open-label titration phase (N=84) continued to a DB/DD phase; 10 episodes were randomly treated with FPNS and over-encapsulated placebo (5 episodes) or IRMS and nasal spray placebo (5 episodes). Pain intensity (PI) (11-point scale) and pain relief (5-point scale) were measured at 5, 10, 15, 30, 45, and 60 minutes. The primary endpoint was pain intensity difference at 15 minutes (PID15). Secondary endpoints included summed pain intensity difference (SPID), onset of pain improvement (≥ 1 -point PI decrease), and clinically meaningful pain relief (≥ 2 -point SPID decrease). Primary statistical analyses of efficacy were performed on the modified intent-to-treat population. FPNS significantly improved mean PID15 scores compared with IRMS ($P=0.0396$; $N=79$). Statistically significant differences in PID scores were sustained from 15 to 60 minutes ($P<0.05$ for all time points). Seven hundred forty BTCP episodes were analyzed: 57.5% of FPNS-treated episodes showed onset of pain improvement by 5 minutes, and 95.7% showed it at 30 minutes ($P<0.05$ vs IRMS). Clinically meaningful pain relief was seen in 64.8% of FPNS-treated episodes by 10 minutes ($P=0.0146$). Furthermore, more

FPNS-treated episodes had mean SPID values of ≥ 3 and ≥ 4 at 10 minutes (46.8% and 33.3%, respectively; $P<0.05$ vs IRMS). FPNS provides clinically meaningful pain relief and a more rapid onset of analgesia than IRMS, therefore better matching the typical time course of a BTCP episode.

1053575

ENGAGING ONS CHAPTER MEMBERS: INCREASING THE USE OF SOCIAL MEDIA IN YOUR CHAPTER. Jennifer Graff, RN, BSN, OCN[®], CHPN, Thomas Johns Cancer Hospital, Richmond, VA

The Oncology Nursing Society (ONS) encourages its members to get involved with oncology in any way they can, including connecting with others over the internet. Facebook, Twitter, and LinkedIn are just a few sites that increase connectivity of nurses from around the world. ONS uses social media to also help connect those nurses unable to go to Congress and still be a part of the action. In Richmond, there was not much use of social media in the chapter. The webmaster of the Richmond area chapter of ONS sought to increase connectivity with the members in the local chapter who are otherwise separated by corporate lines. The webmaster and the board wanted to see if posting on the social media sites increased chapter participation. A convenience poll of members at a meeting showed that 80% already had a Facebook page. After approval from the board, the webmaster presented a PowerPoint presentation to the chapter showing the chapter's Facebook page and explaining the other forms of social media. A challenge was made to the chapter to "friend" the chapter's Facebook page. Public events, educational sessions, and meetings will be posted to the Facebook page, which automatically posts to the friends' pages. This will keep everyone in the loop without the members having to log onto a different site (i.e. the local chapter website). A query on the RSVP form for chapter meetings will discover how the member found out about the meeting. The chapter is still in the data collection phase of this project, with final data completing by May. The expectation is that members will be able to connect with the ONS chapter as they are logging onto Facebook to catch up with family and friends and that no one will miss a meeting announcement or educational opportunity. Once the first phase of this project is complete, plans are in place to also explore other sites such as Twitter. Having an energetic and enthusiastic chapter invigorates all of oncology nursing in the Richmond area. Through improved chapter networking, more community outreach programs are planned to better serve our patients needs.

1053601

NURSE, PHYSICIAN, AND PATIENT PERSPECTIVES ON CANCER PATIENTS HAVING ONLINE ACCESS TO LABORATORY RESULTS. Elizabeth Rodriguez, DNP, RN, OCN[®], Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; Bridgette Thom, MS, Nursing, Memorial Sloan Kettering Cancer Center, New York, NY; and Susan Schneider, PhD, RN, AOCN[®], FAAN, School of Nursing, Duke University, Durham, NC

Web-based patient portals allow patients to interact with their providers and access various applications. For the past four years, the patient portal at this NCI-designated comprehensive cancer center provided patients online access to appointments, hospital and physician bills, patient education, forms, and secure messaging (e-mail) with the provider's office. Patient feedback indicated a strong desire for online access to their laboratory results; however, nurses and physicians expressed concerns about the effect on workload and fear of increasing patient anxiety. To compare the perspectives of oncology nurses and physicians regarding online access to lab results for cancer patients pre- and post-implementation, and to evaluate the impact on workload. To assess patients' perspectives related to impact on satisfaction, communication with their provider, and quality of care post-implementation. To

measure the impact on patient portal registrations and number of visits to the laboratory results page. The Medical Board approved the display of laboratory results on the patient portal, and a clinical committee convened to determine which results to display. The information systems team built the interface between the patient portal and the clinical information system. In June 2009, the laboratory results display was implemented for over ninety laboratory tests. Nurses demonstrated greater support than physicians with regards to patient access, their level of comfort with patient access, and the patient's ability to interpret results. Survey results and the workload study demonstrated no change in workload. Patient surveys revealed high levels of satisfaction, indicating positive impact on patient-provider communication and quality of care. Usage statistics demonstrated an increase in patient portal registrations and visits to the laboratory results page over the implementation period. Patient portals offer patients an increased level of access to both their providers and health information. Providing patients with online access to laboratory results is a growing trend. In the oncology population, providing clinical information to patients has the potential to increase satisfaction while engaging patients in their own care. Considering input from nurses, physicians, and patients creates a comprehensive approach toward implementation that may support sustainability of the innovation.

1053611
KNOWLEDGE AND ATTITUDES REGARDING PAIN AMONG ONCOLOGY NURSES. Frances Cartwright, PhD, RN, AOCN®, Oncology Services, New York University Langone Medical Center, New York, NY; Wendy Budin, PhD, RN, FAAN, Nursing Research, New York University Langone Medical Center, New York, NY; and Ann Marie Conlon, MSN, RN, Pain, New York University Langone Medical Center, New York, NY

Decades of research document inadequate pain management. Improved pain management benefits not only patients but also health care institutions. The cost of uncontrolled pain is enormous leading to increased morbidity, extended lengths of stay and repeated hospital admissions, also leading to lost income and increased insurance coverage. The assessment and management of pain among patients with cancer is a particular challenge for nurses. The purpose of this study was to determine the knowledge and attitudes about pain and pain management among oncology nurses. By surveying nurses' current knowledge and attitudes about pain and its management, deficiencies can be identified and focused educational interventions can be provided. As part of an interdisciplinary pain initiative in a large urban academic medical center in the northeastern U.S. all nurses, physician, physical and occupational therapists were invited to complete an online version of McCaffery and Ferrell's Knowledge and Attitude Survey Regarding Pain. Of the 479 registered nurses who responded to the survey, a subsample of 71 nurses who worked exclusively in oncology was analyzed for this presentation. Descriptive statistics were used to determine total score and ratings of individual items. Data analysis revealed some misconceptions about administration and duration of analgesic administration; however, almost all nurses (96%) were not concerned about overmedication or addiction in patients receiving medication for pain. Knowledge of pharmacology items was consistently lower than that of non-pharmacology items. There were 11 pharmacology items in which more than 50% of the nurses answered incorrectly. Continuing education regarding pain management remains important for oncology nurses. Adoption of evidence-based practice requires ongoing education of nurses. Data from this study are being used to design a curriculum involving content about pain and pain management.

1053612
INTEGRATING PSYCHOSOCIAL CARE INTO ONCOLOGY PRACTICE. Carol Tringali, MS, RN, AOCNS®, Penn State

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The number of people touched personally by cancer continues to grow. Therefore, people experiencing emotional distress in need of psychosocial support has increased. In 2007, the Institute of Medicine (IOM) released the report - Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs. The Oncology Nursing Society (ONS) assembled a project team in 2009 to survey oncology nurses' current psychosocial care practices and perceived needs related to care of patients and families with cancer. The survey, based upon recommendations published in the 2007 IOM Report - Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs, examined the following categories of nursing practice: aspects of nursing practice related to psychosocial care, barriers/problems encountered in provision of care; nursing educational needs; met and unmet needs of patients/families; and recommendations for future research in psychosocial care. Survey results were compiled. A report was presented to the ONS Board. One key recommendation in the report was development of an education plan for members to address specific needs identified by the project team. An education project team convened in 2010 to address this education recommendation. This team embarked upon a themed "2011 - Year of Psychosocial Care". Throughout the year, the team will implement presentations that focus on psychosocial assessment, intervention, and education to increase competence for integrating psychosocial care into oncology practice. The team will assemble and update resources like web courses, a psychosocial resource webpage, and a supplement of CJON and ONF psychosocial articles published in the year 2011. Examples of the educational opportunities and resources will be presented, as well as information to assist local chapters or institutions in promoting the 2011 ONS initiative "Year of Psychosocial Care." In the upcoming "2011-Year of Psychosocial Care", oncology nurses will improve practice skills in psychosocial assessment, interventions, follow-up, education, and program development. Oncology nurses can positively impact quality improvement in the management of the whole patient during their cancer experience. Raising awareness of psychosocial needs, barriers, recommendations, and resources will empower oncology nurses to improve practice and meet the standard endorsed in the IOM Report.

1053619
INVESTIGATING POCKET CARDS TO IMPROVE CANCER PATIENT KNOWLEDGE OF CHEMOTHERAPY. Carla Johnson, RN, MN, OCN®, Mayo Clinic in Arizona, Scottsdale, AZ; Kelly K. Curtis, MD, Mayo Clinic in Arizona, Scottsdale, AZ; and Donald W. Northfelt, MD, Mayo Clinic in Arizona, Scottsdale, AZ

Cancer patients typically receive treatment-related written information when starting chemotherapy. We observed that cancer patients at Mayo Clinic often cannot recall cancer drugs' names and expected side effects, despite receiving written information. We investigated whether pocket cards could improve cancer drugs' names and side effects recall compared to written information alone. To study the effectiveness of chemotherapy pocket cards as a tool to assist patients in their retention and knowledge of chemotherapy treatment and potential side effects. Knowles theory of androgogy. Malcolm Knowles theory for adult learning emphasized adults as self-directed and responsible for decision making. Adults approach learning as problem-solving and they learn best when the information is relevant and of immediate use. In this study we utilized our chemotherapy orientation class and plus or minus chemotherapy pocket cards to present relevant materials for our cancer patients to enhance their learning and

retention of information. We randomized 100 cancer patients starting chemotherapy to receive pocket cards plus written information or written information alone. Each pocket card listed the cancer drugs' names and 3-5 common drug side effects. Written information included a drug information sheet and printed information from the CareNotes™ System (Thomson Reuters), listing cancer drugs' names and common side effects. Cancer patients were tested for cancer drugs' names and side effects recalled at treatment start, again at 4-6 weeks and 8-10 weeks. RESULTS Of 100 cancer patients randomized (50 to pocket cards plus written information and 50 to written information alone), 66 completed the study. Demographics: median age 64 years (24-81 years); 41 male; 59 female. At 8-10 weeks, no significant difference between groups was observed for cancer drugs' names recalled correctly ($p = 0.79$) or median side effects recalled ($p = 0.34$). Cancer drugs' names recalled declined at 8-10 weeks (29% named cancer drugs' names correctly at treatment start versus 20% at 8-10 weeks). Median side effects recalled was unchanged at 8-10 weeks ($p = 0.19$).

Pocket cards do not appear to improve cancer patients cancer drugs' names recall better than written information alone, nor do pocket cards increase recall of drug side effects. Cancer patients recall of cancer drugs' names decreases over time. Additional education provided several weeks after chemotherapy has begun may be warranted to reinforce cancer patients knowledge of important treatment-related information.

1053622

IMPACT OF A PATIENT ACUTE CHANGE TEAM AT A CANCER HOSPITAL. Jennifer Kelley, BSN, OCN®, Huntsman Cancer Hospital, Salt Lake City, UT; Kris Gilbert, RN, Quality Patient Safety, University of Utah, Salt Lake City, UT; Bernadette Bittner, APRN, Huntsman Cancer Hospital, Salt Lake City, UT; and Susan Childress, RN, MN, Director of Nursing, Huntsman Cancer Hospital, Salt Lake City, UT

The significance of providing a mechanism for rapid response to acute patient conditions is well documented in the literature. Most programs focus efforts on inpatient populations where patients are routinely more acute. Cancer hospitals, however, have many unique challenges, one of them is the high acuity of their outpatient population. Specifically outpatient BMT patients, Phase I trials, and complex chemotherapy infusions. This organization has found that a Patient Acute Change Team (PACT) has made a positive impact on the care of their outpatient population as well as the inpatient areas. Support cancer patients across the continuum when presenting in distress with acute changes. Initially suggested by a nurse educator as best practice, this program evolved through the efforts of a multidisciplinary work team. With the support and engagement of the CPR committee, the University of Utah Quality Department, Huntsman Nursing Education Department, and cancer hospital administration, a solid program was implemented. Guidelines and a policy were developed, staff education and tools produced, and evaluation occurred with every event to produce a strong program. Data will reflect that a year after implementation, patients at risk have received timely interventions and appropriate level of care. Moral distress associated with feelings of helplessness, have been addressed as staff nurses receive the support of a team of experts when their patients present with acute changes. Nursing staff and other members of the team also receive individual education during the event to help them with critical thinking skills in a supported nonjudgmental environment. As a national patient safety goal, many organizations have embraced these teams to respond to patient acute changes. This project reflects the need to have a program in place that supports the outpatient arena as much as the inpatient population.

1053631

IMPROVED ADHERENCE TO ORAL ENDOCRINE THERAPY THROUGH INCREASED NURSING EDUCATION AND

SUPPORT. Penny Moore, RN, MSN, OCN®, Comprehensive Breast Center, The James Cancer Hospital and Solove Research Institute, Columbus, OH; Joanne Lester, PhD, CRNP, AOCN®, Comprehensive Breast Center, The James Cancer Hospital and Solove Research Institute, Columbus, OH; Pennie Arch, RN, BSN, OCN®, Department of Nursing Research, James Cancer Hospital and Solove Research Institute, Columbus, OH; Kim Catania, CNS, AOCN®, Department of Nursing Research, James Cancer Hospital and Solove Research Institute, Columbus, OH; and Amy Rettig, CNS, CBHN, Comprehensive Breast Center, The James Cancer Hospital and Solove Research Institute, Columbus, OH

To achieve optimal therapeutic and survival benefits from adjuvant endocrine therapy in women with hormone receptor positive breast cancer, oral therapy is recommended for a period of at least five years. Recent studies document that less than half of all women take their adjuvant oral endocrine therapy as prescribed. Patient education is vital to patient adherence to treatment modalities. Clinic nurses in this Midwest comprehensive breast clinic noted that patients seen in follow-up often revealed they had stopped taking their oral endocrine. Observations of patient education administered by clinic nurses demonstrated gaps related to adherence to oral endocrine therapy, including (1) absence of education about the reason for taking adjuvant treatment, e.g. demonstrated increased survival rates and decreased risk of recurrence, (2) lack of detailed teaching guidelines, and (3) absence of follow-up calls by nursing staff for newly-prescribed oral agents (similar to those in practice for chemotherapy). The purpose of this pilot quality project was to evaluate a short-term, focused nursing intervention in breast cancer survivors initiating oral endocrine therapy for the first time. Elements of the intervention included education to enhance about ongoing adherence, benefit of adherence to cancer therapy, and personalized follow-up phone calls. All patients received 1:1 education using the new teaching guideline. Patients were asked if they understood the importance of taking their therapy as prescribed. A script for follow-up telephone calls was created in the electronic medical record. Items covered in follow-up telephone calls included the ability to obtain prescription, cost, and experienced symptoms. The Modified Morisky Scale was used to assess adherence. Patients were also asked if they found the call helpful and if they were satisfied with the patient teaching they had received. A pilot project involving thirty patients was completed with the above educational interventions. Follow-up telephone calls occurred for patients using the scripted telephone call back tool. Patients reported adherence, satisfaction with patient teaching, and noted support and additional education when side effects were reported. This pilot quality project offered nurses the opportunity to improve patient outcomes through focused education and follow-up telephone calls. Future recommendations include continuation of the practice of focused education that emphasizes purpose of therapy and importance of adherence. Follow-up support is also recommended. Due to the experienced difficulty in reaching patients by telephone during working and non-working hours, properties of the patient portal within the electronic medical record patient portal will be explored to assist with communication.

1053640

THE IMPACT OF MULTIPLE SYMPTOM EXPERIENCES ON QUALITY OF LIFE IN KOREAN PATIENTS WITH LUNG AND STOMACH CANCER. Eunjung Ryu, PhD, RN, College of Medicine/Nursing, Chung-Ang University, Seoul, Republic of Korea; Kyung Sook Choi, PhD, RN, College of Medicine/Nursing, Chung-Ang University, Seoul, Republic of Korea; and Mei R. Fu (Qiu), PhD, RN, ACNS-BC, New York University, New York, NY

Stomach and lung cancers are the most commonly diagnosed cancers and leading causes of death in Korea. Clinical practice

has revealed that patients with stomach and lung cancer very often experience multiple symptoms through cancer diagnosis, treatment, recovery, or at the end of life. Advances in cancer treatment have lengthened survival from these two deadly cancers. The identification of the impact of multiple symptoms on patients' quality of life (QOL) during disease and treatment trajectory is essential to the successful completion of cancer treatment and ongoing recovery. To evaluate the impact of multiple symptom experience (symptom occurrence and distress) on QOL and identify the predictors for QOL in patients with stomach and lung cancer. The theoretic framework for the study is based on self-regulation theory. The framework suggests that the stressor (symptom occurrence) initiate the emotional response (distress). Stressor cues an individual to take action, ask for help, and use known coping behaviors to eliminate the stressor or to alleviate the emotional response to the stressor. If coping behaviors are adequate, the stressor is eliminated or distress is decreased. A sample of 101 male and female patients who were receiving active treatment for lung (n=60) and stomach cancer (n=41) completed the study. Data was collected using a Demographic and Medical Information, Symptoms Experience Index-Korean Version, the Eastern Cooperative Oncology Group performance status, and the Functional Assessment of Cancer Therapy-General Questionnaire. Data analysis included descriptive statistics, t-test, stepwise multiple regression. Model fit was evaluated through the R2 for the overall model and incremental change in R2. Symptom experience (summation of occurrence and distress) is significantly associated with QOL. Patients who scored higher in the symptom experience reported poorer QOL. Patients with stomach cancer reported higher symptom occurrences and poorer QOL than patients with lung cancer (t=2.165, p=.034). Higher symptom occurrences and poorer functional performance status were significant predictors for poor QOL. It is essential to assess multiple symptom experience in clinical practice. When patients report higher multiple symptom occurrence and poor functional status, nurses or other healthcare providers should implement interventions to alleviate symptoms and improve patients' functional status.

1053647

INCREASING NURSES' KNOWLEDGE OF CANCER SURVIVORSHIP: ASSESSING THE IMPACT OF ONLINE CONTINUING NURSING EDUCATION (CNE). Joni Watson, MSN, MBA, RN, OCN®, Nurse Oncology Education Program, Texas Nurses Foundation, Austin, TX; Kristin Hamlett, MA, MSLE, Nurse Oncology Education Program, Texas Nurses Foundation, Austin, TX; and Gina Kuenstler, BSN, RN, OCN®, Nurse Oncology Education Program, Texas Nurses Foundation, Austin, TX

The Nurse Oncology Education Program (NOEP) provides CNE to nurses in all fields to change professional practice and improve patient outcomes. According to the Institutes of Medicine, "A workforce of knowledgeable health professionals is critical to the discovery and application of health care practices to prevent disease and promote well-being." With nearly 28 million cancer survivors worldwide, nurses must be aware of the specific issues cancer survivors face everyday. In a 2009 NOEP survey of 521 nurses, 42% indicated the need to learn more about cancer survivorship. This presentation uses Howard's retrospective method to measure self-assessed change in nurses' cancer survivorship knowledge after completing electronic slidecasts on three topics - adolescent and young adult cancer, late effects, and sexuality. Learners used a 5-point scale to rate their knowledge of 11 content topics Before and After completing the slidecasts. Group averages for each content item were calculated and the difference evaluated in terms of the percentage change and the percent of potential improvement (PPI) achieved. PPI provides another measure of impact when little improvement can be measured either because initial scores are high or the total range is small and is calculated [(After - Before) / (Maximum Possible Score - Before)] x 100. Substantial knowledge change was measured for

all 11 content areas in the three courses. Percentage change ranged from 14.5% to 32.6% for the 11 content areas. Calculation of PPI revealed for all 11 measures, over half the possible improvement in self-assessed knowledge was achieved, as PPI varied from 51% to 62%. NOEP's online CNE has substantially increased nurses' self-assessed cancer survivorship knowledge. By removing the bias typically captured when the education itself changes the learner's understanding of the measured constructs, the retrospective methodology removes error and provides a more accurate measure of actual knowledge change due to the learning activity. Consideration of PPI (in addition to percent change) provides context for evaluation. In this case, PPIs of 50% or greater show these learning activities were highly effective in increasing nurses' self-assessment of their cancer survivorship knowledge.

1053672

ACHIEVING "MEANINGFUL USE" WITH THE USE OF ELECTRONIC FLOW SHEET DOCUMENTATION IN AN ACUTE CARE ONCOLOGY SETTING. Diane Llerandi, RN, MSN, AOCNS®, Nursing, Memorial Sloan Kettering Cancer Center, New York City, NY; Donna Miale-Mayer, RN, BSN, MSN, Nursing, Memorial Sloan Kettering Cancer Center, New York City, NY; Katie Ruan, RN, BSN, Nursing, Memorial Sloan Kettering Cancer Center, New York City, NY; Jacqueline Patterson, RN, BSN, Nursing, Memorial Sloan Kettering Cancer Center, New York City, NY; and Paul Honmyhr, RN, BSN, Nursing, Memorial Sloan Kettering Cancer Center, New York City, NY

Our 43 bed inpatient hematology unit recently integrated electronic flow sheets into nursing practice to achieve the goals outlined in the American Recovery and Reinvestment Act of 2009 relating to the maintenance of the patient's clinical information. Over the last two years, a multidisciplinary team consisting of acute care, critical care, PACU, pediatrics, and nursing informatics staff developed and refined an electronic flow sheet to monitor electronic continuous infusions, vital signs, and intake & output via a user-friendly interface. The goal of electronic flow sheet documentation is to improve accuracy, accessibility, legibility, patient safety, standardization, continuity of care and achieve «meaningful use» as defined by the Act. The pilot unit for the rollout was strategically chosen for its unique ability to utilize all aspects of documentation. The inpatient acute care hematology patient population requires frequent vital sign monitoring, high volume intravenous hydration, chemo/biotherapy, and multiple blood product transfusions. The team took advantage of the program's design by incorporating preset vital sign monitoring times in an attempt to aid in the decrease of patient falls and increase patient safety by required toileting of patients at each vital sign check and linking the 6:00am vital sign check with the daily weight in order to have weights available for rounds and administer diuretics earlier in the day. Staff found the flow sheet user-friendly and easy to incorporate in their daily practice. It has streamlined nursing workflow with accurate, easily accessible, clear and timely clinical data that supports well-coordinated care. During the pilot, the team recognized a need to incorporate mobile technology with the electronic flow sheet to further improve point of care documentation. Nursing informatics and nursing leadership are currently testing various mobile devices to meet this goal. The electronic flow sheet has been successfully implemented on two surgical oncology units and ICU. Inpatient fall rates will be prospectively tracked to see if there is a correlation between standardized toileting rounds and earlier administration of diuretics, and a decrease in the incidence of falling when patients are hurrying to the bathroom during nighttime hours.

1053674

AMBULATORY NURSING: THE IMPLEMENTATION OF AN ELECTRONIC DOCUMENTATION TOOL. Maryellen

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The use of electronic health records (EHR) to improve the quality and safety of patient care is an essential component of healthcare. Hospitals are using intelligent systems to support clinicians in the provision of care and clinical decision making, in order to increase efficiency and effectiveness in the responsibilities of patients' care. In the ambulatory setting, well-planned system design, project management, staff education, and post-implementation support are key factors of successful implementation of EHR. Ambulatory nurses play pivotal roles in utilizing patient portals for e-mail communication, updating patients' health records, transferring electronic clinical information, and contributing to the seamless coordination of care. This presentation will describe the educational strategies used to successfully implement an electronic nursing documentation form in ambulatory care and report staff satisfaction survey results. At this NCI comprehensive cancer center, a multidisciplinary task force of nursing informatics, ambulatory nurses, and clinical information system analysts was charged with implementing a new electronic documentation tool for telephone communications. A pilot group of 22 nurses was selected from medical and surgical services. Classroom based educational sessions were provided to staff along with web-based educational materials. Pre and post staff satisfaction survey was conducted prior to the staff trainings and 2 weeks after implementation. The project was rolled out over six months, starting with three services. Overall nurses' satisfaction greatly improved from 56% to 96% with the new form when compared to the previous note. Nurses reported documentation to be more accurate, easier to read and provided more relevant patient information. As a result of this success the new form was implemented across the institution to over 30 services in multiple locations. Teaching methods, tools, outcomes and evaluations used for the successful implementation of this new nursing documentation will be reviewed. One of the key findings from this project was the importance of standardizing nursing terminology to improve the quality of patient care.

1053683

THE EFFICACY, TOLERABILITY, AND SPEED OF ONSET OF FENTANYL PECTIN NASAL SPRAY IN THE TREATMENT OF BREAKTHROUGH CANCER PAIN: A MULTICENTER, PLACEBO-CONTROLLED, DOUBLE-BLIND, TWO-PHASE CROSSOVER STUDY. Carrie Smith, RN, Gabrail Cancer Center, Canton, OH; Nashat Gabrail, MD, Gabrail Cancer Center, Canton, OH; Allen Burton, MD, MD Anderson Cancer Center, University of Texas, Houston, TX; Evangeline Reyes, MD, Compassionate Cancer Care Medical Group, Inc., Riverside, CA; An Nguyen, MD, Compassionate Cancer Care Medical Group, Inc., Fountain Valley, CA; and Donald Taylor, MD, Georgia Center for Cancer Pain Management and Palliative Medicine, Marietta, GA

Breakthrough cancer pain (BTCP) affects up to 95% of patients with cancer pain, but oral fentanyl formulations do not consistently match the typical time course of BTCP, which is rapid in onset and lasts for 30-60 minutes. To tailor fentanyl delivery for the treatment of BTCP, fentanyl pectin nasal spray (FPNS) has been developed to provide both rapid and controlled nasal delivery of fentanyl. Assess the efficacy and tolerability of FPNS in treating BTCP. Randomized, placebo-controlled, double-blind (DB) multicenter study. The study was conducted in 114 cancer patients experiencing 1-4 BTCP episodes/day while taking ≥ 60 mg/day oral morphine (or equivalent) for cancer pain. Patients who completed a titration

phase (n=83) continued to a DB phase, when 10 episodes of BTCP were treated with the effective dose identified during titration (7) or placebo (3). Pain intensity (PI) was measured using an 11-point categorical scale and pain relief (PR) using a 5-point scale. Both PI and PR were measured at 5, 10, 15, 45, and 60 minutes post-dose. The primary endpoint was the summed pain intensity difference at 30 minutes (SPID_{30min}). Secondary efficacy endpoints included pain intensity difference (PID) from baseline, PI, and PR. Safety was assessed by adverse events (AEs) and both objective and subjective nasal assessments. Compared with placebo, FPNS significantly improved mean SPID_{30min} scores (P<0.0001) and significantly improved SPID scores as early as 10 minutes (P<0.05) and up to 60 minutes (P<0.0001). Significant differences in favor of FPNS were found in PI as early as 5 minutes (P<0.05). Similar benefits were also seen with PID, with a trend at 5 minutes (P=0.07) that was significant from 10 minutes onward (P<0.01). PR was significant from 10 minutes (P<0.001) and at all time points to 60 minutes (P<0.001). Only 5.3% of patients withdrew from titration due to AEs; no significant nasal effects were reported. FPNS provided rapid and effective analgesia in BTCP and was generally safe and well tolerated. FPNS is convenient and easy to use by patients. No significant local irritation or side effects were seen. Intranasal drug delivery provides rapid onset of action to achieve rapid relief of BTCP.

1053706

CHEMOTHERAPY AT THE MAYO CLINIC: A PHOTO GUIDE TO HELP YOU PREPARE. Sherry Looker, RN, BSN, OCN®, Medical Oncology, Mayo Clinic, Rochester, MN; Crystal Hilger, RN, BSN, OCN®, Medical Oncology, Mayo Clinic, Rochester, MN; and Kelli Fee Schroeder, RN, BSN, OCN®, Medical Oncology, Mayo Clinic, Rochester, MN

Patients diagnosed with cancer undergoing chemotherapy can present with different levels of anxiety at their initial visit for chemotherapy. Informing patients about their chemotherapy experience, knowing what to anticipate about the treatment, and understanding what is happening 'behind the scenes' by viewing a photoguide with text are ways to relieve some of the patient concerns and help relieve anxiety about the experience. The purpose of the study currently underway is evaluating 100 cancer patient's responses to the photoguide, who are receiving their first chemotherapy treatment in the Cancer Treatment Unit at Mayo Clinic, in hopes that it will decrease anxiety levels and give patients a better understanding of what to expect prior to beginning treatment. Approval from the Institutional Review Board was granted to approach a total of 300 patients that have received the booklet prior to their first treatment, with a goal of completing 100 evaluation forms of the booklet. All new adult chemotherapy patients are given the photo booklet by a clinical assistant, provider, or our cancer education center prior to their initial visit in chemotherapy. When patients report for their first day of treatment, a chemotherapy infusion nurse verifies if the patient had an opportunity to review the booklet. If they had, the patient will then be asked to complete an anonymous evaluation form about the booklet. Surveys will be collected and answers collated to evaluate the effectiveness of the photo guide. From the survey results, we will determine benefit of the photoguide for our patients. Preliminary results are encouraging, and our aim will be to also include hospital based patients in the educational offering.

1053711

INFORMAL CAREGIVERS OF PEOPLE WITH HEAD AND NECK CANCER. Maura F. Edmonds, RN, MSN, CRNP, School of Nursing, University of Maryland, Wilmington, DE; and Deborah B. McGuire, PhD, RN, FAAN, School of Nursing, University of Maryland, Wilmington, DE

Every year half a million people worldwide, including approximately 40,000 people in the United States, are diagnosed with

cancer of the head and neck (including the oral cavity, pharynx, paranasal sinuses, nasal cavity, larynx). A multitude of challenges accompany a diagnosis of head and neck cancer, including side effects such as pain, skin desquamation, xerostomia, and mucositis. In addition, changes in the ability to eat and speak can drastically alter the individual's way of life. For individuals who assume the role of informal caregiver, entry into a new and frighteningly unfamiliar world is inevitable, yet how they prepare themselves for this role is poorly understood. The goal of this study is to gain a better understanding of the process undertaken by informal caregivers of head and neck cancer patients to become caregivers. This study is guided by Symbolic Interactionism. This grounded-theory qualitative study is being conducted at a large urban NCI-designated cancer center in the mid-Atlantic. Theoretical sampling guides data gathering, thus when theoretical saturation is reached, enrollment will cease. Participants undergo three consecutive interviews focused on how they prepare for becoming caregivers, and what their experiences have been. Demographic data collected for patients and caregivers include age, gender, marital status and ethnic background. Caregivers' relationships to patients are also ascertained. To date, four participants have been enrolled. Interviews are taped and transcribed, with the resulting data organized using Atlas ti software and subjected to constant comparative analysis. This study is in progress. To date, three themes have emerged: Witnessing, Coping, and Balancing. As data collection continues, these themes will be refined and expanded. Information gathered from this inquiry should ultimately help inform the development of tailored interventions that will address caregivers' needs and concerns as they undergo the dynamic process of becoming caregivers. Provision of support and education to head and neck cancer caregivers should enhance their comfort and competency in their newly acquired role.

1053722

ACCESS TO HEALTHCARE: UTILIZING ONCOLOGY NURSES TO EASE NEW PATIENT TRANSITION TO A GYNECOLOGIC ONCOLOGY PRACTICE. German Rodriguez, MSN, RN, Ambulatory Nursing, New York University Clinical Cancer Center, New York, NY; and Elisheva Hertz, MSN, RN, OCN®, Ambulatory Nursing, New York University Clinical Cancer Center, New York, NY

Access to oncology healthcare has become increasingly complex. Oncology nurses play an integral role in transitioning patients into our healthcare system. In our gynecological oncology practice, we identified new patients were waiting up to three days to receive confirmation of initial appointment visits. This resulted in patient and physician dissatisfaction and concerns for decreased patient volume. The purpose of this project was to increase access to gynecological oncology service by improving timeliness of scheduling new patient appointment visits, and to optimize capacity while promoting better communication. We created a New Referral Clinical Nurse (NRCN) role and a dedicated referral line. The nurse collaborated with a multidisciplinary team to generate an algorithm depicting clinical criteria for new patient selection by physician preference, and created a standardized template for screening potential patients. We established a decentralized model, where each secretary was assigned to one physician practice with a dedicated telephone line. We implemented an electronic disposition reconciliation form and educated clinicians to reconcile patient activities daily. The percentage of new patients who received confirmation of appointment on the same day increased from 47% to 85% at the end of four months. The volume of new scheduled visits increased from 63 to 102 patients. We established guidelines for overbooking new visits and orchestrated additional office hours. We generated a process for referral to general gynecologists within our center when an oncology visit was deemed unnecessary. We enhanced the clinical specificity of the existing Dictaphone referral template letter. Overall, patients and physicians were very satisfied with the improvement in access

to the gynecological oncology services. The role of the oncology nurse is a fundamental component of improving patient access to healthcare services. The clinical nurse evaluates whether the patient is appropriate for our practice, determines how quickly the patient should be seen, refers to a general gynecologist when necessary, and counsels the patient on what to expect at the first visit. This eliminates the time that it previously took for a secretary to receive patient records and review them with the physician. It also increases patient satisfaction in and confidence with the practice.

1053725

THE IMMEDIATE POSTOPERATIVE THORACTOMY PATIENT: CHARACTERISTICS OF SHOULDER PAIN AND EFFECT OF RANGE OF MOTION EXERCISES. Sarah Beatty, BSN, RN, Nursing, The Ohio State University, James Cancer Hospital and Solove Research Institute, Columbus, OH; Joanne Lester, PhD, CRNP, AOCN®, Nursing, The Ohio State University, James Cancer Hospital and Solove Research Institute, Columbus, OH; and John Borstad, PhD, PT, Physical Therapy, The Ohio State University, College of Allied Health, Columbus, OH

It is estimated that 75-85% of post-thoracotomy patients may experience moderate to severe ipsilateral shoulder pain postoperatively. The etiology of this painful phenomenon is largely unknown. Post-thoracotomy pain has been observed in this patient population despite the use of multiple pharmacologic and non-pharmacologic interventions. Video-assisted thoracic surgery (VATS) has positively affected postoperative shoulder pain, although this procedure is not always a surgical option depending on the extent and location of the tumor. A recent study utilized range of motion (ROM) to the affected shoulder in postoperative thoracotomy patients with positive outcomes. Expanded research about the effectiveness of this intervention is needed. The purpose of this study is to 1) characterize the pain as experienced by immediate-postoperative thoracotomy patients, and 2) analyze the efficacy of ROM exercises to improve shoulder function and decrease shoulder pain. The theory of unpleasant symptoms has been used in this study to effectively understand the components of postoperative shoulder pain and to investigate the physiologic influences that may affect the characteristics of pain. Mediation of this influence using ROM exercises will be studied and its resulting effect on performance. A descriptive study was conducted to characterize post-thoracotomy shoulder pain (n= 50). An assessment instrument was incorporated in the thoracotomy charts for nurses to document postoperative pain assessments every eight hours. Included was a preoperative baseline assessment. Descriptive data from this study is useful to characterize this unique pain phenomenon with consideration of physiologic influences and how those may be mediated with an intervention study. The next phase of the study will include a randomized study that will incorporate ROM techniques performed postoperatively at the bedside. Patients will be randomized to the (1) control group, or (2) intervention group preoperatively. ROM exercises will be initiated on the intervention group in the postoperative care unit, and subsequently performed on each shift (every 8 hours). Patients will be assessed and asked to rate their pain in a similar manner as they did in the collection of the preliminary data. The data obtained from the first segment of study was useful in characterizing the pain phenomena as experienced by postoperative thoracic surgery patients. The researchers hypothesize that early initiation of ROM exercises will have a positive influence on the relief of shoulder pain and immobility in the post-surgical patient. This would offer a nurse-sensitive outcome using a non-pharmacological intervention for the bedside nurse to decrease pain and increase functionality of the shoulder.

1053732

SERVANT LEADERSHIP: DEVELOPING BEDSIDE NURSES LEADERSHIP ROLES TO ENHANCE STAFF SATISFACTION.

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A servant leader is defined as an individual who has the quality of influencing and leading others. According to Marquis & Huston (2009), servant leaders are most importantly a servant first, and then a leader. Successful leaders motivate through personal trustworthiness and self confidence, characteristics which servant leadership values. In oncology nursing, with the special demands of patients with cancer, servant leadership is especially useful. The servant leadership model is effective in team building, encouraging professional growth, and improving patient care outcomes. The purpose of this project was to adopt the servant leadership style on a nursing unit at MD Anderson Cancer Center to improve problem solving and quality of interpersonal relationships, therefore allowing the nurses to better deal with difficult situations often found on oncology units. Unit based in-service and staff meetings were provided to charge nurses for developing their leadership skills and foster the principles of servant leadership. Follow-up discussion during charge nurse meetings included a review of servant leadership books and literature to improve the standards of nursing leadership. The fundamentals of servant leadership are a desire to serve and align well with institutions' "caring" core values and are inherent in the nursing profession. Applying these principles with our charge nurses will help in leadership development by improving teamwork, involvement in decision-making, and practicing caring behaviors. Servant leadership encompasses many of the core values of nursing: caring, integrity and respect. Servant leadership in nursing will benefit the institution, nurses and patients and their families because it embodies behaviors that can lead to improved quality of care, patient and staff satisfaction. Nurse leaders can build an improved relationship with their staff while improving patient satisfaction and patient care outcomes.

1053737

EARLY PALLIATIVE CARE INTERVENTION IN NEWLY-DIAGNOSED LUNG CANCER PATIENTS: EFFECT OF INTENSIFIED SYMPTOM MANAGEMENT. Jocelyn Zerkle-Kidd, BSN, RN, Nursing, The Ohio State University, James Cancer Hospital and Solove Research Institute, Columbus, OH; Joanne Lester, PhD, CRNP, AOCN®, Nursing, The Ohio State University, James Cancer Hospital and Solove Research Institute, Columbus, OH; Sharla Wells, PhD, Palliative Care, The Ohio State University, James Cancer Hospital and Solove Research Institute, Columbus, OH; Robert Taylor, MD, Palliative Care, The Ohio State University, James Cancer Hospital and Solove Research Institute, Columbus, OH; and Greg Otterson, MD, Hematology/Oncology, The Ohio State University, James Cancer Hospital and Solove Research Institute, Columbus, OH

Patients with newly-diagnosed lung cancer are burdened with many stressors related to their disease and treatment. Pain, psychological distress, and treatment-related symptoms may negatively affect quality of life. Integration of palliative services has demonstrated a positive effect on patient distress, symptom control, pain, and quality of life in patients with metastatic lung cancer. Referrals to services such as palliative care typically occur later in the cancer trajectory. The National Comprehensive Cancer Network (NCCN) guidelines for lung cancer recommend formalized supportive care interventions after two or three failed attempts at chemotherapy, or in patients with a significantly decreased performance level. These researchers hypothesize that newly-diagnosed, symptomatic lung cancer patients may benefit from early intervention of the palliative care team. The purpose of this study is to measure the effect of a palliative care intervention in newly-diagnosed lung cancer patients on quality of life and symptom control. Specific aims include measurement of the effect of (1) early supportive care intervention, (2) interdisciplin-

ary care, and (3) enhanced education on symptom identification and management. The NCCN guidelines for lung cancer provide a framework for integrating a supportive care intervention into standard oncology care. The theory of unpleasant symptoms allows for investigation in mediation of situational influences on symptoms as experienced by the lung cancer patient and the effect on performance indicators as related to quality of life and symptom management. A randomized study with longitudinal, repeated measures will be conducted in symptomatic, newly-diagnosed lung cancer patients at a Midwest comprehensive cancer center. Participants will be randomized to (1) control group receiving standard oncology care, or (2) intervention group with palliative care and standard oncology care. Measurements over six months will include the Functional Assessment of Cancer Therapy-Lung (FACT-L), Supportive Care Assessment, and the NCCN Distress Thermometer. Descriptive statistics will be used to characterize the symptom experience, quality of life indicators, and supportive care interventions. Chi-square will be used to investigate differences between groups and time periods in the early cancer trajectory. It is hypothesized that participants receiving early supportive care interventions by an interdisciplinary palliative care team will experience higher quality of life and symptom control/management as compared to patients receiving standard treatment. Information gained will be helpful to design an expanded research study for a longer surveillance period.

1053752

EFFECT OF WEEKLY VS EVERY-THREE-WEEK DARBEPOETIN ALFA DOSING ON FREQUENCY OF CLINIC PROCEDURES: EXPLORATORY ANALYSIS OF A PHASE 2 TRIAL EXAMINING DIFFERENT DOSING SCHEDULES OF DARBEPOETIN ALFA IN ANEMIC CANCER PATIENTS RECEIVING CHEMOTHERAPY.

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Cancer patients often develop chemotherapy-induced anemia (CIA), increasing their risk for transfusions and fatigue. Darbepoetin alfa (DA) is approved for treating CIA on a weekly (QW) or every-three-week (Q3W) schedule. Understanding how different DA-dosing schedules affect clinic-procedure frequencies may help nurses optimize anemia care. To describe the number of doses and weeks of dosing associated with a DA-dosing schedule (QW or Q3W) in a clinical-trial setting. Understanding how different schedules affect dosing (potentially affecting nursing resources and patient-time burden) may assist nurses to optimize care and increase patient adherence to anemia therapy. An exploratory analysis of clinical-trial data examined the number of DA doses (QW or Q3W dosing schedule) during a chemotherapy course. A Q3W schedule was hypothesized to result in fewer doses, potentially reducing resource utilization. In a phase 2 trial, patients (≥ 18 -years old) with anemia (hemoglobin < 11 g/dL) and nonmyeloid malignancy receiving chemotherapy were randomized to receive DA 150mcg QW (n=374) or DA either 500mcg Q3W (n=161) or 300mcg Q2W (n=217) depending on chemotherapy schedule. The primary endpoint was hemoglobin change from baseline to week 13; end-of-treatment was at 25 weeks. This exploratory analysis examined clinic-procedure frequency for the QW and Q3W groups. For the QW vs Q3W group, mean (SD) hemoglobin change from baseline to week 13 was 0.9g/dL(1.6) vs 0.7g/dL(1.4) and mean (SD) hemoglobin at week 25 was 11.3g/dL(1.7) vs 11.4g/dL(1.5). For the QW vs Q3W group, the mean (SD) total doses received was 14.0(6.6) vs 5.6(2.3) and the mean (SD) number of office visits up to week 13 was 11.6(8.6) vs 9.1(6.5). Mean (SD) total weeks of dosing were similar in the QW (17.3[7.3]) and Q3W (16.9[7.0]) groups. For the QW vs Q3W group, the percentage of patients with > 2 doses withheld was 36% vs 9% and the percentage who missed a DA dose at a scheduled clinic visit was 48% vs

24%. These results suggest that, though QW and Q3W DA schedules have similar efficacy, Q3W dosing decreases clinic-procedure frequency and may potentially assist nurses to optimize patient adherence and decrease clinic-resource utilization.

1053760

CREATING AN EXEMPLAR FOR EVIDENCE-BASED PRACTICE CHANGE: APPLICATION OF THE PROMOTING ACTION ON RESEARCH IMPLEMENTATION IN HEALTH SERVICES THEORETICAL FRAMEWORK. Cynthia Smith Idell, RN, BA, MSN, AOCN®, Clinical Practice and Education, City of Hope, Duarte, CA; Margaret Irwin, RN, MN, PhD, Oncology Nursing Society, Pittsburgh, PA; Amy Sebastian-Deutsch, RN, CNS, AOCNS®, Professional Development/Education, Memorial Hermann Hospital System, Houston, TX; Susanne Conley, RN, MSN, CPON®, NEA-BC, Clinical and Professional Development, Dana Farber Cancer Institute, Boston, MA; Marianne Bunce-Houston, RN, MS, CNS, Transformation and Innovation, Contra Costa Regional Medical Center, Martinez, CA; and Laura Houchin, RN, MSN, AOCNS®, Oncology Ambulatory Clinics, Duke University Medical Center, Durham, NC

Identifying characteristics of successful evidence-based practice (EBP) change is challenging. Education is an important practice change component but alone doesn't engender change. In 2007, the Oncology Nursing Society (ONS) convened advanced practice nurses to brainstorm ways to increase utilization of Putting Evidence Into Practice (PEP®) resources. Their White Paper recommended an action-oriented conference with one year subsequent mentoring to achieve EBP change. The Promoting Action on Research in Health Services (PARIHS) theoretical framework was selected. PARIHS views successful practice change as a function of evidence, context, and facilitation. In 2009, the ONS Foundation funded a Project Team to operationalize the White Paper. The EBP Project Team was charged with creating an exemplar to implement and to sustain practice change. Another goal was increased EBP resource use. A competitive application call yielded team members with EBP expertise. A June 2009 strategic planning retreat and intensive work over a 5 month period resulted in the 1st Institute for Evidence-based Practice Change (IEBPC) with 10 cohort teams, 5 mentors, and 8 expert faculty. Key interventions capturing White Paper recommendations were: 1) Cohort teams - a target (staff nurse), champion (advanced practice nurse), and sponsor (manager) to attend IEBPC and to implement desired practice change; 2) Interactive conference design similar to Leadership Development Institute with didactic content followed by mentored group work; and 3) One year Mentor / Cohort team assignment to facilitate practice change. Qualitative and quantitative outcomes to measure cohort success and theoretical model utility for contextual, evidence and facilitation variables were employed. Qualitative themes emerged from monthly blogs. Quantitative measures included: Organizational Readiness to Change; mentor evaluation; project-specific outcomes captured at intervals; and conference evaluations. Preliminary data revealed successful EBP changes and highlighted the significance of reflective blogging. The PARIHS framework is an invaluable tool for effecting practice change. IEBPC project design overcomes contextual barriers, enhances facilitation and promotes robust evidence use. IEBPC is an exemplar to tackle sustainable practice change at the point of service. Data from a 2010 IEBPC is being combined with 2009 results to illuminate necessary characteristics for successful practice change.

1053766

THE ROLE OF ONCOLOGY IN READINESS PREPARATION OF OUR NATION IN THE EVENT OF A NUCLEAR DISASTER. September Mitchell, BSN, OCN®, CHTC, BMT, Banner Blood and Marrow Transplant Program, Phoenix, AZ; Lori D'Ambrosio,

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Bone Marrow Transplant programs in particular play a significant role in the readiness preparation of our nation in the event of a nuclear disaster somewhere in the world. Each year hundreds of radioactive sources are lost or stolen: between 1995 and 2003, 612 radioactive devices were unaccounted for, lost or stolen. Since the inception of the Homeland Security Advisory System in 2002, the terrorist threat scale has fluctuated from yellow to red denoting an "elevated" to "severe" risk of terrorist attacks. As well as, in the United States today, twenty-nine states operate nuclear power plants. The purpose of this article is to discuss one transplant program's approach to developing, implementing, and disseminating a radiation disaster preparedness plan and incorporating that plan into the facility's larger disaster plan. In 2008, the Banner Blood and Marrow Transplant Program (BBMTP) residing inside of Banner Good Samaritan Medical Center (BGS MC) entered into a collaborative partnership with the Radiation Injury Treatment Network® (RITN) in an effort to better prepare our state and our nation to provide comprehensive evaluation and treatment for victims of radiation exposure or other marrow toxic injuries. As a member of the RITN, the BBMTP has conducted two table top exercises, developed treatment guidelines, educated more than 40 staff from the BBMTP and BGS MC representing a cross-section of the interdisciplinary team and ancillary departments. Additionally, the BBMTP has participated in one nation-wide drill for a radiation injury disaster, and participated in the education of state and local agencies. These collaborative efforts have served to expand the RITN's network and to facilitate a coordinated response in the event of a radiation disaster. Collaborating with the RITN, the BBMT program has provided treatment options for mass casualties with marrow-ablative injuries. The staff of the BBMT has also provided community education for hospital readiness in case of disaster for the hospital in the Phoenix area. The current world political climate, the world's reliance on nuclear power, and the demonstrated potential for radiation disasters such as Chernobyl necessitate a closer look at radiation disaster planning which is an integral component of a comprehensive disaster plan and a significant opportunity for collaboration with oncology.

1053774

IMPROVING PATIENT COMFORT AND SAFETY DURING VENIPUNCTURE. Daniel MacManus, RN, MSN, MBA, OCN®, Moores Infusion Center, University of California San Diego Medical Center, San Diego, CA

There is a body of evidence that identifies cold as a common theme for increased anxiety, decreased comfort levels, and vasoconstriction with attendant decreased venous access in the outpatient oncology population. This evidence clearly points to the need for interventions to improve comfort and ease of venous access in this vulnerable population. Infusion nurses are in an ideal position to optimize the patient experience by taking measures to alleviate suffering associated with cold ambient temperature. The primary purpose of this project was to increase patient comfort and safety during peripheral intravenous catheter placement, while decreasing costs associated with multiple attempts to place peripheral intravenous catheter. A secondary, though equally essential, purpose of this project was to determine which device would best enable infusion nurses to safely apply heat to patients. Temperature monitoring was performed and recorded in real time, and the data were analyzed. Data regarding patient's thermocomfort, number of venipunctures performed, prior chemotherapy, and whether they would prefer to have their blood drawing arm warmed or not was gathered. A literature review was performed for safety and effectiveness of heating products. The data collected suggest a significant number of patients would benefit from heat application before venipuncture. The Theratherm® heating pad was determined to be the best device

for safely applying heat to patients prior to venipunctures. The literature highlights the benefits of applying local heat to increase thermal comfort, improve success at venipunctures and reduce patient anxiety. This is a significant issue for oncology patients; and infusion nurses have the ability to alleviate the suffering associated with physical and emotional discomfort. This practice improvement project validates the benefits of local heat application to increase peripheral vasodilation, increase patient comfort, and reduce anxiety. It also demonstrates that heat application can be performed safely and cost effectively.

1053811

PATIENT FLOW IN AN ACADEMIC OUTPATIENT CLINIC: UTILIZING LEAN METHODOLOGY TO CREATE EFFICIENT PATIENT FLOW, INCREASE PATIENT AND STAFF SATISFACTION AND DECREASE PATIENT WAIT TIMES. Reiko Torgeson, MN, RN, OCN®, General Oncology/Hematology Clinic, Seattle Cancer Care Alliance, Seattle, WA; Brent Jarosek, BA, Finance/Decision Support, Seattle Cancer Care Alliance, Seattle, WA; and Laura Butcher, MPH, CPHQ, Business Development, Seattle Cancer Care Alliance, Seattle, WA

General Oncology/Hematology Clinic at the Seattle Cancer Care Alliance (SCCA) is an outpatient clinic with 33 exam rooms, 6 consult rooms and averages 140 daily patient visits. There are more than 14 specialties including multidisciplinary clinics and approximately 75 providers who practice in the clinic. Due to increased patient volumes, the rooming process became a source of delay which resulted in patient and provider/staff dissatisfaction. The clinic was chosen to undergo the first Rapid Process Improvement Workshop (RPIW) at SCCA, utilizing the Lean methodology. The project goals were to improve patient flow, communication and staff/faculty satisfaction. Initial data collection showed weekly average for patient wait time to be approximately 20 minutes. Staff/provider satisfaction was 2.9 out of 5; patient satisfaction was 4.2 out of 5. Workshop team consisted of MAs, RN, LPN, patient service representative, nurse manager, decision support staff and the manager of strategic development. Team came together for 1 week to review current process, collect data, create new processes and standard work documents. Essential supplies were ordered and medical assistants were grouped into teams. The new process was put in place the first day of work after the workshop. Daily audits of the standard work processes were conducted and reviewed at 30, 60 and 90 day RPIW report outs. At the end of the workshop, we reduced the number of steps in the flow from 49 to 20, which demonstrated increased efficiency and less walking for patients. Average wait time goal of less than 15 minutes was met with a weekly average of 13 minutes from check in to being brought back to the exam room. Daily audits demonstrated difficulty in following standard work processes. With real-time feedback, 100% compliance with standard work was achieved by the 90 day audit. By the 90 day audit, staff satisfaction was 4.3, provider satisfaction was 3.8 and patient satisfaction was 4.3. Improvements continue to occur and standard work continues to be revised. Efficient patient rooming is essential to any clinic setting. Having standardized work processes has significantly improved patient wait times as well as patient and provider/staff satisfaction.

1053814

INNER STRENGTH IN CANCER SURVIVORS: THE ROLE OF SPIRITUALITY IN ESTABLISHING CONNECTEDNESS. Joanne Lester, PhD, CRNP, AOCN®, Nursing Excellence, The Ohio State University, James Cancer Hospital and Solove Research Institute, Columbus, OH; and Deborah Rufener, SN, College of Nursing, The Ohio State University, Columbus, OH

A diagnosis of cancer can yield uncertainty in the lives of patients and family. Through a process of discovery, the patient

and their family often use spirituality as an integral component of their coping mechanisms. There are a number of definitions for the term spirituality. The varying content of these definitions can be a source of confusion to nurses as they address components of assessment, intervention, and evaluation of spirituality. The term may be defined differently between nurses, between nurse and patient, between nurse and family, as well as between the patient and their loved ones. These unknowns may create lapses in the ability to enhance the value of spiritual strength. The purpose of this study was to obtain conceptual data from cancer patients related to their definition of spiritual care, the provision of spiritual, and the role of the healthcare provider. The theory of inner strength describes the developmental process through which the cancer survivor attains a sense of support and nurturance to develop a new normal. Spirituality may promote connectedness, an integral component of inner strength that leads to a sense of self-determination and mastery. An explorative, descriptive study design was used to facilitate understanding of what spiritual care means to cancer patients. Focus groups with group interviews and open discussion were conducted to examine the perceived needs of spiritual care in cancer survivors, as well as gaps in care that may exist. Seventeen cancer survivors were interviewed with varying demographic characteristics creating a heterogeneous sample. Data was transcribed and reviewed to identify themes related to spiritual care. Strong correlations between inner strength, knowing one's personal spirituality and creating a "new normal" emerged. One participant said "it is partly spiritual, but it's that inner strength that gives you that ability to fight what you have to fight." Survivors described having a strong sense of self regardless of treatment circumstances and walking different paths but sharing a journey. These themes support the theory of inner strength model, particularly connectedness by nurturing supportive relationships with self, family, friends, and a spiritual power. Cancer survivors have a positive self concept and sense of self determination which enhance quality of life. The theory of inner strength is an effective model to examine expressed needs and concerns of cancer survivors. Application of data to this model enables the health care provider to nurture the development of inner strength. Interventions to enhance self-determination and mastery of a 'new normal'; following a cancer diagnosis may improve quality of life and self-management.

1053824

ADVENTURES IN BLOOD AND MARROW WONDERLAND.

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The orientation for a blood and marrow (BMT) unit for a graduate nurse is challenging for the orientee and the preceptor. The challenges that must be overcome are compounded by the multiple medications, blood products, infusion pump types, patient acuity and the pace that must be maintained. A check list was designed to be completed over a two day process that would involve the hospital environment but exclude the BMT unit. To make this two day program more interesting it was called an 'adventure' and similarities were made between this BMT program and the novel Alice in Wonderland. The story of a young girl (the orientee) on an adventure attempting to make sense of her new world, growing up and for ever being changed The White Rabbit (the preceptor) carrying a watch, always in a hurry. Direct quotes from the novel were cited to add humor to a detailed and stressful orientation. Just one example of many "How do you know I'm Mad? You must be. Or you wouldn't have come here." The development of an additional program that would allow a superior understanding of patient care, disease type and the BMT program regulations including outside agencies (FACT). The exchanged information which occurred away from the patient unit, served to elucidate the numerous BMT policies, procedures and SOPs.

The complication of this patient population and program was better taught and understood without other competing concerns. To assimilate the details of this patient population and program, the patient care unit was considered a less valuable learning environment. A two day adventure off the patient unit was built into the orientation with a check list which included multiple departments. Included were pre and post transplant topics along with numerous BMT program meetings. The adventure was reviewed and changes were made. The knowledge base of the GNs was considered advanced in comparison to our past orientees. The confidence of these GNs was acknowledged by each GN and our entire BMT Team. This adventure provided the awakening needed for the BMT unit to become a place where reality makes sense.

1053885

SEEKING ZERO CLABSI IN THE HIGHEST RISK PATIENTS: BONE MARROW TRANSPLANT AND ONCOLOGY. Denice Gibson, RN, MSN, AOCNS®, Banner Good Samaritan Medical Center, Phoenix, AZ; and Selma Kendrick, RN, MS, OCN®, Banner Good Samaritan Medical Center, Phoenix, AZ

The goal of the Institute of Healthcare Improvement and the CDC is to eliminate all incidents of hospital acquired infections such as Central Line Associated Blood Stream Infections (CLABSI). The compromised aggregate of Bone Marrow Transplant and Oncology patients makes it is even more critical to ensure these patients never experience a preventable event since this population has often been rendered immunologically defenseless. The elimination of the unnecessary cost of a central line infection and more importantly the prevention of the loss of a patient's life is more involved than just implementing the IHI insertion and maintenance bundle. It is also using the nursing process to further review the potential problems that prevent achieving zero CLABSI. The nursing process was utilized to review every aspect of a potential CLABSI to achieve zero infection rate. 1)equipment was decreased to what was appropriate; 2)drawing, evaluating and reporting blood cultures was standardized. All nurses were validated on central line care and patients were provided a checklist to uphold accountability and assist in educating the patients. Surveillance measures implemented to ensure all practices were 100%. Interdisciplinary team established to review all line infections. Education of coding team on standards to utilize to complete their coding requirements on discharge. Team expanded to establish an interdisciplinary and cross departmental team hospital wide to address CLABSI (i.e.ICUs, General Floors , Surgery, Cardiac Treatment Center, PICC Program, ED, and Radiology) annually renewed charter. Following the successful implementation of the Central Line Bundle insertion and maintenance of the bundle the unit met the original bench mark of 3 infections per 1,000 patient days. Following the implementation of the interventions utilizing the nursing process, the hospital has fallen well below the original

benchmark and has achieved zero in several departments. Key to success of this process improvement was the commitment of the multidisciplinary team and open forums of the processes and while establishing standards of care. The multiple variety of central lines in the BMT/oncology population has made it challenging to create processes to seek zero CLABSI, but with a team effort the zero rate can be achieved.

1053888

A SALUTOGENIC FRAMEWORK TO UNDERSTAND DISPARITY IN BREAST CANCER SCREENING BEHAVIORS IN AFRICAN AMERICAN WOMEN. Regina Conway-Phillips, RN, MSN, School of Nursing, Loyola University Chicago, Chicago, IL; and Linda Janusek, RN, PhD, FAAN, School of Nursing, Loyola University of Chicago, Chicago, IL

AAW have a higher breast cancer mortality rate and a lower survival rate than any other racial or ethnic group. Research has demonstrated that limited access to care reduces mammography screening for AAW. Despite barriers, some AAW do access mammography and engage in breast cancer screening (BCS) behaviors. The study aims were as follows: 1) Evaluate the contribution of SOC, social support and spirituality to BCS motivation and behaviors in AAW and 2) Determine whether general health perception mediates the effect of SOC on BCS motivation and behaviors in AAW, and 3) Determine whether there are differences in SOC, health perception, spirituality, and social support of AAW who take advantage of a free mammography program compared to AAW who do not. The salutogenic theory of health focuses on factors that support well being and increase positive health behaviors. Salutogenesis offers a framework to understand personal factors that allow some AAW to rise above adversity and to engage in health behaviors. Sense of coherence (SOC) is central to salutogenesis, as a person's SOC determines how they perceive their life and whether they use the available resources. This two group cross sectional design used multivariate, logistic and multiple regression analyses to address the study aims. This study enrolled 134 women with 53 in the Illinois Breast and Cervical Cancer program (IBCCP) group and 81 in the non-IBCCP group. The findings demonstrate that for this sample of AAW there was significant differences in the levels of spirituality in the subgroups of non-IBCCP women and that the levels of social support moderated the affect of SOC on BCS behaviors. Given that there was no independent relationship between SOC and either BCS motivation or behaviors, it negated pursuit of the hypothesis that health perception mediated the effect of SOC on BCS motivation or behaviors. Spirituality is a significant predictor of BCS behavior and motivation among non-IBCCP women. Overall, participation in free BCS programs was predictive of BCS motivation and behavior. This speaks to the importance of such programs in explaining the disparities in BCS behaviors in AAW.

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Delaney, E. (ps)	1052070	Llerandi, D. (ps)	1053672	Rice, H. (pd)	1046763	Williams, L.A. (ps)	1050665
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Dougherty, M. (ps)	1050350	Lore, B. (ps)	1053389	Rodriguez, E. (ps)	1053601		
				Rodriguez, G. (ps)	1053722	Zandstra, F. (ps)	1053483
Edmonds, M.F. (ps)	1053711	MacManus, D. (ps)	1053774	Roesser, K. (ps)	1052995	Zerkle-Kidd, J. (pd)	1053737
Esteves, B. (ps)	1052744	Madison, J. (ps)	1052799	Romvari, E. (ps)	1053269	Zhong, Y. (ps)	1051352
		Martin, C. (ps)	1052014	Ryu, E. (ps)	1053640	Zimmerman-Crumbaugh, M. (ps)	1053370
Fallon, M. (ps)	1053552	Mathew, L. (ps)	1051635				
Fessick, S. (pd)	1053378	Maze, M. (pd)	1018778	Salvaggio, R. (ps)	1052950		