

Poster Abstracts

Each abstract has been indexed according to first author. Abstracts appear as they were submitted and have not undergone editing or the *Oncology Nursing Forum's* review process. Only abstracts that will be presented appear here. For ONS Congress® scheduling information, visit congress.ons.org.

Data published in abstracts presented at the 47th Annual ONS Congress are embargoed until the conclusion of the presentation. Coverage and/or distribution of an abstract, poster, or any of its supplemental material to or by the news media, any commercial entity, or individuals, including the authors of said abstract, is strictly prohibited until the embargo is lifted. Promotion of general topics and speakers is encouraged within these guidelines.

Digital Object Identifier: 10.1188/22.ONF.E2

Abstracts are indexed by first author and page number.

Adams, C.	6	Boyde, T.	66, 67	Delengowski, A.	72, 110
Adams, J.	64	Bradford, V.	12, 44, 47	DeMeyer, E.	72
Aguiar, B.	6	Brooks, D.	68	Desvignes, K.	19
Alamoudi, F.	145	Brown, G.	68	Dickey, E.	111
Albanese, E.	99	Browne, C.	104	Digirolamo, S.	19
Alfonso, L.	7	Bruce, S.	13	DiMaggio, A.	72
Almasri, B.	8	Burge, A.	105	Dodson, C.	150
Amacher, L.	9	Burnett, L.	148	Dolan, S.	20
An, E.	100	Burrell, S.	148	Donato, K.	20
Andrade da costa, M.D.A.	4	Calvo-Schimmel, A.	149	Donnelly, T.	111
Armstead, A.	55	Campbell, H.	105	Dorlette, D.	112
Armstrong, S.	9	Campbell, Y.	106	dos Santos, D.	63
Artrip, S.	10	Carpenter-Marshall, B.	13, 69	Douglas, T.	73
Assalone, D.	106	Carter, K.	14	Du Pen, A.	113
Baer, B.	64	Carter, P.	150	Eisenberg, S.	113
Baes, A.	146	Chandler, H.	15	Elkin, E.	21
Baum, J.	10	Chen, Y.J.	16	Ewer, R.	73
Bearup, L.	100	Clark, D.	16	Fedoronko, K.	114
Beauchemin, M.	146	Clark, S.	107	Fernwood, E.	74
Beaver, C.	65	Colvin, C.	16	Ferreira, E.B.	4
Beck, J.	101	Conway, L.	69	Flannery, M.	151
Beck, M.	147	Corbett, M.	17	Foster, K.	74
Benson, L.	65	Coumar, A.	70	Fradkin, M.	114
Bentleyewski, E.	66	Crapser, N.	71	Friend, P.	75
Bingham, R.	101	Crayton, K.	17, 18	Gaillard Ulysse, F.	115
Birkhoff, S.	147	Cronin, J.	108	Gaskell, L.	115
Birmingham-Williams, L.	102	Crowe, A.	108	Gaspar, K.	21
Blecher, C.	102	Culmone, K.	109	George, J.	22
Bocchetta, N.	103	Dalpiaz, N.	71	Gibbs, D.	76
Boswell, A.S.	11	De Domenico, E.	62	Gitzinger, S.	76
Bourgeois, J.	104	Dela Rosa, M.	55	Goozee, K.	116
Bowman, P.	11	Deleeuw, C.	109	Gopinadh, N.	116

Graf, S.P.	151	Lutz, B.	123	Pusag-Weber, T.	132
Graham, S.	117	Mahan, D.	124	Radicke, J.	40
Grandas, C.	56	Malick, D.	81	Radid, A.	36
Guo, J.-W.	152	Maloney-Lutz, K.	33, 81	Raipuria, H.	133
Hacker, E.	153	Mancini, K.-A.	33	Reilly, L.	41
Hamel, K.	22	Mancini, V.	34	Reis, P.	41
Hamilton, N.	153	Manson, S.	82	Renner, L.	42
Hansen, A.	23	Marchand, K.	35	Ridad, A.	36
Harris, C.	154	Mark, B.	125	Robertson, D.	133
Hartkopf Smith, L.	23	Market, M.	125	Robinson, N.	43
Heller, E.	77	Marshall, V.	158	Rodgers, G.	88
Hendershot, A.	141	Martinovich, J.	126	Roesser, K.	89
Henderson, C.	118	Matousek, C.	82	Rokakis, E.	134
Herman, R.	24	Mayorga, M.	35	Rosamilia, M.	43
Hicks, A.	25, 118	McClelland, R.	83	Rosbough, J.	44
Hill, K.	25	McCormick, K.	126	Rosselli, E.	89
Hirschey, R.	154	McLaughlin, P.	159	Rowell, M.	90
Holtslander, L.	26	McNally, G.	83	Russo, T.	90
Howard, A.F.	155	Mea, R.	127	Salleroli, A.	91
Huang, L.-T.	156	Mercado, F.	58	Schlarman, L.	134
Huenerberg, K.	119	Metsker, J.	58	Schomburg, L.	135
Huff, C.	26, 77	Miles, J.	84	Schrameck, B.	45
Ippolito, T.	27	Missland, J.	84	Servodidio, C.	91
Ito, K.	28	Mitchell, M.	127	Sharma, B.	92
Jansen, C.	119	Montgomery, K.	159	Shelton, B.	135
Jellen, S.	120	Mooney, K.	128	Sheng, Y.	162
Jiang, X.	28	Morgan, K.	85	Shin, J.	163
Johann, M.	29, 78	Morgan, M.	128	Shuey, K.	164
Johnson, D.	78	Morrison, K.	129	Shuffler, S.	136
Johnson, L.	120	Nenner, A.	5	Silcox, J.	93
Johnston, P.	79	Nesting, M.	129	Singh-Kandah, S.	94
Jones, R.	156	Newell, K.-A.	36	Sitarz, J.	164
Julien, J.	29	Nolan, T.	160	Smith, Mandeep	45
Kadian, R.	30	Octaviano, J.	86	Smith, Melissa	165
Karas, M.	56	Oishi, K.	87	Smith, N.	46, 136
Keenan, K.	30	Oplinger, C.	130	Smolarek, S.	137
Kim, J.	31	Oppegaard, K.	161	Starr-Manning, C.	46
Kong, E.	14	O'Sullivan, K.	86	Stirling, S.	94, 137, 165
Kristeleit, R.	57	Ou, S.	37	Storms, S.	138
Kuck, K.	79	Page, S.	87	Sumpio, C.	139
Lacatus, G.	121	Park, S.-H.	161	Sundberg, C.	139
Leap, K.	121	Parra, J.	131	Sylvestre, C.	59
Lee, J.	158	Patel, A.	131	Szabo, P.	95
Lee, H.	157	Patrick, T.	37	Taylor, B.	60
Lehto, R.H.	122	Patullo, J.	132	Thigpen, A.	140
Leighliter, M.	31	Peterson, K.	38	Thomas, A.	61
Lewallen, N.	32	Poor, E.	162	Todd, A.	140
Llamoza, J.	32	Porinchak, M.	38	Triglianos, T.	5
Llewellyn, E.	122	Portz, D.	39	Trzaska, J.	47
Lott, E.	4	Pratt, K.	40	Turkoglu, N.	48, 141
Lucas, J.	123	Prodocimo, B.	88	Uranga, C.	95
Luttrell, J.	80	Pruett, J.	59	Valenti, R.	142

Van Kuiken, K.	61	Willford, K.	50	Yoder, L.	145
Vandross, J.	166	Williams, G.	96	Young, A.	97, 98
Wang, H.-L.	166	Wong, M.	50	Young, N.	98
Ward, A.	49	Wright, M.	51	Youssefi, F.	53
Weinhold, H.	167	Wuckovich, M.	51, 52	Yu, H.	169
Wheatley, T.	142, 143	Wulff, C.	52, 144	Zhang, Y.	170
Whetstone, V.	49	Wyatt, G.	68	Zhong, X.	98
Whisenant, M.	167	Xu, L.	169	Zhu, S.	54
Wilkins, A.	144	Ydrogo, C.	53, 97	Zielinski, T.	99

ADVANCED PRACTICE

P1 SCREENING OF CANCER PATIENTS DURING THE COVID-19 PANDEMIC IN AN ONCOLOGY CENTER: FLOW OF CARE ANALYSIS

Maria dos anjos Andrade da costa, Hospital Sírio Libanês, São Paulo; Jessica Soledade Ribeiro, Hospital Sírio Libanês, São Paulo; Daiana Ciriaco Nascimento, Hospital Sírio Libanês, São Paulo; Caroline Pinheiro Macedo, Hospital Sírio Libanês, São Paulo; Leticia Vieira Karakama, Hospital Sírio Libanês, São Paulo; Jeane Santana Santos, Hospital Sírio Libanês, São Paulo

COVID-19

Addressing the need to implement an intervention to minimize the risk of covid-19 in chemotherapy clinics. The aim of this study was to evaluate the applicability of screening for the identification of cancer patients with respiratory symptoms undergoing chemotherapy and at risk in the Oncology outpatient clinic during the covid pandemic 19. This is a quantitative, descriptive field research with an exploratory aspect, retrospective cut, carried out in the chemotherapy clinic of a large, private and philanthropic general hospital, located in the city of São Paulo. Screening was carried out by telephone on the day before the appointment, where a nurse guided by an instrument questioned the presence of symptoms, diagnosis or contact with contaminated or possibly contaminated people. The sample consisted of 54 patients who took part in 268 evaluations, where 105 evaluations were by call center and 163 in-person evaluations. Results: Regarding the 268 assessments, no risk for covid was identified, there was also no record of RT-PCR exam collection within 15 days after the assessment. The covid confirmation rate was 0%, below the general population, possibly related to preventive care and education carried out during the period. Adherence to telephone contact was low, making it possible to check the face-to-face evaluation. The fact of identifying 3 patients at risk for covid-19 justifies the permanence of the practice.

P2 NURSE-LED FOLLOW-UP OF CANCER PATIENTS AFTER RADIOTHERAPY: AN INTEGRATIVE REVIEW

Elaine Barros Ferreira, RN, PhD, University of Brasilia, Brasília; Giovanna Almeida, RN, University of Brasília, Brasília; Giovana Paula Rezende Simino, RN, PhD, School of Nursing, University of Minas Gerais, Belo

Horizonte; Beatriz Aguiar, RN, MSc, University of Brasilia, Brasilia; Paula Reis, RN, PhD, University of Brasilia, Brasília

Oncology Nursing Practice

Nurse-led follow-up strategies have been implemented in oncology to support recovery and rehabilitation of patients. Cancer patients undergoing radiotherapy require post-treatment follow-up to manage possible physical or psychosocial conditions. The purpose was to identify the nurse-led strategies adopted for monitoring cancer patients after radiotherapy. Integrative review following an Integrative Review framework. The search was performed at CINAHL, Cochrane Library, LILACS, PubMed, Scopus, and Web of Science. All the studies were critically appraised for methodological quality using the Joanna Briggs Institute Critical Appraisal Checklist. Seven studies were included. Patient follow-up strategies included an algorithm for standardizing consultations and symptom management, telephone contact, face-to-face counseling by trained nurses, with a sexual rehabilitation intervention combined with a patient information booklet and a virtual follow-up clinic for PSA control. Six studies had a low risk of bias, and a moderate risk of bias. Different follow-up strategies for cancer patients after the end of radiotherapy, carried out by nurses, were identified, namely: outpatient follow-up using an algorithm, face-to-face follow-up, telephone follow-up and virtual follow-up. More evaluations and descriptions are needed about the effects of nurse-led monitoring on survival outcomes, patient satisfaction, perception of improvement in signs and symptoms, as well as measuring the cost-benefit impact of these strategies on health services. As contributions to the field of nursing, it is noteworthy that the studies included in this integrative review presented encouraging results regarding the follow-up of patients after radiotherapy by a leader nurse, since the follow-up practices led by nurses can be safe and effective, allowing to combine teaching, guidance, management and counseling conducted by nurses, improving patient safety.

P3 SURVIVORSHIP CLINIC FOR OUTPATIENT ONCOLOGY PATIENTS

Emily Lott, CRNP, MSN, OCN®, CHPN, Penn Medicine Cherry Hill, Cherry Hill, NJ

Survivorship

There is significant funding and focus on oncology patients during active treatment with regards to chemotherapy, immunotherapy, radiation and other curative

means. While oncologists consider the goal for cancer patients to be remission, there are often complications from the past cancer itself or cancer treatments that are lifelong for the patient. These symptoms continue even when patients are cancer free. Often, there is no plan going forward to help manage these symptoms and concerns. These patients are referred to primary care providers that do not have the expertise in these conditions. Therefore, the clinical program proposed in the outpatient oncology setting is a survivorship clinic lead primarily by nurse practitioners. The clinic should be structured for providers to review common symptoms after cancer treatment such as pain, anxiety, emotional distress and outlets for support for these patients. Preventative care measures and appropriate genetic testing would be included as well. There would be a standardized charting template in the electronic medical record to make sure all topics that are discussed are documented for future providers to refer to. Nurse practitioners would run this clinic, with collaborative discussions with physicians since nurse practitioners should have more time to spend with patients developing relationships. This would allow doctors to see more new patients to help the practice grow and produce revenue. This survivorship clinic would be of value to the health care organization by promoting quality of life among prior patients to have them continue to speak highly of the organization and refer their family and friends. The visits themselves would bring revenue in, too. Lastly, if there is any sign of cancer recurrence these patients would already be monitored in the survivorship clinic and early detection would lead to better outcomes. Therefore, the patients, community, health care organization and providers would all benefit from the implementation of a survivorship program. It would be a positive financial investment that should produce net gain within the first year of implementation.

P4 CANNABIS AND SYMPTOM MANAGEMENT IN CANCER: SAFETY, EFFICACY, AND IMPLICATIONS FOR CLINICAL USE

Amber Nenner, RN, BSN, Columbia University, New York, NY; Ryan Sandler, RN, MSN, Columbia University, New York, NY; Felita Salim, RN, BSN, OCN[®], Columbia University, New York, NY

[Symptom Management and Palliative Care](#)

While the United States holds one of the leading positions in cancer research and treatment among the developed countries, an area of improvement still remains in the management of oncologic pain and

the palliation of associated symptoms. According to The American Cancer Society, 70-90% cancer patients with advanced disease and 50% of those in active treatment will experience some degree of pain. According to the current published research, the role of cannabis and cannabinoid products in the management of cancer-related pain, chemotherapy induced nausea/vomiting (CINV), anorexia and cachexia, and quality of life remains unclear. As a result, there have not been any official guidelines on the use of cannabis as an alternative or in conjunction with standard opioid treatment. This poster aims to explore the role and safety of cannabis in the supportive care of cancer burden. We conducted a thorough search through Pubmed, CINAHL, and Embase using various search terms and inclusion/exclusion criteria allowing us to narrow our focus to 8 studies consisting of retrospective chart reviews, systematic reviews, integrative reviews, and prospective cohort studies. Our findings showed that while cannabis alone did not provide sufficient pain relief for patients, it did show that in conjunction with opioid therapy, it provided greater pain relief than by opioid therapy alone. Cannabis did also provide improvement in CINV as well as appetite. While cannabis may not provide adequate symptom management for all, it is absolutely worthy of consideration as a potential adjuvant therapy for adult patients with cancer.

P5 EXPANDING LEADERSHIP AND PROFESSIONAL DEVELOPMENT OPPORTUNITIES FOR ADVANCED PRACTICE PROVIDERS

Tammy Triglianos, DNP, ANP-BC, AOCNP[®], University of North Carolina, Chapel Hill, NC; Judy Prewitt, DNP, RN, AOCN[®], Duke Health System, Durham, NC; Kelly Tan, PhD, RN, University of North Carolina, Chapel Hill, NC; Rachel Hirschey, PhD, RN, University of North Carolina at Chapel Hill, Chapel Hill, NC

[Professional Development](#)

Advanced Practice Provider (APP) involvement in professional organizations improves clinical practice, APP contributions to policy and practice changes, and patient outcomes. Additionally, increased APP involvement in Oncology Nursing Society (ONS) chapter educational activities utilizes APP clinical expertise to improve nursing knowledge and thus care delivery across all chapter members. The purpose was to increase opportunities for APP engagement, leadership, and professional development within the Triangle ONS (TONS) chapter. A TONS APP member inquired with TONS leadership to identify pro-

fessional development opportunities. Subsequently, three TONS board members partnered with the APP to assess APP member needs and expertise and apply findings to develop a plan for increased APP engagement in TONS. Specifically, the team added APP focused items to an established TONS member survey. Open and closed ended questions focused on identifying APP: (1) learning needs, (2) content expertise, and (3) readiness to present continuing education sessions. Thirteen APPs completed the survey. Descriptive statistics were completed in excel for quantitative data and qualitative data was reviewed by two team members to identify common themes. Results indicate that TONS can improve APP support in the following areas: (1) mentorship and leadership training, (2) education in side effect management, and (3) networking. Seven respondents expressed interest in providing an educational presentation in their content area. Findings were applied to develop a proposal for the TONS Board to support a quarterly APP led speaker series; Board support was unanimous. Four APP continuing education sessions will be offered by TONS in 2022. Session topics will include Gastrointestinal Oncology, Adolescent and Young Adult, Bone Marrow Transplant, and Breast Oncology. TONS leadership, mentorship and scholarship co-chairs will work with presenters 1:1 to help prepare and practice their presentations. It is anticipated that the program will: (1) enhance TONS APP writing and presentation skills, and thus preparation for additional presentations and national organization engagement, (2) increase APP networking opportunities, and (3) leverage the expansive content expertise of TONS APPs for continuing education across membership. This project provides an exemplar of an innovative collaboration between TONS APP membership and leadership to simultaneously enhance APP professional development while also disseminating cutting-edge information on disease processes and treatments to membership who ultimately deliver transformative oncology nursing care.

CLINICAL PRACTICE

P6 “BOOM-BOOM” VERY LOW DOSE, 2 FRACTION RADIATION THERAPY FOR THE TREATMENT OF INDOLENT NON-HODGKIN LYMPHOMA IN THE PALLIATIVE SETTING

Catherine Adams, BSN, RN, OCN®, Memorial Sloan Kettering Cancer Center, New York, NY; Grace Cho,

BSN, RN, CMSRN, Memorial Sloan Kettering Cancer Center, New York, NY; Joachim Yahalom, MD, Memorial Sloan Kettering Cancer Center, New York, NY
[Oncology Nursing Practice](#)

Very low dose radiation therapy (VLDRT) given as 2 Gy in 2 fractions (referred as “boom-boom” due to its quick administration) is a palliative treatment alternative to the current standard of 24 Gy for indolent non-Hodgkin lymphomas (NHL) such as follicular lymphoma and marginal zone lymphoma (MZL). VLDRT treatment has been available for more than 10 years in many academic settings. However, a review of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Oncology Nursing Society data demonstrated no information on this type of radiation treatment option in the nursing literature. The purpose of this poster is close the gap in the nursing literature, educate oncology nurses about the rationale for the use of VLDRT for certain non-Hodgkin lymphomas (NHL), and highlight the benefits of a shorter treatment schedule and decreased radiation related toxicity for the patient. Indolent lymphomas such as FL and MZL have been long known to be extremely radiosensitive. A randomized study by Lowry et al demonstrated that a dose of 24Gy (12 Treatments), compared to historical doses of 40-45 Gy (20 treatments), proved effective for control of most cases of localized FL and this dose became the standard of care for this population. A United Kingdom randomized study called FORT then compared the use of 24 Gy vs 4 Gy for radical or palliative local control of follicular lymphoma or marginal zone lymphoma demonstrated that while 24 Gy remains the standard dose for curative treatment of localized disease, 4Gy remains an excellent alternative in the relapse and palliative setting. Preparation of the patient for treatment with VLDRT remains the same as treatment with the 24Gy. The low dose allows for retreatment to the same field as needed. The plan of treatment is developed using either a CT, a PET/CT simulation, or a clinical setup. Immobilization devices are created and used during the simulation scans and treatments to ensure stability of the field of treatment. While radiation related toxicities were low in both FORT treatment groups, the rapid treatment schedule of only 2 consecutive days vs 12 days is significant to promote improved quality of life in the palliative setting.

P7 ASSOCIATION OF SINGLE NUCLEOTIDE POLYMORPHISMS WITH SEVERITY OF ACUTE RADIATION DERMATITIS IN BREAST

CANCER PATIENTS: SYSTEMATIC REVIEW AND META-ANALYSIS

Beatriz Aguiar, RN, MSc, University of Brasilia, Brasilia; Ana Normando, MSc, University of Campinas, São Paulo; Eliete Guerra, PhD, University of Brasilia, Brasilia; Elaine Ferreira, RN, PhD, University of Brasilia, Brasilia; Paula Reis, RN, PhD, University of Brasilia, Brasilia

Oncology Nursing Practice

Radiation dermatitis (RD) is an adverse skin reaction that affects approximately 95% of breast cancer patients undergoing radiotherapy. This reaction has an impact on the continuity of treatment, on the quality of life, and on the patients' body image. Radiogenomic studies have investigated the potential of Single Nucleotide Polymorphisms (SNPs) to predict the occurrence of severe RD. The purpose was to identify in the literature the SNPs that may be associated with the occurrence of severe RD. This systematic review followed the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) criteria. The search was performed at CINAHL, Cochrane CENTRAL, EMBASE, LILACS, PubMed, Scopus, and Web of Science. Additionally, a search was performed in the gray literature and in the reference list of the articles included. The Joanna Briggs Institute Critical Appraisal Checklist for Cohort Studies tool was used to assess risk of bias from the individual studies. Meta-analysis of association between SNPs and severe RD was performed using Cochrane Collaboration's Review Manager[®] 5.4 software (RevMan 5.4). The certainty of the evidence was assessed using the Grading of Recommendation, Assessment, Development, and Evaluation (GRADE). Sixteen cohort studies were included in this review. Most had a low risk of bias ($n=13$). The association meta-analysis of 21 SNPs showed that seven genotypes are associated with severe RD and five genotypes are associated with lower RD in breast cancer patients. However, the CT genotype of the SNP rs3957356 in the *GSTA1* gene (OR: 5.57; 95%CI: 1.73–17.87; $p=0.004$) and the GG genotype of the SNP rs2282367 in the *MAT1A* gene (OR: 2.03; 95%CI: 1.18–3.48; $p=0.01$) showed low certainty of evidence for association with severe RD. All other genotypes have very low evidence certainty. Significant data show that genotyping of SNPs may be a strategy for predicting severe RD in breast cancer patients. The identification of the association of SNPs with the occurrence of severe RD to contribute to the planning of radiotherapy and to improve the nursing follow-up of patients who are more likely to develop severe RD, based on clinical and genetic evaluation.

P8 A QUALITY IMPROVEMENT PROJECT TO REDUCE HOSPITAL READMISSIONS IN THE ONCOLOGY PATIENT POPULATION

Laura Alfonso, MSN, RN, OCN[®], UCLA Medical Center, Santa Monica, Santa Monica, CA; Maria Quirch, MSN, RN, OCN[®], UCLA Santa Monica Hospital, Santa Monica, CA; Yesenia Valle, MSN, RN, NEA-BC, OCN[®], UCLA Santa Monica, Santa Monica, CA

Oncology Nursing Practice

Hospital readmissions negatively impact healthcare organizations and patients alike. Readmissions are costly, resulting in financial losses for organizations while also causing poor patient experiences. Oncology patients are associated with higher readmission rates due to the complexities of their disease. They face high symptom burden as result of their cancer and treatment, such as pain, nausea, vomiting, and fatigue. In an effort to address this issue, the readmissions reduction steering committee implemented a system-wide screening tool—Better Outcomes by Optimizing Safe Transition (BOOST). BOOST prompts nurses to identify if patients meet any of the eight predetermined high risk readmission categories as part of their daily assessment. While this screening tool appears promising, the effectiveness of this tool has yet to be proven in the oncology population. The purpose was to identify oncology diagnosis with the highest readmission rate for solid tumor oncology patients and complete in-depth gap analysis to identify the root causes for readmission. Using the BOOST screening tool, baseline data will be collected on the 30-day readmission rate of patients on the solid tumor oncology unit from 10/2020 through 12/2020. An interdisciplinary workgroup will evaluate the data to develop a clinical pathway for the oncology diagnosis to enhance patient care, ensure a safe discharge and post-hospital care. After the clinical pathway for the oncology diagnosis is implemented, readmission rates for that sub-group will be collected monthly. Results will determine if deeper analysis of risk factors and oncology specific interventions strengthen the efficacy of the BOOST screening tool. The BOOST screen tool was created to identify patient specific risk factors and target interventions to mitigate those risks and prevent unplanned readmissions. Navigating the health system and providing care to cancer patients requires a unique skill set. Deeper analysis of risk factors and oncology specific interventions are needed to optimize the BOOST screening tool for the oncology patient population.

P9

BARRIERS AND FACILITATORS OF CHRONIC PAIN SELF-MANAGEMENT AMONG PATIENTS WITH CANCER: AN INTEGRATIVE REVIEW

Batool Almasri, RN, Willimantic, CT

Symptom Management and Palliative Care

Chronic pain is one of the most common and debilitating symptoms that burden cancer patients. Significantly, home is considered the primary setting for chronic cancer pain management. National and international clinical guidelines recommended self-management approaches as a core component of cancer pain management. Therefore, understanding patient perspectives and defining the main barriers and facilitators of chronic cancer pain self-management are essential improve patients' overall quality of life. The purpose was to identify the main barriers and facilitators for chronic cancer pain self-management. An integrative review was used. It was guided by the five stages framework that identified by Souza et al. (2010); (1) preparing the guiding question, (2) searching or sampling the literature, (3) data collection, (4) critical analysis of the studies included, (5) discussion of results. A comprehensive literature review was conducted using the electronic databases of PubMed/MEDLINE, CINAHL, Scopus, and Psych INFO. The eligibility criteria and two levels of screening process were applied to determine the relevant studies. Twenty-four studies were identified. The main facilitators were supportive ambiances, active participation of the cancer patients in health care including self-discovery and self-awareness, acquiring pain knowledge, and using a pain diary. The main barriers included concerns regarding the use of pain medications, deficit knowledge and negative beliefs and attitudes, unsupportive ambience, and psychological distress. Additionally, some patients' characteristics could be related to these barriers such as age, gender, race, marital status, educational level, level of pain, and presence of comorbidity. Patients with chronic cancer pain experience multiple barriers and facilitators when attempting to take on an active role in managing their pain. The main facilitators include support and active participation, while the main barriers include negative attitude, deficit knowledge and unsupportive ambience. A thorough review of the literature did not reveal any study that reviewed or analyzed the main factors that affect the process of chronic cancer pain self-management. By assessing for these factors, health care providers can support cancer patients to overcome the barriers, maximize the facilitators and succeed in managing chronic pain on their day-to-day

life. Also, health care providers and researchers should incorporate different strategies to fill the gap between the available pain education programs and the presence of knowledge deficit among cancer patients.

P10

EXPERIENCES OF CANCER PATIENTS LIVING WITH CHRONIC PAIN: A META-ETHNOGRAPHY

Batool Almasri, RN, Willimantic, CT

Coordination of Care

Chronic pain is one of the most common and debilitating symptoms in cancer patients. Despite efforts to improve chronic cancer pain management, evidence-based recommendations geared toward exploring the most effective management for chronic cancer pain are still a challenge. Understanding the experience of cancer patients living with chronic pain provides the basis for the assessment and management of chronic cancer pain. The purpose was to review, synthesize and interpret the findings of qualitative studies related to the experience of cancer patients with chronic pain. Meta-ethnography was guided by the analysis method of Noblit and Hare (1988). It has been called meta-ethnography, referring to the method of systematic comparison, which involves the translation of studies into one another to create new meanings. A comprehensive literature review was conducted using the electronic databases of PubMed/MEDLINE, CINAHL, Scopus, and Psych INFO. After applying the eligibility criteria and two levels of screening process to determine the relevant studies, eight qualitative studies were identified, published between 2015 and 2020. Study metaphors were clustered into four major themes reflecting the experience of cancer patients with pain: (1) excruciating pain: the anguish of living with cancer pain, (2) effects of pain on daily life, with three sub-themes; the physical, psychological and social effects of pain, (3) relationship with health care, with two sub-themes; access to health care and issues with medication, and (4) coping and management strategies. This meta-ethnography study demonstrated the main difficulties that face cancer patients living with chronic pain. Cancer Pain is referred to as a total pain; it impacts the biopsychosocial framework and generates multidimensional changes. The patient's physical problems prepared the ground for their psychosocial problems. Being dependent on others, interrupted hope for future and trumps the will to live. Understanding the experience of chronic pain among cancer patients will enable health care providers and researchers to develop appropriate pain management strategies. Patients with cancer pain need

much more attention from health care providers (especially nurses) in pain assessment and management interventions. Health care providers should offer high-quality care using a holistic approach to reduce chronic pain and pain-related physical and psychosocial symptoms.

P11 **HAIRS THE DEAL: IMPLEMENTING SCALP COOLING FOR CHEMOTHERAPY-INDUCED ALOPECIA AT A COMMUNITY-BASED CANCER CENTER**

Linda Amacher, BSN, RN, OCN[®], Froedtert and the Medical College of Wisconsin, West Bend, WI; Denise Herriges, BSN, RN, OCN[®], Froedtert and the Medical College of Wisconsin, West Bend, WI; Denise Portz, MSN, RN, ACNS-BC, AOCNS[®], Froedtert and Medical College of Wisconsin, Milwaukee, WI; Joann Schultz, RN, OCN[®], Froedtert and the Medical College of Wisconsin, West Bend, WI; Sarah Beisbier, BSN, RN, Froedtert and the Medical College of Wisconsin, West Bend, WI

Symptom Management and Palliative Care

Chemotherapy-induced alopecia is a side effect of many cancer treatments and one of the most feared side effects in greater than 75% of patients. Scalp cooling machines are a recent supportive care intervention in the United States. For a while, the only option was patient-managed cold caps. Following the 2017 US FDA clearance, more facilities now offer scalp cooling. The decision to implement a scalp cooling program in the cancer network was based on evidence of safety and effectiveness, in addition to patient interest. The purpose of this project was to implement a scalp cooling program for patients in a community-based cancer center that is part of a large Midwest academic cancer network. An interprofessional team was created to drive program implementation. Led by an oncology clinical nurse specialist, the team included nurses, providers, a scheduler, managers and aesthetic wellness coordinators. This team evaluated costs, machine support, space, scheduling, and staff workload. Roles, workflows, scheduling templates, nursing documentation texts, patient education and evaluation tools were created. Staff training included how scalp cooling works, clinical data and efficacy, cooling machine system procedures, including patient introduction and education. Nurses and aesthetic coordinators specifically learned about patient enrollment, prescription, consent, cap fitting, system operation, and patient hair care and education materials. Within two months of implementation, eight patients have

enrolled and over 35 scalp cooling treatments have been completed. Two patients stopped scalp cooling after two cycles due to feeling overwhelmed and questioning effectiveness. However, two other patients have since completed all cycles and expressed high satisfaction, having retained more than the 50% of the hair loss expected. Staff have also expressed satisfaction in the amount of training received, resources provided, and are proud that scalp cooling is offered. The goal is to enroll 15 patients prior to implementing scalp cooling at a second site. Having an advanced practice nurse driven program was a key to successful implementation. Nurses are at the forefront of promoting and educating patients throughout the care continuum for supportive care interventions such as scalp cooling. There was quick adoption by nurses and processes were integrated into clinic and infusion workflows without significant challenges. Other cancer centers may wish to consider program development using a nurse-driven model.

P12 **CARE ESCALATION IN A 24-HOUR ONCOLOGY URGENT CARE**

Stephanie Armstrong, DNP, RN, NP-C, Froedtert and the Medical College of Wisconsin Clinical Cancer Center, Milwaukee, WI

Oncology Nursing Practice

The 24-hour cancer clinic is an oncology specific four bed urgent care embedded within the inpatient unit of an academic medical center in southeast Wisconsin. In an effort to provide continuity of care, the clinic provides accessible solutions for non-emergent urgent care needs for individuals receiving cancer treatment. Over the past year, the clinic has seen significant growth. With this increase in utilization, came increased patient acuity within the 24-hour clinic space. Under the urgent care model, certain conditions require escalation in order to maintain patient quality and safety. The 24-hour cancer clinic, given its proximity to inpatient services and the unique integration efforts made during its development, showed potential for making streamline transfer of care a possibility. Reality, however, proved more challenging. Barriers including, existing ambulatory charting platforms and transfer pathways, would need modification in order to make this concept a reality. A pathway was developed to allow direct transfer to the Intensive Care Unit (ICU) for those patients requiring intensive care in the 24-hour clinic. Under the new pathway, patients requiring critical care, no longer needed admission through the standard emergency

department pathways. Instead, care is coordinated at the bedside of the 24-hour clinic allowing for efficient transfer from the 24-hour clinic directly to a critical care inpatient space. Under the new process, the care team with in the 24-hour clinic, along with the rapid response team, and on call critical care fellow coordinate admission under an expedited process allowing for efficient care with minimal care delays. To date three patients have utilized this pathway since implementation on July 1, 2021. These patients were effectively transferred to the ICU with little care delay. Feedback from the participants in the pathway role out have been positive. The project remains in its preliminary phases of evaluation. More time is needed in order to determine the efficacy of this pathway long term. With pathways like this in place, the potential for more acute patients within this care space is a growing possibility. The direct transfer of patients from an ambulatory clinic directly to an ICU is novel concept; one that has the potential to limit care delay and promote efficient and timely care for the oncology population.

P13 **EVIDENCE INTO PRACTICE: DEVELOPING AN ULTRASOUND GUIDED PERIPHERAL IV INSERTION PROGRAM FOR CRITICALLY ILL ONCOLOGY PATIENTS**

Stacy Artrip, MS, APRN-CNS, OCN®, The James Cancer Hospital at Ohio State University Wexner Medical Center, Columbus, OH; Michele Weber, DNP, RN, APRN-CNS, APRN-CNP, CCRN, CCNS, OCN®, AOCNS®, The James Cancer Hospital at Ohio State University Wexner Medical Center, Columbus, OH
[Oncology Nursing Practice](#)

Patients in oncology focused ICUs present unique challenges in IV access as they are both chronically and critically ill. The difficulty in gaining and maintaining IV access stems from poor vein assessment, choosing the incorrect gauge PIV, multiple attempts causing vein trauma and scarring, and needing urgent access. Our institution found an increase in Vascular Access Team (VAT) consultations to place Ultrasound-Guided PIVs (UGPIV). Thus, our team developed a nurse led self-sustaining UGPIV training program specific to the ICU oncology population. By utilizing a PICOT question and librarian collaboration, we found 15 articles that described UGPIV training programs from various healthcare settings. The literature focused on emergency rooms with a few from ICUs, but zero described challenges for ICU oncology patients. We used synthesis tables to subjectively assess the literature. Literature elements fo-

cused on class time and skills, initial competence, and competency maintenance. To integrate evidence, our team reviewed course content and skills with institution experts. We developed a badge buddy for nurse reference in UGPIV best practice. We provided best practice updates to our current UGPIV users. Nurses who have attended responded positively to class. Several asked for a second clinical day with the VAT to gain more confidence. This could be the result of placing UGPIVs in a highly specialized population with challenging vasculature. To date, 21 nurses are trained with 574 UGPIVs placed since April of 2021. Outcomes are ongoing and will be tracked using an EMR tracking tool quarterly. A robust UGPIV program for critically ill oncology patients has positive patient outcomes. Direct benefits for this patient population include shorter time to obtaining IV access, detailed vein assessment, knowledge of potential vein trauma, and fewer sticks. This program also has vital future implications to the critically ill oncology population. As these patients move through their treatment plans, the goal for them is to clinically improve and discharge home. However, many of these patients will require future IV access and they will still have viable veins thanks to the mindfulness of UGPIVs placed in the past by our UGPIV trained oncology ICU nurses.

P14 **OUTPATIENT CHEMOTHERAPY TREATMENT CHAIR SCHEDULING GUIDELINES—IMPROVING EFFICIENCY AND PROACTIVELY MANAGING VOLUME**

Jaida Baum, MSN, RN, OCN®, UPMC Hillman Cancer Center, Natrona Heights, PA; Rebecca Smith, BSN, RN, UPMC Hillman Cancer Center, Butler, PA; Heidi Robinson, MSN, RN, OCN®, UPMC Hillman Cancer Center, Pittsburgh, PA; David Burkey, RN, UPMC Hillman Cancer Center, Beaver County, PA
[Oncology Nursing Practice](#)

The process of managing outpatient oncology treatment infusion center staffing is undoubtedly complex. Volume is dependent on the plethora of variables that impact whether or not a patient is treated such as; performance status, efficacy of treatment, management of side effects, tolerance to the infusion, ect. It was identified that proactivity is imperative to manage infusion center volume based off of available oncology nurses at our community sites. The purpose was to proactively assign target patient treatment numbers for scheduling team members to reference to most efficiently utilize nursing resources while maintaining focus on quality care delivery. Nurse managers receive

schedule of nurses available for the month. They then collaborate with treatment schedulers to establish target treatment numbers for the month. The schedulers and nurse managers continually assess target numbers throughout the month to determine what days are better/worse for putting on patients to balance schedule. The nurse managers also evaluate the clinical situation on high volume days and discuss with regional leadership any staffing needs necessary proactively if/when needed to best care for the volume of patients. This provides flexibility to get patients into the clinic who need to start treatment asap or need supportive care to avoid hospitalization. Proactively establishing and continually assessing the target numbers balances nursing resources. Typically, the oncology nurses are able to care for 8-10 treatment patients per 8 hour day with varying complexity of chemotherapy, immunotherapy, and supportive medications. This provides the ability to deliver quality care and also be efficient with our nurse resources. Efficient treatment scheduling in the outpatient oncology setting is imperative to delivery of quality care and satisfaction of oncology nurses who have a strong affinity to caring, educating, and supporting their patient population. The safe administration of chemotherapy is paramount, and, thus, the optimal management of workflows in the chemotherapy unit is a primary concern for any practice. Processes to improve the experience for both patients and the staff caring for them is of utmost importance for us to continually investigate in our oncology nursing world.

P15 **ASSURING COMPETENCY ACROSS DIVERSE CLINICAL SATELLITE**

Amy S. Boswell, MSN, RN, OCN[®], Seattle Cancer Care Alliance, Seattle, WA; Tammy Arce, RN, Seattle Cancer Care Alliance Issaquah, Issaquah, WA; Melissa Farleigh, BSN, RN, Seattle Cancer Care Alliance at EvergreenHealth, Kirkland, WA; Glenda Gottfred, BSN, RN, OCN[®], Seattle Cancer Care Alliance Peninsula, Poulsbo, WA; Rae Niculescu, MN, RN, OCN[®], Seattle Cancer Care Alliance at EvergreenHealth, Kirkland, WA; Hanahlyn Park, MSN, RN, OCN[®], Seattle Cancer Care Alliance at University of Washington Medical Center–Northwest, Seattle, WA; Katheryn Christiansen, BS, MHA, Seattle Cancer Care Alliance, Seattle, WA

Oncology Nursing Practice

At an NCI-designated comprehensive cancer center in the Northwest, 5 community clinics in diverse geographic locations serve about 13,000 patients annually. Rapid growth has occurred over the last 2 years without standardization of maintenance and documentation

of annual clinical competencies. Key stakeholders, including nursing leadership, APN nurse educator, and site-specific professional practice coordinators (PPCs), were engaged to design system-wide consistency of annual staff practice validation documentation and required expertise. The purpose of this project was to design a standardized program for annual competency validation at 5 ambulatory oncology community clinics to meet regulatory requirements and promote best clinical practice for patient outcomes. A clinical assessment of practice needs specific to each site, treatment modality, and clinical role was conducted. The APN and PPCs from each site met to assess and align standardization of competencies to be monitored annually. Method for competency selection included high-risk, low-volume procedures, trends or issues identified within incident reports, topics requested by local leadership and staff, and the need for practice alignment across sites. The program includes the clinical roles of registered nurse (RN), licensed practical nurse (LPN), medical assistant (MA), and certified nursing assistant (NAC) within medical oncology, radiation oncology, and infusion. Weekly working meetings were held with the APN and PPCs to develop content of competencies. A REDCap database was developed to track role-specific content/skills and dates of annual competency confirmation per site and staff member. Implementation of competency assessments and documentation has a goal of 100% compliance at all sites by October 31, 2021. Ongoing process evaluation will continue and post-program assessment will be conducted with all staff feedback to inform next year's annual confirmation of competencies. This collaborative effort between the central academic medical center and the clinical community sites facilitated standardization of professional practice expectations and competency standards across all clinical areas of our system while meeting the unique needs of each site. Patient safety and adverse events are integral to competency and so will be monitored via the incident report system. It is essential that organizations assure clinical practice standards and quality are consistent across diverse ambulatory oncology care settings. Meeting the needs of the patient closer to their homes at community clinics compels cancer centers to have consistent standards to assure best care delivery.

P16 **ONCOLOGY NURSES SUPPORTING ADVANCE CARE PLANNING DISCUSSIONS ON SOLID TUMOR ONCOLOGY UNIT**

Pamela Bowman, MSN, RN, OCN[®], Duke Cancer Institute, Durham, NC; Yousuf Zafar, MD, Duke Cancer

Institute, Durham, NC; Yvonne Acker, RN, BSN, CPHQ, Duke University Health System, Durham, NC; Michelle Hocutt, MSN, RN, NE-BC, Duke Cancer Institute, Durham, NC

End of Life

Healthcare providers on this solid tumor oncology unit use patient metrics from electronic medical records (EMR) to guide advance care planning (ACP) discussions. Patient metrics, developed by the health system's Patient Quality and Safety, alert the oncology provider team when advance care planning discussions are needed. Oncology nurses on this oncology unit participated because they are often present when patients receive bad news. Literature suggests ACP conversations help patients avoid unwanted aggressive care. Develop a process to include oncology nurses in advance care planning conversations with patients. Provide oncology nurses with knowledge and communication tools useful when having follow up conversations with patients. Nurses on unit received education about SPIKES, the cognitive framework for goals of care discussions that providers use, and NURSE, the framework that nurses use to respond to the "E" (emotion) in SPIKES in follow up discussions with patients. Nurses learned empathy phrases that allow patients to share feelings. New staff received the same education as part of unit onboarding. Nurses received instruction on using ACP-specific smartphrase in EMR. Sixty-one nursing staff participated in educational offering. Initial EMR reporting at 30 days post-education revealed no nursing notes written. However, informal conversations with nurses indicated conversations occurred with about 4 end-of-life patients. Nurses reported using advance care planning tab to read notes from multidisciplinary team to learn status of patient. On this oncology unit, nurses are ideally notified when providers have bad news discussions with patients as part of a 2012 nursing project so nurse can attend. As nursing staff turnover and frequent changes in providers in this teaching hospital occurred, drift from this practice was inevitable. The ACP project presented an opportunity to renew the expectation that nursing participate in bad new conversations and learn skills to have follow up conversations with patients. We worked with the informatics team to develop a nursing specific smartphrase. Nurses documented "biggest concerns" of patient in order to inform multidisciplinary team. The EMR data tracking of ACP notes reported usage and was a useful feedback tool. Our oncology unit was first to include nursing in this hospital-wide advance care planning

project because of our experience attending bad news conversations. Our smartphrase template was used hospital-wide as it reflected nurses' contributions to advance care planning conversations.

P17 **ESTABLISHING AN ONCOLOGY TRIAGE AND SAME DAY SERVICE**

Victoria Bradford, RN, BSN, MBA, UC San Diego Health Cancer Services, La Jolla, CA; Archana Ajmera, MSN, ANP-BC, AOCNP®, University of California San Diego, La Jolla, CA

Oncology Nursing Practice

Most cancer patients will have significant symptoms at some point during their cancer journey. If these symptoms (pain, nausea, vomiting and so forth) aren't managed effectively or happen when their care team is not available, they may use Emergency Department services. Through the Outpatient Quality Reporting Program (OP-35), CMS now holds physicians and systems accountable for ED visits and hospitalizations by patients receiving chemotherapy. We established a Triage/Same Day Service to manage urgent patient issues, in collaboration with primary disease team and Emergency Services. The purpose of the project was to establish process for rapid assessment, intervention and evaluation of patients with urgent symptoms by Disease Team or the Triage APP and RN to: (a) decrease ED/inpatient admissions, (b) strengthen communication and improve utilization of the ED Observation Unit through oversight of referral process, (c) ensure early intervention to decrease severity of symptoms and length of stay in event of inpatient admission, and (d) increase patient and family wellbeing and experience. Interventions were to (a) establish multidisciplinary work group (physicians, APPs, RNs, Quality leadership), (b) determine target patient population through data and program review, (c) develop Operating Model: hours of operation, triage RN staffing and training, triage APP staffing and training, and EMR visit type, (d) develop standard workflows for incoming patient calls: Call Center and Administrative Assistant routing and Oncology RN Telephone Auto-Attendant with scripting to route calls to appropriate resource if RN unavailable, (e) develop patient care workflows: triage RN assessment of patient issue and EMR to align with disease team recommendations for management of issue, triage RN pages Physician to review issue and determine if team or Triage APP will see patient, and Triage RN dispositions and documents plan (patient scheduled and seen same day by disease team, patient scheduled and seen same day by Triage APP), (f) If

patient seen by Triage APP, real-time collaboration with disease team for management of patient (patient able to return home with plan, patient scheduled for hydration/blood products in Infusion Center, patient referred to ED Observation Unit). Evaluation includes monthly discussion and metric review with multiple groups and metrics (Patient Satisfaction scores, Triage/Same Day Service calls/visits, ED and ED Observation visits by disease team, and Inpatient LOS). Feedback and metrics have been overwhelmingly positive for program—we look forward to sharing more at ONS Congress 2022.

P18 **ENGAGING NURSING STAFF WITH** **ASYNCHRONOUS PALLIATIVE CARE**

Susan Bruce, MSN, RN, OCN®, AOCNS®, Duke Raleigh Cancer Center, Raleigh, NC; Jennifer Gentry, DNP, ANP-BC, GNP, ACHPN, FPCN, Duke University Hospital, Durham, NC; Cindy Bohlin, MSN, RN, PCCN, Duke University Hospital, Durham, NC; Dorothy Filippi, MSN, RN, CCRN-K, Duke University Hospital, Durham, NC; Heather Sullivan, MSN, RN, CNL, Duke Raleigh Hospital, Raleigh, NC

Symptom Management and Palliative Care

The coronavirus infectious disease (COVID) pandemic has underscored the importance of palliative care, the crucial role that nurses have in providing it and the need for innovation to provide essential training. This need for expansion of palliative care training required innovation adaptations to the course to virtual delivery. The purpose was to provide an asynchronous model of providing palliative care education. Using the well-known End of Life Nursing Education Consortium (ELNEC) curriculum, palliative care nursing education was offered through an online learning management system. ELNEC training is traditionally offered in an in-person synchronous format, but the need to minimize close physical interaction and accommodate off-shift schedules was best met through an online, asynchronous method. The ELNEC curriculum encompasses many foundational concepts in palliative nursing. In addition to recorded lectures, participants were engaged through interactive discussion forums, video clips, and self-reflective activities. Course content could be completed at an individual pace over 6 weeks. Lectures and learning activities were broken down into shorter segments and grouped conceptually. Weekly reminders helped participants stay focused and faculty shared responsibility for monitoring and providing feedback for discussion posts. The capstone of the course was bringing learners together in a vir-

tual classroom. Using a complex case study, learners were encouraged to apply key concepts from the curriculum in an interactive group setting. The course concluded with a focus on self-care and strategies to promote resilience. Twenty-nine nurses completed the training and over 96% believed that the course increased knowledge and competence in palliative care. Though evaluations were positive, a faculty debriefing was conducted to further refine educational methods for future courses. Online, asynchronous palliative care nursing education can be successfully implemented and applied while engaging learners in an interactive format. The use of this creative format can be instrumental in delivering any course content. It is simple to replicate in any community or academic setting. Due to the sensitive nature of subject matter and lack of face-to-face assistance, participants should be offered resources for psychosocial support.

P19 **100.4. DON'T LET IT SOAR. A** **COMPREHENSIVE APPROACH TO** **MANAGING NEUTROPENIC FEVER**

Bianca Carpenter-Marshall, MSN, RN-BC, NE-BC, Baylor University Medical Center, Dallas, TX; Lucy Horton, BSN, RN, Baylor University Medical Center, Dallas, TX; Shawnette Graham, MSN, RN, OCN®, Baylor University Medical Center, Dallas, TX; Sasilekha Jyothik, MSN, RN, OCN®, Baylor University Medical Center, Dallas, TX; Lisa Chartrand, BSN, RN, NE-BC, Baylor University Medical Center, Dallas, TX; Kathleen Shuey, MS, RN, ACNS BC, AOCN®, Baylor University Medical Center, Dallas, TX

Oncology Nursing Practice

Neutropenia can lead to life-threatening consequences when the patient develops a fever resulting in increased morbidity and mortality. Time to initiation of antibiotics contributes to the successful treatment of this at-risk group. Initial review of data indicated opportunities to increase compliance with initiation of antibiotics within 60 minutes. A project was initiated in a 96-bed cancer hospital to have antibiotics started within 60 minutes from time of fever in a minimum of 70% of febrile neutropenic patients. A multidisciplinary team was formed consisting of oncologists, internal medicine, pharmacy, nursing, and laboratory to evaluate identified issues and determine next steps. Data was reviewed monthly evaluating time from fever to blood cultures, blood cultures to antibiotics, and fever to antibiotics. Identified barriers included availability of antibiotics on the unit, order set inconsistencies, laboratory personnel availability, commu-

nication, and escalation of issues with non-oncology providers. An audit form was developed to assist with case review. SBAR communication tool was implemented along with a poster to reinforce information. A decision tree to decipher escalation process by provider team. A train-the-trainer model was implemented leveraging charge nurses to complete education and lead unit huddles. Physician led education sessions using a hybrid approach. A road show by nursing leaders provided additional information to staff on all shifts and followed up on individual questions. The multidisciplinary team reviews monthly data by patient and provider evaluating time. A pre- and post-survey was developed to evaluate knowledge and comfort level of bedside leaders. Time to antibiotic administration improved to 100% in the latest month. Initial nursing data indicated 92% of staff were familiar with the management of neutropenic fever. The initial survey had a low response rate. Post-implementation survey completion was encouraged during the road show. Data showed improvement with 100% positive rate. Survey questions included identification of neutropenic fever, management, and interventions in the care of febrile neutropenic patients, and comfort level in managing patients. The Professional Development Specialist incorporated use of technology to facilitate completion of survey using a QR code to access the pre- and post- data. Hybrid education model was utilized with in person physician inservices on the inpatient unit allowing access by remote users. An educational cart on wheels was taken to each unit by leadership for the road show.

P20 **IMPLEMENTING THE RESEARCH NURSE** **ROLE AS A LIAISON**

Kelly Carter, BSN, RN, University of Rochester, Wilmot Cancer Center, Rochester, NY; Jamie Littleton, MSN, RN, CCRC, University of Rochester Medical Center, Rochester, NY

[Coordination of Care](#)

A Western New York Cancer Center working towards National Cancer Institute (NCI) designation identified a gap in communication between the Clinical and Research teams. The Clinical Trials Office (CTO) has a team of non-clinical research coordinators to facilitate coordination of the research participants. Clinical teams were already in place including clinic, infusion, and inpatient nursing. The Research Nurse Program was implemented to improve communication, patient care, and clinical trial collaboration across clinical teams. The model chosen embeds a

Clinical Research Nurse (CRN) with clinical trial and cancer care knowledge as an integrated part of the patient's care team. The CRN is able to bridge the gap between the CTO and Clinical teams by acting as a liaison between the research and nursing teams providing a valuable resource to both. This support empowers bedside nurses to feel confident and competent in the care they provide to research participants while fostering positive relationships between teams increasing knowledge and excitement about clinical trials. The CRN shadowed the different teams in the regional gynecologic oncology office to identify key areas of need. The role was re-designed and implemented beginning in May of 2020 to best address the gaps in communication, coordination, and care. The partnership was then brought to the breast, leukemia, and multiple myeloma teams over the next 12 months. The CRN role is developed and implemented based on the disease specific team's needs in addition to the role's basic model. Beginning in the regional locations allowed the role to be developed in a small controlled setting. This was also an opportunity for the regional sites to influence the way the main facility cares for their patients. Informal evaluation from other teams has been positive, citing greater support and communication while also feeling heard when an issue arises. Providers appreciate the extra support from a nurse when caring for their patients. Patients appreciate the support and communication from a nurse who understands all aspects of their care. Collaboration between the CRNs is increasing as we add new nurses, increasing our impact. The nontraditional model allows a few passionate experts to make a big difference on patient care and support the clinical teams.

P21 **STRATEGIC IMPLEMENTATION FOR** **PROVIDING KIDNEY REPLACEMENT** **THERAPY DURING COVID-19**

Elizabeth Kong, MSNed, RN, CDN, CEN, Memorial Sloan Kettering, New York, NY; Mariea Casas, MHA, BSN, RN, CDN, CCRN, Memorial Sloan Kettering, New York, NY

[COVID-19](#)

The project objective was to describe our response to the COVID-19 pandemic to ensure uninterrupted kidney replacement therapy (KPT) for our acute kidney injury and chronic end-stage renal disease patient cohort. With the onset of the COVID-19 pandemic, our 514-bed NYC Magnet recognized NCI-designated comprehensive cancer center mobilized all patient care areas to meet the needs and safety of our patients and staff. As a

result, a collaborative team inclusive of dialysis nurses, Renal and ICU management medical teams was developed to spearhead guidelines to improve KRT treatment outcomes for acutely ill and chronic end-stage renal disease patients. As the number of COVID-19 positive patients increased throughout the organization, strategic planning began with expanding the ICU by relocating the in-patient hemodialysis treatment area to a designated COVID-19 unit equipped to accommodate hemodialysis in private negative pressure rooms for both COVID-19 positive and non-COVID-19 patients. Early identification of our inability to secure additional continuous renal replacement therapy (CRRT) machines led to incorporating the use of shift therapy to optimize our available equipment, along with our supply chain preemptively increasing the purchase of CRRT and hemodialysis supplies. As the ICU expanded across two distinct units, nursing practice changes included setting up the CRRT equipment outside the COVID-19 positive patient's room, decreasing nursing exposure time, and obtaining CRRT waste line extension sets for use in rooms without designated drainage systems. To mitigate possible access issues, the right internal jugular was spared for dialysis catheter lines placement, and the use of a larger bore catheter became the standard of care. In addition, the policy for TPA dwell time was standardized to two hours to manage clotted or sluggish hemodialysis catheters. The dialysis unit comprised of only registered nurses, coordinating with essential departments to stock supplies for both the ICU and the temporary unit, providing terminal cleaning in-between patient treatments, and transporting patients between units was crucial. To increase our staffing, re-orientation was provided to a previously employed dialysis tech. In addition, the nursing staff of our relocated unit was all provided re-orientation on the Hemodialysis Emergency Disconnect procedures in the event of an adverse event. Throughout the pandemic, the hemodialysis nursing staff supported the ICU nurses as resources while providing CRRT for patients with acute kidney injury.

P22

DEVELOPMENT OF A COVID-19 INFUSION UNIT FOR ADMINISTRATION OF ANTI-SARS-COV-2 MONOCLONAL ANTIBODY (MAB) THERAPY

Hilary Chandler, BSN, RN, OCN[®], CRNI, Kelsey-Seybold Clinic, Houston, TX

COVID-19

Some patients with COVID-19 are at a heightened risk for hospitalization due to age and/or comorbid-

ities. Anti-SARS-CoV-2 monoclonal antibody therapy reduces the risk of COVID-19-related hospitalization among high-risk patients by ~70%. Because COVID-19 is a highly infectious viral illness, rigorous safety protocols are needed for patient, visitor, and staff protection when treating patients with COVID-19 infection. The purpose of the project was to develop an infusion unit and protocol for the administration of anti-SARS-CoV-2 monoclonal antibody therapy (mAb) to high-risk patients with COVID-19/. A staff lounge was converted to a negative air pressure isolation suite, named the Infusion Specialty Unit (ISU). The unit includes an ante-room for donning/doffing of PPE and a dedicated building entrance and exit for patients. A comprehensive workflow was created for patient evaluation, medication ordering, and mAb infusion treatment in the ISU. Through multidisciplinary teamwork, the protocol allows qualifying patients to be treated with mAb therapy within 24-48 hours of physician referral. From November 2020 through August 2021, the Infusion Specialty Unit has successfully treated 1,070 patients with anti-SARS-CoV-2 mAb therapy. Safety recommendations implemented in the Infusion Specialty Unit include full PPE precautions for staff, including N95 or higher-level respirators, dedicated medical equipment, dedicated entrance and exit for COVID-19 positive patients, and negative air pressure. By converting under-utilized space into an isolation unit, the organization has been able to offer a novel therapy to patients with COVID-19.

P23

EXAMINATION OF ALTERNATIVE EASTERN THERAPIES ON BREAST CANCER SYMPTOM RELIEF

Yi J Chen, Columbia University School of Nursing, New York, NY; Jessica Cheng, Columbia University School of Nursing, New York, NY; Angeline Pan, Columbia University School of Nursing, New York, NY
Symptom Management and Palliative Care

Breast cancer is the most commonly diagnosed cancer in women in the United States. According to the American Cancer Society, there are more than 3.8 million women diagnosed with breast cancer and/or have finished treatment for breast cancer. Although cancer research and treatment therapies are progressively advancing, there are still areas of improvement when it comes to oncological symptom management and palliative care. According to the National Comprehensive Cancer Network (NCCN), 30% to 75% of patients diagnosed with breast cancer and have been undergoing treatments reported fatigue and sleep dis-

turbances. Around 33% of breast cancer survivors still reported persistent fatigue up to 10 years after treatment. The NCCN publishes annual guidelines and provides recommendations for providers to prescribe non-pharmacologic and/or pharmacologic interventions to help address patients with cancer-related fatigue. However, there are areas of improvements in symptom management that can better address fatigue and poor sleep quality in patients with breast cancer. Eastern therapies, including Tai Chi, Qigong, acupuncture, and acupressure, are not included in standard medical care, but they have been shown to have beneficial properties in improving fatigue and sleep disturbances. We have conducted a thorough literature search through PubMed, EMBASE and CINAHL. By including and excluding key terms and criterias, we have narrowed our focus to 4 randomized controlled trials and systematic reviews. Our findings revealed that these therapies are safe and can serve as potential adjuvant and alternative therapies to the gold standard treatments for fatigue.

P24 **SETTING THE STANDARD FOR** **INVESTIGATIONAL DRUG ADMINISTRATION**

Dana Clark, BSN, RN, OCN[®], Winship Cancer Institute of Emory Healthcare, Atlanta, GA; Claudia Garcia, BSN, RN, BMTCN[®], Northside Hospital, Atlanta, GA; John Bourgeois, MMHC, BSN, RN, OCN[®], CCRP, NEA-BC, Winship Cancer Institute of Emory University, Atlanta, GA; Susan Rogers, BS, RPh, Emory Healthcare, Atlanta, GA; Esther Park, PharmD, Emory Healthcare, Atlanta, GA; Donald Harvey, PharmD, BCOP, FCCP, FHOPA, Emory Healthcare, Atlanta, GA

Oncology Nursing Practice

In Phase One Clinical Trials, novel drugs are administered to Oncology patients. Patients are monitored for hypersensitivity reactions, and blood sampling for pharmacokinetics (PKs) and pharmacodynamics (PDs) are performed. For patient safety, it's imperative to know when the intravenous investigational product (IP) first reaches the patient. PK/PD samples are critical to drug development. Because PK/PD timing is centered around the beginning of infusion (BOI) and end of infusion (EOI), accuracy is vital. In the absence of protocol guidance, there can be variation in the different types of tubing used and if the tubing is primed with drug or with a compatible solution. These inconsistencies can alter BOI and EOI times and all subsequent PKs/PDs. The purpose of this quality improvement project was to standardize our practices of priming and flushing to improve

patient safety and maintain low exposure risk to staff while improving data accuracy. A literature review including ONS and ASCO standards and USP 800 recommendations was performed. Front line nurses were surveyed regarding best practices. A group of pharmacists and nurses decided that we would begin priming a standard infusion tubing set with drug for all non-hazardous IPs. This would give us an accurate BOI time. We determined a 10ml post-infusion flush would ensure all drug was infused resulting in an accurate EOI time. It was also decided that we would begin using Closed System Transfer Devices (CSTDs) on all infusions. These interventions are contingent on if the protocol does not explicitly prohibit them. Priming tubing of non-hazardous medications with drug eliminates the guesswork around when the drug first reaches the patient. More importantly, the nursing team is better prepared for reactions. The data is more accurate for BOI and EOI times and all subsequent PKs/PDs. Using CSTDs on all infusions reduces staff exposure to known and unknown hazardous drugs. Phase One clinical trials are the first step in testing new treatments in humans. They require close monitoring for hypersensitivity and strict timing on the collection of PKs/PDs. Protocols typically leave specifics on administration up to facility standards. The changes made through this project allow for better patient monitoring and more accurate data collection.

P25 **A NOVEL APPROACH TO SUBCUTANEOUS** **IMMUNOTHERAPY ADMINISTRATION**

Christina Colvin, MSN, APRN, AOCNS[®], CRNI, Cleveland Clinic, Cleveland, OH; Georgina Rodgers, BSN, RN, OCN[®], NE-BC, Cleveland Clinic Health System, Cleveland, OH

Oncology Nursing Practice

Recently, a number of intravenous immunotherapies have been converted to large volume subcutaneous formulations. These formulations reduce patient treatment times, but is a new type of administration procedure for our nursing teams. The volumes are up to 15 mL and injection durations are up to 8 minutes. Hyaluronidase is added to enhance absorption, but erythema, edema, pruritus, and rash at the injection site are not uncommon and can occur up to 24 hours following injection. The nurses voiced concern related to the volume, duration of injection, and necessity to maintain needle stability. For the comfort of the patient and nurse, we adopted the method of using a flexible catheter for administration, rather than an injection needle. This method creates more space be-

tween the nurse and patient, which provides increased nurse comfort. As a result, injection site stability and absorption are enhanced due to slower administration time. The first step was to consult pharmacy regarding risk for altering medication integrity using equipment different from study trials. Next, national nursing guidelines were used for procedure development and required equipment. To ensure full dose, a post-administration flush was included. Finally, nurse education, training, and provision of appropriate supplies was conducted. Use of the catheter for administration resulted in lack of occlusion, lack of reports of complications at the administration site, and reports of nurse satisfaction and comfort with the procedure, in comparison to the trials using needles for administration. When clinical trials are being designed, investigators may not be aware of equipment available for safe administration practice. For example, catheters used for subcutaneous injection, rather than metal needles. The oncology nurse plays a significant role in safe administration of medications used for cancer treatment. Therefore, to improve patient outcomes and promote the use of equipment that enhances the patient and nurse experience, nurses must advocate for safe medication administration practices. Since the first medication was introduced, two more have been FDA approved and implemented with no complications. Adding the new medications requiring this administration method has been relatively seamless, including updates to the job aide and providing the nurses with general drug information. Using catheters for subcutaneous injection provides safe and comfortable administration of large volume immunotherapy medications requiring long injection times.

P26 IMPLEMENTATION OF AN EVIDENCE-BASED HYPERSENSITIVITY ALGORITHM REVISION IN AN ADULT AMBULATORY ONCOLOGY CLINIC

Megan Corbett, MSN, RN, NPD-BC, OCN[®], Dana-Farber Cancer Institute, Boston, MA; Bridget Scullion, PharmD, Dana-Farber Cancer Institute, Boston, MA; Marylou Nesbitt, MS, APRN-BC, AOCN[®], Dana-Farber Cancer Institute, Boston, MA

Treatment Modalities

Cancer chemotherapy and immunotherapy is associated with infusion reactions, which are unplanned and range from mild, moderate to severe and life-threatening anaphylaxis. This is an oncologic emergency requiring the interdisciplinary team to have a well-developed, evidence-based approach, where all clinicians demonstrate competency and can respond im-

mediately and ensure safe recovery from the reaction. First responders and the support team need to know their roles and responsibilities and depend on others to do the same during emergency reaction management. The purpose of this project was to share one institution's approach in reviewing and updating a hypersensitivity treatment algorithm in an adult ambulatory oncology clinic. An interdisciplinary team (nursing, pharmacy, allergy service) met to review current practice and outcomes associated with acute infusion reaction management. A literature search was conducted to update the algorithm with current evidence-based interventions needing to be adopted. Based on this review, the existing algorithm was updated, clinicians were educated, and a new algorithm was adopted and implemented. Key updates in this algorithm include: a standard grading scale for reaction severity, guidelines for medication administration based on symptoms and severity, when to draw tryptase levels, administration of glucagon for patients not responding to epinephrine taking beta-blockers, significance and appropriate use of epinephrine, when not to re-challenge with causative agent and the documentation of the allergen in the medical record. This presentation will describe the team review of current practice and evidence-based literature, interventions supporting algorithm implementation, the updated algorithm and ongoing implementation support strategies. Clinician education was the main intervention for implementation of a new acute infusion reaction management algorithm. One month before go-live, an online, interactive education module was assigned to nurses, physicians, pharmacists, nurse practitioners and physician assistants. Successful achievement of this education included completion of the interactive module and a passing test score of 100%. Evaluations of this offering will be presented along with ongoing strategies for compliance. Standardizing an approach for acute infusion reactions in oncology is equally as important as the standards in place for providing basic life support. Interventions must be based on evidence, roles and competency must be defined and re-evaluated and the interdisciplinary team needs to be involved at all phases of reaction management.

P27 CARE OF COVID + PATIENT/S ON AN INPATIENT SURGICAL ONCOLOGY UNIT

Kelly Crayton, MSN, RN, NE-BC, Baylor University Medical Center, Dallas, TX; Allison Steen, MSN, RN, OCN[®], NE-BC, Baylor University Medical Center, Dallas, TX; Shermajal Mangabat, BSN, RN, Baylor University

Medical Center, Dallas, TX; Swetchell Demelo, BSN, RN, Baylor University Medical Center, Dallas, TX; Jorissa Daquiera, BSN, RN, Baylor University Medical Center, Dallas, TX; Nora Rogney, BSN, RN, Baylor University Medical Center, Dallas, TX

COVID-19

COVID impacted many areas within the last year, including the cancer hospital. During the initial surge, there was a decrease in hospitalized oncology patients as many opted to shelter at home. The typical surgical oncology population includes ovarian, pancreatic and colorectal cancer patients both pre and post-surgical intervention. As the cancer hospital census decreased, the leadership team identified a need to house high-risk COVID + patients requiring chemotherapy within the hospital, while safeguarding an immunosuppressed population. Within the facility, all inpatient rooms (96-beds) in the cancer hospital are positive pressure. Working with the facility management eight rooms on a 24-bed surgical oncology unit were converted to negative pressure. COVID + patients, or suspected cases, were triaged to this unit and housed in a negative pressure room. Patients whose testing came back negative were relocated to other oncology units. iPads were upgraded and deployed for physician and nursing communication with the COVID + patients. Based on the criteria developed by a multidisciplinary oncology leadership team, hematologic patients requiring chemotherapy were housed on the unit as well. The supervisor from Bone Marrow Transplant assisted with educating nurses regarding treatment side-effect management, utilization of order sets, and care maps. Multiple patients with suspected COVID had chemotherapy initiated on the unit prior to transfer after two negative tests. The COVID + patients remained on the unit for the duration of the therapy. Nurses expressed comfort with managing hematologic patients receiving chemotherapy. An indirect benefit was improved collaboration between the medical oncology/hematology and surgical oncology units. With the support of nursing leadership, surgical oncology successfully managed hematologic patients. Nursing staff enhanced skills related to the administration of chemotherapy. Additionally, the nursing staff became the cancer hospital experts on managing individuals with COVID. The COVID surge presented unique issues when working with an immunosuppressed population. Within three days of initial conversations, oncology leadership and staff flexed to successfully accommodate the first COVID + patient.

P28

A PARTICIPATORY PROGRAM ON FALL PREVENTION IN SURGICAL ONCOLOGY PATIENTS

Kelly Crayton, MSN, RN, NE-BC, Baylor University Medical Center, Dallas, TX; Lauren Camunez, MSN, RN, OCN®, Baylor University Medical Center, Dallas, TX; Kellie Duncan, BSN, RN, Baylor University Medical Center, Dallas, TX; Michael Diva, RN, Baylor University Medical Center, Dallas, TX; Bailey Rogers, BSN, RN, Baylor University Medical Center, Dallas, TX; Elizabeth Phillips, BSN, RN, Baylor University Medical Center, Dallas, TX

Patient Education and Safety

Fall related injuries have increased over time. The rise may be due to an increase in complexity of hospital patient populations. By 2030, the cost of falls is anticipated to be over \$100 billion. In August 2020, the Surgical Oncology at a university medical center experienced an increased number of patient falls, resulting in a fall rate of 8.56 patient falls per 1000 patient days. Preliminary review of post fall data revealed that patient falls occurred when patients were toileting or showering, were unwitnessed, or when the patient obtained assistance from a family member. The project goal was to “achieve zero preventable harm” through focus on improving Nurse-Sensitive Quality Indicators. A work group was established to examine patient fall data and develop strategies to reduce patient falls. The team developed a fall prevention bundle and scripting for use when team members educated patients and their families on fall prevention. A validation tool was developed which assessed each nurse’s competency to evaluate patients’ fall risk, appropriately implement the department’s fall prevention bundle, and utilize scripting with patients and families. Nurses’ knowledge on fall prevention was rated pre- and post-implementation. Debriefs were implemented post-fall to determine opportunities for preventing future falls. Badge buddy cards with information about the fall prevention bundle and scripting were given to all staff. Signage was placed in patient bathrooms to remind them to call a team member for assistance with toileting. Patient chair alarms were implemented for all high fall risk patients. In December 2020, the patient fall rate decreased to 2.28 falls / 1000 patient days. In January 2021 and February 2021, there were no patient falls. The implementation of a fall prevention bundle, scripting, and skills validation for registered nurses resulted in a decrease of patient fall rates / 1000 patient days. The change in nursing practice aligns with the Nursing Strategic Plan related

to achievement of zero preventable harm by focusing on improvement of patient fall rates. A lean process was utilized to identify opportunities and reset expectations. Staff education was accomplished through use of train-the-trainer model. A validation tool was created to decrease variation from patient to patient.

P29 DEALING WITH THE LOSS OF HUMAN TOUCH DURING THE PANDEMIC FOR ONCOLOGY PATIENTS

Kimako Desvignes, MSN, RN, NE-BC, CMSRN, Cedars-Sinai, Los Angeles, CA; Carol Mention, MSN, RN, CCRN-K, Cedars-Sinai, Los Angeles, CA; Michelle Williams, PhD, MSN, RN-BC, Cedars-Sinai, Los Angeles, CA; Gena Smith, MSN, RN, Cedars-Sinai, Los Angeles, CA

Psychosocial Dimensions of Care

Most patients admitted through the emergency department to the Oncology unit are newly diagnosed, have not achieved remission, or has relapsed. This is a vulnerable time for these patients, spiritually, mentally, and physically. This is a time when these patients need human touch the most and we are missing this part of their care because of the pandemic. The goal is to increase touch, comfort, warmth, through gifting special blankets and beanies for Oncology patients throughout their stay. To introduce another source of touch, comfort, and support for oncologic patients during the COVID-19 pandemic, that is personable, patient centered, that provides support, and comfort during their hospitalization. In the fourth quarter of FY21, unit leadership started identifying newly diagnosed patients, patients scheduled for stem cell transplants, oncology patients requiring surgical interventions, on two units. Nursing leaders rounded and delivered specially made blankets and beanies these patients. A survey will be created to collect baseline data and data post intervention. 77 patients were gifted blankets and beanies. They were provided as a source of comfort, warmth, and touch. The touch that the patients have not able to receive. The warmth and comfort that they are not able to feel from a hug or an embrace from a family member or staff member. The patients that have received this special gift has expressed their gratitude through tears, words of thanks, taking pictures with their blanket and beanies, and posting pictures on social media. Although we have not begun data collection, we anticipate seeing an improvement in patient's feeling that they have received the warmth, touch, and psychosocial support by 20%. The loss of touch as part of human caring in nursing, has been a struggle for patients and nursing

during the pandemic. The gift of the blanket and beanie has been a way to introduce warmth, comfort, and touch back into the care of Oncologic patients. With the planned data collection method. We will be able to provide evidence of the effectiveness of this intervention and promote its expansion to other units. Patients are experiencing great losses in care due to the pandemic. There is a desire to capture the psychosocial aspect of care provided to Oncology patients during the pandemic. Currently, this not being surveyed.

P30 ADMINISTERING SUBCUTANEOUS (SUBQ) HYALURONIDASE INJECTIONS WITH A MEDICATION EXTENSION SET (EXSET)

Sarah Digirolamo, RN, Yale New Haven Health - Smilow Greenwich, Greenwich, CT; Elizabeth Gineo, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT; Evanica Rosselli, BSN, MSN, OCN®, Yale New Haven Hospital, New Haven, CT; Nicole Bocchetta, MSN, RN, OCN®, Smilow Cancer Hospital/Yale New Haven Health, New Haven, CT; Catherine Sumpio, PhD, RN, AOCNS®, Smilow Cancer Hospital, New Haven, CT

Oncology Nursing Practice

In 2017 our large health system began administering subQ injections of medications containing hyaluronidase and currently administer three including Rituxan, Daratumab and Pertuzumab/trastuzumab over times ranging from 3 mins- 8 mins. These are viscous solutions that can be difficult to administer. Nurses reported dissatisfaction and discomfort during injection. Additionally, during the COVID19 pandemic, nurses reported feeling uncomfortable giving subQ injections for minutes at a time as they were unable to adhere to social distancing guidelines. The purpose of this project was to initiate use of a subQ ExSet to improve body mechanics, increase ease of use and promote social distancing during administration of hyaluronidase containing medications. After exploring many options our working group, consisting of nursing professional development specialists, pharmacists, a patient education specialist and frontline staff, chose an ExSet. Selection criteria included: approval for subQ use, availability, staff familiarity, and presence of safety features (needle safety lock to protect the RN and patient). Six pilot sites throughout our health system were chosen to trial the product as an option for administering these medications. Our working group created an education sheet detailing the administration process. Nurses who participated in the pilot were asked to complete a survey. 100% of

survey respondents indicated difficulty with administering injections/dexterity via traditional needle. Only 20% of survey respondents indicated difficulty administering utilizing the extension set and 0% of respondents reported difficulty with dexterity using the extension set. 80% indicated they would prefer to utilize the extension set rather than the traditional needle. Nurses at each site who volunteered to participate used the ExSet for 6 injections. The use of a subQ ExSet has made it easier for nurses to administer subQ injections with hyaluronidase. Early on a concern was addressed about residual drug in the ExSet leading to patients not receiving the full dose. After exploring solutions our working group implemented use of the “air sandwich” technique ensuring patients receive the full dose. Our working group has outlined a safe way to administer hyaluronidase containing medications using an ExSet, which has not been previously described with similar anticancer medications. Injection technique with the ExSet improves self-reported body mechanics to potentially prevent work related repetitive stress injury.

P31 RECTAL CANCER: DETECTION, TREATMENT, AND SURVEILLANCE

Stephanie Dolan, APRN-CNP, Wexner Medical Center at The Ohio State University, The James Cancer Hospital and Solove Research Institute, Columbus, OH

Screening, Early Detection, and Genetic Risk

Rectal Cancer is the third most common cancer in both men and women. Rectal cancer is highly curable if detected in the early stages. It is more likely to occur as people get older and the majority of people with the disease are over 50. Nearly all rectal cancers develop from polyps and the majority of rectal cancer cases are preventable. The purpose of this abstract and information is to bring awareness and education to the field for early detection, treatment, and surveillance in all ages. Evaluation begins with a physical exam and history and physical. This may be followed by digital rectal exam. A proctoscopy is an office based exam of the rectum that is used as well for further evaluation. Colonoscopy may follow to detect further abnormal areas and biopsy. Once rectal cancer is confirmed, the patient is evaluated further by oncology and a colorectal surgeon. Staging is performed and includes MRI Pelvis as well as CT scans and possible PET scan. CEA assay is performed as well. Rectal cancer treatment often involves a combination of therapies. Surgery is often used to excise the cancer cells. Other treatments, such as chemotherapy and radiation ther-

apy, may be used after surgery to kill any cancer cells that remain and decrease the chances of recurrence. If there is a concern that the cancer cannot be removed completely without causing injury to nearby organs and structures, it may be recommended that the patient undergo chemotherapy and radiation therapy as the initial treatment. These combined treatments tend to shrink the cancer and make it easier to remove during surgery. In some families, gene mutations may be passed from parents to children and increase the risk of rectal cancer. Two genetic colorectal cancer syndromes include Lynch Syndrome and Familial Adenomatous Polyposis. Genetic testing can detect these syndromes and assist in the need and awareness for earlier surveillance among family members assisting in prevention. A new strategy in Rectal Cancer is the watch-and-wait strategy. The watch-and-wait strategy offers a non-invasive therapeutic alternative for rectal cancer patients who have achieved a clinical complete response (cCR) after chemoradiotherapy.

P32 ESTABLISHING AN AMBULATORY ONCOLOGY RAPID RESPONSE TEAM FOR EMERGENT SITUATIONS

**Karen Donato, BSN, RN, OCN®, University Hospitals Seidman Cancer Center, Westlake, OH; Tracy Kustra, BSN, RN, OCN®, University Hospitals Cleveland Medical Center, Westlake, OH
Oncology Nursing Practice**

Emergent situations are commonplace in ambulatory oncology settings because of the high acuity of outpatients and the high-risk medications administered. New national pharmacy guidelines surrounding the preparation of hazardous drugs led this organization to merge 2 of its satellite locations into 1 larger center. Cost of reconstructing both pharmacies would have been high. Furthermore, the sites were less than 5 miles apart. One satellite suite expanded and both existing teams came together under 1 roof. Each team was familiar with the Emergent Situation policy. Separately, each site was a smaller team. An emergency required “all hands on deck.” When staff doubled, most continued to respond to emergencies, leaving the remaining patients uncovered and creating role confusion. Equally ambiguous was the Provider (Physician/Advanced Professional Practitioner) response, resulting in delays. The purpose of this presentation demonstrates how creating a Rapid Response Team (RRT) clarified roles, streamlined patient care, improved staff satisfaction, and how this process can be tailored at other institutions. A task force convened.

They reviewed recent cases, discussed the current response and ways to improve it. Literature searches were performed with minimal specific results. It was decided to form a RRT, consisting of 1 Provider, the Direct Care RN, 1 Medical Assistant, at least 2 Infusion RNs, the Charge Nurse, and 1 Pharmacist. Notification of an emergency was made possible through the existing wearable messaging device. The previous policy was revised, clarifying roles and responsibilities and staff training took place. The pilot program started November, 2020. Reactions to emergent situations improved and are more streamlined. Staff surveys showed the current procedure works better and the appropriate amount of staff are responding. Emergencies are less chaotic. Staff membership to the RRT is voluntary and are typically the same each day. Most volunteers have some background in emergency medicine. As a core group, this team has become enmeshed and function well together. All Providers are required to participate on assigned days. The Medical Director was instrumental in eliciting Provider buy in. Further clarity comes from assigning Provider coverage. This creates reliability. The Provider responds whether the patient is his/her personal patient or not. Creation of a RRT may benefit other large ambulatory oncology centers.

P33 **A COVID-19 SCREENING TOOL FOR** **ONCOLOGY TELEPHONE TRIAGE**

Emmika Elkin, MSN, RN, OCN®, NPJ-BC, UCSF Health, San Francisco, CA

COVID-19

Symptoms associated with COVID-19 infection have made the assessment and triage of cancer patients extremely complicated. The purpose of this abstract is to describe the development and implementation of a COVID-19 screening tool for oncology telephone triage at UCSF Health. An Ambulatory Oncology Clinical Nurse Educator and three School of Nursing faculty members worked on the development of an oncology specific triage tool based on the challenges that oncology nurses were having with the generic COVID triage tool. A thorough search of the published literature, as well as pertinent websites, verified that no screening tool for oncology patients was available at the time. The screening tool met a number of essential criteria: (1) simple and easy to use, (2) included the most common signs and symptoms as knowledge of COVID-19 infection changed, (3) was congruent with the overall screening procedures of the medical center, (4) included questions about risk factors for

and environmental exposures related to COVID-19, and (5) assessed patient's current cancer history and treatment status. Oncology clinicians can modify this tool to triage patients as well as to screen patients in a variety of outpatient settings (e.g., chemotherapy infusion units, radiation therapy departments). Over a period of 3 weeks, the content and specific questions on the tool were modified based on information obtained from a variety of sources and feedback from the triage nurses. A thorough search of the published literature, as well as pertinent websites (e.g., CDC, ONS, NCCN), verified that no screening tool for oncology patients was available. Oncology nurses will continue to play a critical role in triaging patients undergoing cancer treatments to protect them from potential exposure to the virus and provide appropriate interventions to manage COVID-19 emergencies, as well as emergencies associated with cancer treatment and ongoing symptoms associated with either condition. This cancer specific triage tool was a crucial intervention to allow our triage nurses to assess and differentiate the myriad of symptoms that overlap between COVID and cancer, while also considering environmental and behavioral risk factors, increasing severity of symptoms, and those that warrant emergency treatments. Although much has changed since this tool was originally created, refinements to oncology triage through the lens of COVID-19 are still needed.

P34 **NEW NURSE MENTORSHIP ON INPATIENT** **ONCOLOGY UNIT**

Kate Gaspar, RN, BSN, BMTCN®, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins Hospital, Baltimore, MD; Dena Hofmeister, RN, BSN, OCN®, CCRN, Johns Hopkins Hospital, Baltimore, MD; Kathy Mooney, MSN, RN, ACNS-BC, BMTCN®, OCN®, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD

Professional Development

Weinberg 5C/D recently experienced high turnover among newly hired nurses; 2019 retention data shows that 40% of new hires resigned within less than 18 months. The project aims to implement and evaluate a unit-based mentorship program on Weinberg 5C/D. A core group of experienced nurse-mentors provide support and clinical guidance for new nurses. The overall goal is to help new nurses feel more connected and comfortable on the unit, and reduce early staff turnover. The mentorship program begins 10-12 months after the initial hire date and contin-

ues until the 2-year mark on the unit. New graduate nurses select a nurse-mentor from a core group of nurse-mentors. Nurse-mentors are trained via virtual presentation outlining program goals and mentor responsibilities. Nurse-mentors initiate communication with newly hired nurses and maintain weekly personalized check-ins both face to face and via email for the duration of the mentorship program. Email surveys were sent to 10 nurses who participated in the mentorship program and 10 who were hired before initiation of the program. The nine-question survey asked about feeling comfortable on the unit, job satisfaction, perceived opportunities for professional growth, and confidence with clinical skills. There were 8 survey responses from the mentored group and 7 responses from the non-mentored group. We compared the survey results from the non-mentored group with the mentored group. The non-mentored group scored more favorable regarding job satisfaction and confidence with clinical skills. 100% of the non-mentored group strongly agreed that they feel comfortable on the unit compared to 57.14% of the mentored group. The mentored group was surveyed after working 6 months on the unit compared to the non-mentored group which was surveyed after working on the unit over 18 months. Differences in time on the unit between groups could account for increased comfort levels, and proved difficult to compare the two groups at this time. When the mentored group is re-surveyed at 18 months, we expect they will rate higher comfort levels than at the 6th month mark. We plan to continue this nurse mentorship program and conduct surveys at 6- and 18-months post hire, and compare 18-month retention data. We plan to share this pilot program with other oncology units.

P35 **CANCER CAREGIVER BURDEN**

Jincy George, APRN, MD Anderson Cancer Center, Houston, TX

Psychosocial Dimensions of Care

It is estimated that there are four million cancer caregivers in the United States. A large majority (69.1%) of them faces various emotional burdens. Cancer caregivers are asked to make various treatment decisions as well as end-of-life decisions, which can add to their stress and burden. They are unpaid and often unprepared to perform various intense and complex care for the cancer patients at home. Since they are an integral part in cancer patients' treatment planning and care, it is of utmost importance in reducing emotional burden and improving the self-efficacy among them.

The purpose of this integrative systematic review of the literature is to assess the factors affecting cancer caregiver burden and the outcomes of preparedness training, in reducing cancer caregiver burden and improving their self-efficacy. This integrative systematic review of literature only included studies that were published between 2009–2019, using the databases like CINAHL, Medline, Pub med, and Cochrane library. The search terms used were caregiver burden, caregiver preparedness and self-efficacy, with a total of 968 studies found initially. After the screening and exclusion process, 12 most appropriate studies with a total of 1,898 cancer caregivers were included. The study design involved randomized controlled trials, quasi experimental, and descriptive longitudinal, along with descriptive and cross sectional correlational methods. Among the 12 studies, 66.6% showed that a structured caregiver preparedness intervention decreases their emotional burden and improve self-efficacy. These results strongly support the need of standardizing cancer caregiver preparedness and skills training in health care settings to improving caregiver self-efficacy and reducing their burden.

P37 **IMPLEMENTATION OF A MULTI-ORGANIZATIONAL EMERGENCY MEDICAL EVENTS PROCEDURE**

Kimberly Hamel, BSN, RN, OCN®, University of Maryland Kaufman Infusion Center, Bel Air, MD; Peyton Neilson, MSN, RN, OCN®, University of Maryland Kaufman Infusion Center, Bel Air, MD

Coordination of Care

Emergency Medical events occur in an unaffiliated Infusion Center within a hospital setting. There was no methodology for addressing emergent needs of the patient except for calling 911 which is not the best use of resources and would delay care. The purpose of the project was to develop a plan to efficiently and safely provide an emergency response to patient events that occur in the Infusion Center by transitioning care to the unaffiliated hospital. In order to provide safe, appropriate, and timely emergency medical care to patients that are being treated with the Infusion Center; located on an unaffiliated hospital setting. Several emergency response scenarios were presented to senior leaders of both organizations to illustrate the problem. During those meetings an agreement was developed to allow the Hospital's ICU intensivist to intervene within the unaffiliated Infusion Center where an Outpatient Rapid Response/Code Response Team and process were developed. Steps

to implement this process included credentialing the hospital ICU Intensivists in the unaffiliated Infusion Center as well as requiring advanced cardiac life support (ACLS) training for the Infusion nurses and advanced practice providers. The emergency response team training plan included, assessment of emergency nursing skills, rehearsal of emergency management scenarios to address knowledge deficits and improve teamwork. Nursing skills would be re-evaluated to determine further educational gaps. Once the educational gaps were defined, education was specifically designed to meet the stated gaps for all team members that would be impacted. Gaps noted were use of code cart, Zoll, and comfort level with emergent patient management. After all education and mock scenarios were completed for all departments impacted, the official process was implemented, a post survey was completed to determine additional educational gaps, and team member comfort level with participation in an emergency medical event. One hundred percent of the Rapid Response/Code team were educated and functioned in a safe, timely, and appropriate manner that was practiced/defined during the mock educational sessions. Since implementation of the process on June 1, 2021, four emergency events have occurred with some hiccups such as Intensivist not arriving in timely manner and hospitals rapid response team waiting in defined location however, the process worked as practiced. Review of process, tracking of events, and education are on-going.

P38 **DETERMINING ROOT CAUSE: AN INCREASE IN PACLITAXEL HYPERSENSITIVITY**

Amy Hansen, BSN, RN, Seattle Cancer Care Alliance, Seattle, WA; Melissa Farleigh, BSN, RN, Seattle Cancer Care Alliance at EvergreenHealth, Kirkland, WA; Purna Nanayakkara, MHA, MD (MBBS), Seattle Cancer Care Alliance, Seattle, WA; Phuong Tran, RN, Seattle Cancer Care Alliance, Kirkland, WA; Megan Braine, PharmD, BCOP, Seattle Cancer Care Alliance, Seattle, WA; Phueng Cha, PharmD, BCOP, Seattle Cancer Care Alliance, Seattle, WA

Oncology Nursing Practice

The risk of adverse reactions associated with paclitaxel infusions is a common concern for oncology nurses. Hypersensitivity reactions result in significant discomfort and distress for patients and may lead to hospitalization, treatment delay, and discontinuation of first-line therapy. Emergent reactions often result in considerable expense and utilization of resources. At a National Comprehensive Cancer Network-des-

ignated, ambulatory oncology center, there was a noticeable increase in adverse reactions to paclitaxel. The affected patients (N=5) had adverse reactions that took place within a ten-day period, emphasizing the need to decrease reaction risk. The purpose of the analysis was to reduce hypersensitivity reactions to increase patient safety, improve the overall patient experience and potentially lead to better outcomes. A small multidisciplinary work group convened to conduct a root cause analysis to determine contributing factors associated with the events. The members of the work group were broken down into teams who were each assigned a task. Team members analyzed variability in nursing practice, including pre-medication dose, route and time of administration, paclitaxel lot number verification, as well as the impact of a policy change which allowed for the use of a polyethylene lined 0.2 micron filter to administer premedications. Urgent/Emergent Medical Event Records, Electronic Health Records, and current literature was analyzed. Interviews were conducted with the primary nurses managing the adverse events. No correlations were found between the adverse reactions and the use of a 0.2 micron filter to administer pre-medications, nor evident trends relating to paclitaxel lot numbers. Variability in the amount of time between premedication delivery and chemotherapy administration, as well as variability in orders for premedication doses and routes were identified in the analyses. Findings were presented to the Medication Safety Committee, and nursing staff were apprised of the outcome of the investigation. Current nursing policies and procedures were reviewed with infusion staff to assure consistent practice. Recommendations also included development of standardized order-sets for premedication administration route and dose. Reaction rates and compliance to policy and procedure are continually monitored to decrease hypersensitivity reactions and assess the need for additional root cause analyses in the future. The value of interdisciplinary analysis and shared development of interventions improves patient safety and experience.

P39 **RADIATION INDUCED OSTEONECROSIS OF THE JAW: CASE STUDY AND NURSING IMPLICATIONS**

Lisa Hartkopf Smith, MS, APRN, CNS, AOCN®, CHPN, Promedica Hickman Cancer Center, Sylvania, OH
Symptom Management and Palliative Care

Osteoradionecrosis of the jaw (ORNJ) is one of the most serious late complications observed in patients

with head and neck cancer treated with radiation therapy. ORNJ can cause pain, infection, malnutrition, body image changes, depression, and anxiety. Nurses play a critical role in the prevention, assessment, and management of patients at risk/experiencing ORNJ, however, there are few published nursing articles addressing this complicated adverse reaction. The purpose of this presentation is to describe the presentation, incidence, risk factors, pathophysiology, prevention, treatment, and evidence based nursing interventions for patients at risk/experiencing osteonecrosis of the jaw. In addition, a case study will be presented. ORNJ is defined as an area of exposed irradiated bone that fails to heal over a period of 3-6 months, in the absence of local recurrence. The incidence is cited to range from 4-8%. Risk factors include the location and type of cancer, the type and amount of radiation, dental disease, dental implants, tooth extraction, smoking, and alcohol. Treatments include combination therapies, including antibiotics, corticosteroids, vitamin E, hyperbaric oxygen, bone debridement, surgical resection followed by reconstruction, hyperbaric oxygenation (HBO), and bone debridement, and surgical resection followed by reconstruction. Nursing assessment, patient education, and evidence based interventions can help patients prevent and manage this serious, late complication in patients with head and neck cancers who have received radiation. Evidence based information for the nurse's role in prevention, reducing risk factors, oral hygiene regimens, dietary interventions, pain management, and supportive care will be presented and are imperative for successful management of this difficult complication of radiation therapy.

P40

BLINATUMOMAB: LOVE IT OR LEAVE IT?

Robin Herman, MSN, AOCNS®, LAC/USC Medical center, Los Angeles, CA

Treatment Modalities

Blinatumomab is a bispecific CD19-directed CD3 T-cell engager that binds to CD19 expressed on the surface of cells of B-lineage origin and CD3 expressed on the surface of T cells. It is the first FDA approved BiTE therapy for relapse and MRD All for Adults and pediatrics. As exciting as it sounds the logistics of administration and side effect management is very complicated for the patient and the nursing staff. Working at a very large county hospital we have a very large multi-cultural, multiple languages, lower socioeconomic patient population. Ensuring the safety of this patient population on a drug that infuses for 28 days

straight via a central line and has a variety of intense and serious side effects was a major effort with this population. It is very important that the instructions for preparation (including admixing) and administration are strictly followed to minimize medication errors (including underdose and overdose) This drug is delivered at a constant flow rate using an infusion pump that is programmable, lockable, non-elastomeric, and has an alarm. The patients are encouraged not to drive or operate heavy machinery. They have to maintain their CVC, pump and try to manage a regular lifestyle with a pump attached 24/7. This proved to be a complicated issue for many of our patients who need to work and drive. Our first few Patients were not well organized. CVC issues, serious side effects and mixed drugs that could not be given were initial issues. Clearly, we needed a navigator for this patient population. As the CNS I started to closely follow each of the ALL patients on this drug with every treatment. A well-organized education program in their language with lots of practice on the pump and CVC was done with patient and family. Each visit a detailed physical assessment, CVC care and lab evaluation was done before each drug was mixed. Side effect management was also a battle with this population who did not express their symptoms. Two years later and 45 patients we have the administration process down to a fine science. Of the 45 patients, 43 had a complete response and went to transplant. Blinatumomab we love it!!

P41

ORAL CHEMOTHERAPY. EDUCATION FOR NURSING STAFF AND PATIENTS

Robin Herman, MSN, AOCNS®, LAC/USC Medical Center, Los Angeles, CA; Erika Gonzalez, RN, MSN, CNS, LAC/USC Medical Center, Los Angeles, CA

Patient Education and Safety

Oral chemotherapy drugs have skyrocketed in development and usage in the Oncology patient population. At one of the largest county hospitals in the US we have a huge volume of patients who are prescribed oral chemo agents for their Cancer diagnosis. Our cancer population is a mixed bag of multiple ethnicities, languages, lower socioeconomic and education levels. All of these variables add to a complexity of skills needed to teach our patients. We desperately needed an educational framework to educate this patient population on their oral Chemotherapy medications. A program was developed to provide critical information to the patient so they can administer their own oral Cancer medications in a safe manner with the knowledge to identify any issues in admin-

istration or side effects. The infusion clinic where all RNs were chemo certified were unable to take on this large education workload. Our attention turned to the Clinic staff RNs and LVNs who worked in the Oncology clinic with this patient population every day. Our goal was to have them administer this education information on a one to one patient need basis. An Oral chemotherapy class was given to the entire licensed Oncology clinic staff. It included an overview of all FDA approved oral chemo agents, administration requirements, side effect management and patient education skills. Once the education process was completed the Oncology CNS and nurse manager of the infusion clinic moved into the clinic area to provide clinic support to the nursing staff. We spent several clinic days working with the nursing clinic staff to develop a pathway to identify which patients are prescribed Oral chemotherapy agents and then set up RN visits for their education intervention. We then worked side by side with all staff during the patient education visit. Review of the oral medication, administration and side effects were education points for the training. Our biggest obstacle was the nursing staff. They were very resistant to taking on this project and it took a lot of encouragement and support to get them motivated. The other issue was Covid. It did delay the project over a year. Presently we are now active and providing the oral medication education to our cancer patients.

P42 **TEAMMATE SAFETY DURING ADMISSION TO ACUTE CARE AFTER RADIOPHARMACEUTICAL ADMINISTRATION**

Amy Hicks, DNP, RN, ACCNS-AG, NEA-BC, Levine Cancer Institute, Charlotte, NC; James McBride, BSN, RN-BC, Levine Cancer Institute, Charlotte, NC
[Oncology Nursing Practice](#)

For clinics that administer Lutathera, a radiopharmaceutical used to treat neuroendocrine tumors, there are many precautions that must be taken for both patient and teammate safety for seven days following infusion. If these patients experience symptoms of a carcinoid crisis while under treatment, radioactive bodily fluids can pose a risk to healthcare workers caring for this patient during the emergency, transporting this patient to the emergency room, and caring for the patient when they arrive to the hospital. A team of nurses from radiation oncology, the emergency department, and acute care settings, managers from emergency transport, and the radiation safety officer worked to ensure teammate safety throughout the pa-

tient's care through several interventions. A standard operating policy was developed to guide the staff in caring for the patient while preparing for admission to the acute care setting. It provided guidance on patient care aspects, including insertion of a urinary catheter, and placing patient on cardiopulmonary monitors. An emergency kit was developed to provide easy access to safety items. The kit itself is contained in a large yellow pin used to dispose of radioactive waste—to be used in the hospital to keep patient care items before being disposed of by radiation safety. Inside the kit are alert stickers needed for radioactive patient care items, absorbent pads, and a small sharps container. Instructions for the care team regarding safety precautions and contact numbers are also included as well as signage regarding radiation safety precautions. After implementation, there was no notable radiation detected when assayed by the radiation safety officer. The standard operating policy and kit assisted with a smooth transition from radiation oncology via medic through the emergency department and then to the inpatient unit. Patient care items easily available ensured staff safety. Because of the newness of lutetium Lu 177 dotatate, an innovative approach to inpatient admissions was needed. There exists no literature on the safe transfer of patients receiving lutetium Lu 177 dotatate to the acute care setting during carcinoid crisis. This team-based, standardized approach has helped to ensure teammate safety during several similar events since its implementation.

P43 **THE LITERARY ARTIST: PAINTING A VERBAL PICTURE FOR PATIENT AND FAMILY SUPPORT**

Kristen Hill, MBA, BSN, RN, CMSRN, Hospital of the University of Pennsylvania, Philadelphia, PA; Jaclyn Rieco, MSN, RN, OCN®, Hospital of the University of Pennsylvania, Philadelphia, PA; Marcia Brennan, PhD, Rich University, Houston, TX; Hayley Knollman, MD, Abramson Cancer Center University of Pennsylvania, Philadelphia, PA; Kristen Maloney, MSN, RN, AOCNS®, Hospital of the University of Pennsylvania, Philadelphia, PA

[Psychosocial Dimensions of Care](#)

Patients newly diagnosed with cancer, admitted for treatment, symptom management or end of life, often need greater psychosocial support than currently available on an inpatient unit. Support around the patient's psychosocial wellbeing is often difficult to balance with clinical needs, and recognized by patients and staff as a missing piece of comprehensive cancer

care. The purpose of this project is to engage the patient in a productive conversation about any topic the patient is interested in. This will provide a way for the patient to focus on what is important to them as they are an inpatient in the hospital. The Literary Artist program runs one day a week on the inpatient oncology units. The oncology nurses or medical team identify patients based on the following criteria: withdrawn, emotional, flat affect, reporting pain, recently received difficult news. The facilitator of the program uses an iPad to virtually connect patients with the Literary Artist. After working with the patient creatively, the Literary Artist types out the narrative of the conversation in poetic form, which is printed on site and presented to the patient. Between February 2021 and September 2021, 130 artworks were produced. Feedback received from patients participating in the program include appreciation for the interaction and physical literary artwork. Families also shared appreciation, especially apparent in one instance where a patient passed away the day after producing their literary artwork, and the family now has their family member's last words. Providing greater psychosocial and humanistic support to oncology patients during their inpatient admission can be challenging as the physical and technical aspects of care remain at the forefront. In an effort to enhance the patient experience, and provide much needed psychosocial support, the Literary Artist's sole focus is on the patient as a person. In the current inpatient clinical setting with barriers such as visitation restrictions and less resources focused on the psychosocial wellbeing of inpatients, the Literary Artist project utilizes an innovative partnership between an in person facilitator and a virtual Literary Artist to meet the psychosocial needs of the oncology patient. With greater focus on virtual interactions as a result of the current pandemic, this novel approach brings greater resources to the patient's bedside.

P44 IMPROVING END-OF-LIFE CARE THROUGH INTERPROFESSIONAL COLLABORATION WITH DEATH DOULAS: IMPLICATIONS FOR ONCOLOGY NURSES

Lorraine Holtslander, RN, PhD, University of Saskatchewan, College of Nursing, Saskatoon, Canada; Steven Hall, RN, BSN, University of Saskatchewan, Saskatoon, Canada

End of Life

The end-of-life or death doula is an emerging, grassroots role, making its mark in hospice palliative care

in seeking to support people and families during the dying process. Doulas offer a community-based, non-medicalized approach to care that is holistic and person-centred. Exploring and understanding the interprofessional, collaborative roles of oncology nurses and the death doula could optimize patient and family-centred care and improve outcomes at the end of life. However, there are significant implications for oncology nurses to accompany this new and upcoming paraprofessional role. A scoping review, applying the Canadian Hospice Palliative Care Association's Square of Care as a conceptual framework, was completed to describe the opportunities for collaboration as death doulas become part of the team providing end-of-life care. Despite the presence of death doulas, oncology nurses are responsible for assessing the patient's status and well-being. Information-sharing is central to interprofessional collaboration, but oncology nurses must take sensitive measures to maintain the patient's confidentiality and trust when communicating with death doulas. In decision-making processes, nursing knowledge can guide patients in their choices, as well as death doulas. At the same time, it is paramount that the oncology nurse advocates for evidence-based decisions. The plan of care at the end of life must view the individual holistically. Oncology nurses and death doulas can complement each other in their holistic approach to client care. Regarding care delivery, oncology nurses play a medicalized role in care, guided by the philosophy of nursing and person-centred care. Death doulas serve to develop a relationship with the dying person that transcends their illness, further highlighting how the two can complement one another. Lastly, confirmation involves the clients' understanding of the goals of care. While death doulas can advocate for comprehension, oncology nurses can promote health literacy. Death doulas are an emerging role with the potential to make a significant impact at the end of life. Therefore, healthcare professionals should focus efforts on integrating death doulas into the interprofessional care team; however, oncology nurses' understanding of the death doula role is critical to providing quality end-of-life care in parallel. Death doulas offer an innovative, non-medical approach to providing support and comfort, while facilitating person-centred death and dying.

P45 LAB FOLLOW-UP FOR ORAL CHEMOTHERAPY AGENTS

Cynthia Huff, DNP, RN, MSN, OCN®, CRNI, CNL, Long Beach Medical Center/MemorialCare, Long Beach, CA; Nimisha Thakkar, MSN, Long Beach Medical

Center, Long Beach, CA; Elizabeth Gonzell, BSN, RN, Long Beach Medical Center, Long Beach, CA; Cheryl Westlake, PhD, RN, ACNS-BC, FHFSA, FAHA, FAAN, Long Beach Medical Center, Long Beach, CA; Lori Tritto, MSN, OCN®, NPJ-BC, Long Beach Medical Center, Long Beach, CA

Coordination of Care

Oral chemotherapy (OAC) offers numerous advantages to patients and providers by allowing for effective cancer treatment outside the hospital and contributes to an improved quality of life by reducing medical visits. Furthermore, OACs have been accepted by oncology providers, patients, and insurers as an acceptable and often preferred treatment option in oncology practice. Oral chemotherapy treatment errors include variations in prescribing, toxicity monitoring, patient and caregiver education delivery, and drug delivery barriers. The common denominator in adverse patient events include suboptimal lab monitoring and the lack of “close-the-loop” test reporting on final lab test reporting processes. We aimed to review and learn from the literature about system failures related to the management of lab test results and report evidence-based practice strategies to “close-the-loop” on final test results. Test results follow-up was defined as provider follow-up results for tests that were sent to the lab for processing or analysis. A literature review was performed in CINAHL, Cochrane Library, SCOPUS, and PubMed to evaluate best practices for managing lab test reporting in the oncology outpatient clinic setting. The search terms used were oral chemotherapy, safety standards, and lab monitoring. Limiters included research and evidence-based practice (EBP) publications in English published between 2013 and 2020. A total of 88 citations were found of which 17 were relevant and included in the synthesis. Original studies of all types were included if they reported the impact of any organizational system failure on the lab test reporting process in the ambulatory care setting. Inpatient lab test reporting and point of care testing were excluded in the review. In addition, studies which explored provider opinions, patient preferences, or expectations for patient access applications (i.e. MyChart) were excluded. Problems with lab monitoring and follow-up can start the trajectory forward into legal, regulatory, and accreditation domains when communication failures result in patient harm. Closed loop communication for lab reporting can minimize the risks for patients, health care providers, and the organization. Effective communication of test results and timely follow-up are national patient safety goals. The issue of test results manage-

ment and follow-up is multilayered and interwoven in an organization. Close monitoring and follow-up of patients on OACs will improve patient safety and adherence, and potentially reduce drug adverse events and health care costs.

P46

NURSE PERCEPTION OF ANXIETY MANAGEMENT OF ONCOLOGY INPATIENTS

Thomas Ippolito, RN, BSN, MS, Roswell Park Comprehensive Cancer Center, Buffalo, NY; Julie DeLuca, RN, BSN, Roswell Park Comprehensive Cancer Center, Buffalo, NY; Kali Bosinski, RN, BSN, Roswell Park Comprehensive Cancer Center, Buffalo, NY; Joseph Stabile, RN, BSN, Roswell Park Comprehensive Cancer Center, Buffalo, NY

Evidence-Based Practice

Hematopoietic Stem Cell Transplantation (HSCT) is an aggressive therapy designed to treat hematological malignancies and often requires lengthy hospital stays that can generally last longer than four weeks and requires prolonged recovery periods after discharge. Most patients undergoing treatment for cancer experience feelings of physical, emotional, social, and spiritual distress and many often have underlying psychological and physiological distress symptoms. Current guidelines recommend anxiety screening upon admission with referral and follow up if needed. The purpose of this exploratory study was to identify how oncology nurses working on a dedicated HSCT inpatient unit perceive patient’s anxiety and to determine potential ways to incorporate evidence-based mindfulness practices which are shown to decrease physiological distress and anxiety. 31 registered nurses were invited to participate in the study. Data were collected regarding nurse’s perception of anxiety and evidence-based interventions using Microsoft® Forms and analyzed with Microsoft® Excel evaluating measures of central tendency. 54.8% (n=17) nurses participated in the study. 100% of respondents reported that HSCT patients suffered from increased anxiety during their hospital stay and felt that the isolation from family and loved ones because of the pandemic negatively impacted mental wellbeing and increased patients’ anxiety. 82.4% (n=14) of respondents believed anxiety is undertreated during the inpatient stay. 94.1% (n=16) of respondents felt that they would like to integrate non-pharmacologic nursing interventions to treat inpatient anxiety in their everyday practice. Preferred interventions include aromatherapy, meditation, and mindfulness exercises. Patients undergoing treatment for cancer face high levels of

anxiety and depression related to their diagnosis and nursing staff believe that this is increased for HSCT inpatients. There is a strong desire to incorporate holistic non-pharmacologic nursing interventions to treat anxiety. Further research is needed on best practices for the continual assessment and implementation of non-pharmacologic interventions.

P47 **ORAL AND PERIPHERAL CRYOTHERAPY: TRANSLATING EVIDENCE INTO NURSING PRACTICE**

Kimberly Ito, BSN, RN, OCN®, Seattle Cancer Care Alliance, Seattle, WA; Phuong Huynh, MN, RN, OCN®, Seattle Cancer Care Alliance, Seattle, WA

Oncology Nursing Practice

Cryotherapy is a low-cost and low-risk supportive therapy that can improve quality of life for patients receiving certain chemotherapies. Cold-induced vasoconstriction limits local cytotoxic effects of the chemotherapy by preventing it from reaching specific tissue. Long-standing evidence demonstrates the efficacy of cryotherapy in minimizing side effects such as oral mucositis and onycholysis. Evolving evidence supports an extension of uses of cryotherapy, including some benefit in minimizing peripheral neuropathy and oral cold sensitivities. Nurse-led cryotherapy interventions was not standard practice at an NCI designated ambulatory oncology center. Evaluation determined a lack of standardization of both indications for use and who could offer patients the option of cryotherapy. The purpose of this project was to translate research evidence into organizational guidelines to formalize processes for nurses to initiate oral and peripheral cryotherapy. Two nurse educators completed a literature review to assess the evidence surrounding the use of oral and peripheral cryotherapy. A tool was developed outlining the indications, contraindications, instructions for implementation, supporting evidence for efficacy, and required patient education. To promote accessibility to the tool, a new policy was developed with the engagement of an interdisciplinary team. The team included oncologists whose patients may benefit from cryotherapy, quality, and regulatory specialists to define nursing scope, nurse educators, and frontline nurses. Multiple education methodologies were utilized including dedicated education presentations, unit practice newsletter updates, staff meetings, and engagement of local educators to disseminate the new standardized guidelines. The integration of eligibility criteria for initiation and standardization of who can initiate cryotherapy

into policy ensures systematic implementation of evidence-based nursing practice. Standardization enables frontline nurses to engage in quality nurse-led interventions which affirms the role of the oncology nurse as a critical advocate in symptom management for best patient oncology outcomes. An evaluation to determine nurse confidence in initiating patient education and incidence of implementation of cryotherapy as a supportive therapy will be completed at 6 months.

P48 **IMPLEMENTATION OF AN ELECTRONIC LABELING SYSTEM TO REDUCE BLOOD TYPE SPECIMEN REJECTION**

Xiaohong Jiang, DNP student, University of Maryland School of Nursing, Lutherville, MD

Oncology Nursing Practice

In a large, urban hospital based outpatient infusion center, handwritten labels were used for labeling of blood type specimens and patient wristbands. ABO blood specimen rejection rates are high due to illegible handwriting and missing or incorrect patient information. During a two-month period in 2021, 184 ABO blood type specimens were rejected out of 2,750 (6.7%) due to human transcription errors. Rejections lead to increased cost, additional staff resources for specimen recollection, and delayed patient care which negatively impacts patient satisfaction. Staff spend an average 2 minutes on handwriting label, or even more on rewriting it if made mistake on the label. This quality improvement project aims to decrease blood specimen rejection rates by implementing an electronic identification labeling and barcode system for ABO type and screen (T&S) blood wristbands in an outpatient oncology infusion center. This practice change is being implemented as a pilot project over a 12-week period in an outpatient oncology infusion suite. Education was developed and staff competency training was completed before project implementation. Data collection included blood bank rejection criteria including illegible electronic printed labels for ABO T&S specimens; missing collector names; and unlabeled blood specimens and patient wristbands. A pre- and post-implementation survey will determine staff satisfaction with the practice change. After the first week of project implementation, 8 specimens were rejected out of 113 specimens received (7.1%). The rejection rate was higher during the first 3 days of the implementation period, but decreased significantly after reeducation and training. Two of 74 specimens (2.7%) were rejected during the second week of

implementation, falling just below the expected goal rejection rate of 3% set by the blood bank quality control specialist. Preliminary staff interviews suggest the new practice is easier compared to the standard handwritten method. Preliminary results suggest an electronic labeling system may have a significant effect in decreasing ABO T&S specimen rejection rates in the oncology outpatient infusion center. Integration of the electronic identification labeling and barcode system throughout the entire organization is planned if this pilot project is successful.

P49 **STANDARDIZATION FOR NURSING** **HANDOFF IN PERIOPERATIVE SERVICES AT** **A COMPREHENSIVE CANCER CENTER**

Michelle Johann, MSN, RN, PHN, CPAN, City of Hope, Duarte, CA; Kerry Caldwell, MBA, BSN, RN, CNOR, City of Hope, Duarte, CA

[Coordination of Care](#)

The exchange of patient information among health care providers can improve patient safety outcomes and support collaborative communication during a patient's hospitalization. Direct observation noted that verbal handoff among staff members was inconsistent. Therefore, a tool for communication among staff members was designed and implemented to bridge this gap and create a standardized collaborative approach to patient care handoff. Professional staff members at our oncology hospital collectively developed a single-page handoff tool. The designed checklist addressed various roles and responsibilities of clinical staff. This checklist included: patient-specific concerns, modes of communication, the stability of the patient, durable medical equipment, and any special needs of the patient. The goal of this intervention was to provide patient-centered care and support collaborative communication. Surveys helped evaluate the efficacy of this new handoff tool, as well as monthly audits for compliance. Over the course of twelve months, the audits revealed reduced compliance among various areas of perioperative services. The next step was to address barriers and create a new approach or platform to improve compliance and nursing and patient satisfaction. The primary mode of documentation of patient interventions and assessments is computerized, thereby resulting in the best way to improve compliance would be to provide an electronic documentation platform. The discussion among frontline staff was supportive in moving towards electronic handoff documentation. Thereby, the creation of an electronic “ Periop Professional

Exchange Report” was created. The development and implementation of an electronic handoff report increased compliance in all areas of perioperative services, thereby improving patient safety outcomes and providing patient-centered care through collaboration and coordination of care in an acute comprehensive cancer center.

P50 **AFTER HOURS TELEPHONE TRIAGE**

Jerelyn Julien, MSN, OCN®, MSKCC, West Harrison, NY; Kelly Bonenfant, MSN, OCN®, RN, MSKCC, West Harrison, NY; Rori Salvaggio, MS, RN, NEA-BC, Memorial Sloan Kettering Cancer Center, New York, NY

[Oncology Nursing Practice](#)

Oncology nurses play a critical role in symptom assessment, management, and care coordination during telephone triage. Clinical efforts to reduce readmission hospital rates patients were found to include early interventions through telephone triage. After routine business hours, patients are limited to speaking with a hospital operator, on-call doctor, and often referred to an urgent care center. The After-Hours Telephone Triage (AHTT) program, a centralized call system, was created to provide patients telephone triage outside of the clinics routine business hours. The program allows for a patient to speak directly to an oncology nurse after hours. The program improves continuity of care and improved utilization of hospital resources such as symptom care clinics (SCC), urgent care center (UCC), or local partnership hospitals. With the collaboration of key stakeholders, a process map was developed and executed for the cancer patient journey. IT and telecom capabilities were launched to create a custom call back algorithm and manage call prioritization. A staffing model was created followed by recruitment, onboarding, and training of nurses. Streamlined documentation was created tailored to the telephone triage needs of the cancer patient. Key performance indicators identified were overall utilization, triage disposition, referrals, and calls escalated to the doctor. AHTT receives 1300 calls/week. Common reasons for calls are symptom management, prescription refills, and coordination of care. Eighty-six percent of calls are handled by nurses, 9% of calls nurses consult with on-call doctor, and 5% are transferred to the doctor. Fifty-five percent of the calls are triaged to be non-urgent, 25% urgent, and 4% emergent. Forty-one percent of patients are referred to the UCC, 22% are referred to SCC, and 37% are referred to a local partnership hospital. The AHTT is a nurse driven call center program that provides tele-

phone triage to support cancer patients and mitigate symptom burden from cancer treatments. Nursing telephone triage interventions provided by this program can improve patient outcomes and assist with coordination of care. Collaborating with key stakeholders, utilizing technology platforms, and optimizing staffing volume, the AHTT program serves oncology patients outside hours. The findings are guiding educational strategies to optimize nursing practice, future implementation to new services, and innovative workflows to improve patient care.

P51 DEVELOPMENT OF SOP FOR NURSES ON CHEMOTHERAPEUTIC DRUG PREPARATION AND ADMINISTRATION THROUGH INTRAVENOUS, INTRAMUSCULAR AND SUBCUTANEOUS ROUTES IN CHILDREN WITH ONCOLOGICAL DISORDERS: A METHODOLOGICAL STUDY

**Renuka Kadian, MSc Nursing (Child Health Nursing),
All India Institute of Medical Sciences, New Delhi,
India**

Evidence-Based Practice

Emergence of chemotherapeutic drugs has immensely benefitted the current prognosis of childhood cancers but unintentional exposure to harmful agents may endanger life of health care workers who repeatedly gets exposed to cytotoxic drugs. Nurse's safety is key component in human resource strengthening and stabilization. Their safety can be ensured with evidence based standard protocols, use of PPE, spill management. The purpose of the study was to develop SOP for nurses on preparation and administration of chemotherapeutic drugs through IV, IM and SC routes and observational checklists as assessment tools. Methodological study design was used and SOP with reliable checklist was developed in five phases. In first phase, relevant literature was reviewed and current practices were assessed to prepare preliminary draft. FGDs were also conducted with nurses handling chemotherapeutic drugs. In second phase, Delphi technique was used to validate the content of SOP. Three Delphi rounds were undertaken and modifications were made as per suggestions. Final Delphi round was conducted after a pilot study in third phase. In fourth phase, nurses were trained as per SOP. 30 procedures of chemotherapeutic drug administration by nurses through each route were observed to check reliability of observational checklist. In fifth phase, five FGDs were conducted with nurses to assess feasibility and comprehensibility of SOP. The Item Content Validity Index (I-CVI) of SOP and

checklist was 100%. The overall reliability was computed using standardized cronbach's alpha and was found to be greater than 0.70. Standard Operational Protocols are set guidelines which can be used as ready references to clarify doubts and guide for nurses dealing with hazardous drugs. Well-informed nurses perform standard procedures with rationalization and effectively participate in care planning. Comprehensive, valid and feasible SOP along with reliable checklists was developed. It is recommended to use Standard Operating Protocol so that risk of occupational hazards can be minimized and standardized care can be rendered to patients. Observational checklists are reliable assessment tools which can be utilized by supervisors and managers. Generation of evidence and sources for clinical nurses through extensive research methodology and its implementation is best application of nursing research methods which bridges gap between nursing theory and practice.

P52 MAINTAINING SAFE COORDINATION OF CARE IN RADIATION ONCOLOGY WHILE NURSE NAVIGATOR IS ON UNEXPECTED LEAVE

**Kelsey Keenan, BSN, RN, OCN®, Northwell Health,
Lake Success, NY**

Coordination of Care

Northwell Health Department of Radiation Oncology provides comprehensive, individualized care to the oncology patient. Utilizing a multidisciplinary approach, our Nurse Navigator provides coordination of care between our department and medical oncology patients who will undergo concurrent chemotherapy/radiation. Our Nurse Navigator meets every patient at day of sim and sends their treatment schedules to the corresponding offices. From July 15th-September 7th our Nurse Navigator took unexpected leave. To ensure no lapse in coordination of care during this time we had to initiate a plan. Request for travel RN made however, there was no availability. We identified high risk patients and assigned NP/RN on closer management. Beginning August 2nd, we utilized our medical assistant for the transmission of treatment schedules to medical oncology for patients scheduled to receive concurrent chemotherapy/radiation. To enhance communication, an email was sent regarding each of these patients to medical oncology Nurse Navigator and MD. 241 chart audits were conducted from July 1st through August 13th by management to ensure no patients were missed. Prior to chart audits 5 patients identified by staff who needed concurrent chemother-

apy/radiation that medical oncology was unaware of radiation start date. These patients were identified on or prior to first day of radiation and medical oncology accommodated patients for stat chemotherapy. During chart audits 4 patients identified who needed concurrent chemotherapy/radiation that schedules were not sent to medical oncology. Identification of these patients prevented potential error in treatment plan. With combined efforts put forth from our clinical staff and neighboring departments no patients missed concurrent chemotherapy/radiation nor had delays in their treatment. The nurse navigator plays a vital role in care coordination of the oncology patient. Not only does the patient and radiation oncology department rely on the nurse navigator but neighboring departments vitally depend on her to ensure the MDs treatment plan is carried out as intended. Based on the job responsibilities of the nurse navigator combined with the needs of the patients and utilizing a multidisciplinary approach we were able to create procedures moving forward to ensure proper care coordination in the absence of our Nurse Navigator. Patient safety along with ensuring the best treatment possible is being delivered to our patients is the number one priority of our department.

P53 **ABC BASICS: NURSING IMPLICATIONS FOR ANXIETY RELATED TO BONE MARROW TRANSPLANTATIONS (BMT) IN PATIENTS WITH CHRONIC GRANULOMATOUS DISEASE (CGD)**

Junga Kim, RN, National Institutes of Health Clinical Center, Bethesda, MD

Oncology Nursing Practice

Chronic Granulomatous Disease (CGD), a primary immunodeficiency disease (PID), is a rare genetic recessive mutation affecting one of 200,000 people worldwide. CGD impairs phagocytic NADPH oxidase activity in neutrophils resulting in granulomas or “walls” surrounding infections and chronic inflammation. Patients experience recurring life-long bacterial, fungal, and yeast infections of varying severity in the lungs, skin, bones, and lymph nodes, in addition to pain and shortened life expectancy. Compounding the disease are psychosocial issues (anxiety and depression) which can affect adherence and quality of life. This case study presents a 27-year-old woman with autosomal recessive p47^{phox}-deficient CGD, diagnosed at age 12. It provides the perspective of the clinical research nurse (CRN), whose role affords unique glimpses of the ever-changing continuum of patient

care, acute physical and mental health conditions, and evolving wishes. In February 2021, the patient enrolled in a research protocol to receive a high dose peripheral blood stem cell transplantation (PBSCT) from a 10/10 matched unrelated donor (MUD). She received a reduced conditioning regimen followed by post-transplant immunosuppressants to reduce graft versus host disease (GvHD). Her past medical history included liver abscesses, irritable bowel syndrome (IBS), osteoporosis, thrombosis, nonhealing wounds, chronic pain, nausea and vomiting, and migraines. During the transplant protocol, she also exhibited anxiety, depression, sleep disturbances, and eventually mucositis. Her anxiety manifested as hypervigilance and reactivity to downward trends of her medical conditions. Increasing anxiety affected her sleep and pain management, contributing to an overall negative emotional state that ultimately impaired treatment adherence. Attentive nursing care offered numerous opportunities to contribute to a successful outcome. For example, treatment required careful monitoring for infections, including sepsis, osteomyelitis, pneumonia, meningitis, and brain abscess. Additionally, the nurse could maximize compliance to the protocol regimen by providing psychosocial support and advocating for effective pain and mental health management. Identifying and maintaining the proper balance between protocol compliance and patient advocacy enabled the CRN to reduce the distress that could overload the patient’s psychosocial condition and promote her improvement. As often, effective therapeutic communication to address concerns and minimize stress and anxiety contributed to a timely discharge by providing the patient a safe space for open communication and the opportunity to participate in her own care.

P54 **BREAST PROGRAM CARE MANAGEMENT TOOL**

Marjorie Leighliter, RN, BSN, OCN®, Atrium Health/Levine Cancer Institute, Charlotte, NC

Coordination of Care

Levine Cancer Institute (LCI) in Charlotte, NC sees a high volume of over 1200 breast patients every year. Each of these patients experience multiple touch points with different team members along their journey. LCI has various electronic health records used by different departments. Each department’s clinical care team may use additional tracking and data collection methods like notebooks, folders, files, excel spreadsheets, printouts of the charts, etc. to “follow”

the patient through their journey of care. This can create patient care that is fragmented and patient outcomes like efficiency, care close to home, and survivorship can suffer. Additionally, when a provider wants aggregate or population data on certain populations for a particular year or real time; or there is a need to analyze data for utilization or other deliverables, there is not an easy way to collect this data. The current methods—such as the cancer registry which collects much great data, data analytics teams that can pull certain aggregate data if we ask according to what is captured in a particular EHR, or manual metric collection where we spend time with tedious weeding of reports and EHR's to obtain the particular information needed—are helpful, but what if we could make all that better. The goal of the LCI Breast Program care management tool is to capture real time data on breast patients without being redundant of other data capturing tools or being time-consuming for staff. This tool allows staff to save time and material costs by having patient medical information organized in one tool. This will also provide details about the treatment and status of treatment that any of the patient's care providers can easily access. This should increase efficiency and effectiveness. The future goal is to use the tool to survey and collect patient-centered outcomes to be measured for breast cancer patient improvements.

P55 **“WAKE UP”: INCREASING NURSING AWARENESS AND IMPROVING ASSESSMENT AND DOCUMENTATION OF SLEEP DISTURBANCE IN THE AMBULATORY ONCOLOGY SETTING**

Nancy Lewallen, BSN, RN, OCN[®], UT MD Anderson Cancer Center, Sugar Land, TX; Vanessa Jane S. Deocampo, BSN, RN, OCN[®], UT MD Anderson Cancer Center, Houston, TX; Cori Kopecky, MSN, RN, OCN[®], UT MD Anderson Cancer Center, Houston, TX
[Oncology Nursing Practice](#)

Poor sleep quality is the most common symptom of cancer therapy. Lack of quality sleep can lead to a myriad of symptoms and ultimately impair ability to tolerate cancer treatments. Review of documentation by ambulatory nurses revealed a need to standardize sleep assessment, documentation, interventions, and patient education in order to improve addressing sleep disturbance problems in our cancer patients. The purpose of this project was to (a) evaluate and review the current process of sleep disturbance assessment, interventions and documentation, (b) define best practices and educate nurses regarding the pro-

cess of assessment, patient education, and documentation in the Electronic Health Record (EHR), and (c) evaluate effectiveness of nurse education via pre and post education survey and EHR reporting of number of sleep assessment documentations. Clinic nurses met with nursing leadership and education to discuss best practices for assessment and documentation of sleep disturbance in the ambulatory setting. Additional input was provided by multidisciplinary specialties including Sleep Center, Integrative Medicine, Supportive Care, and Psychiatry. A standard process was outlined for concise sleep assessment (using National Comprehensive Cancer Network screening questions), patient education, and documentation. EHR data revealed only 21 occurrences of sleep assessment in the baseline 30-day period prior to nursing education intervention. An educational in-service was implemented to all clinic nurses regarding the high incidence of sleep disturbance and its consequences, a standardized process for assessment and documentation of sleep disturbance, patient education and interventions, and available resources. Elevating staff awareness of the importance of assessing sleep disturbance as well as development of a concise and standard method of documentation resulted in significant and sustained increase in the percentage of sleep assessments during ambulatory visits. Each month, the EHR report reviewed documentation of occurrences of sleep disturbance assessments that showed improvement from 21 (1%) in May 2021 to 210 (30%) in August 2021. Post education quiz results revealed increases of 50% in knowledge of sleep disturbance incidence and 45% increase in knowledge of appropriate assessment and documentation. Standardizing and educating nurses regarding sleep disturbance assessment, patient education, and documentation in EHR can have a significant impact in oncology patients to improve their overall tolerance of treatments and improve patient safety and satisfaction.

P56 **RESTORATION PLANNING: REINTEGRATION OF CTNS INTO THE COMMUNITY, POST-COVID ERA**

Jessica Llamozas, RN, MSN, CPHN, Memorial Sloan Kettering, New York, NY; Lauren Evans, RN, MSN, OCN[®], CCRP, Memorial Sloan Kettering Cancer Center, New York, NY
[Screening, Early Detection, and Genetic Risk](#)

Mexican immigrants have lower rates of cancer screening than other Latino populations. In 2015, cancer was the leading cause of premature death among

Latinos. Increasing awareness to Mexican Latino population is achieved through promotion of early detection cancer and preventative health screenings at the Mexican Consulate of NYC. During the COVID-19 pandemic outreach was suspended resulting in loss of access to preventive health screenings to this at-risk population. The purpose of this project was to describe how Clinical Trials Nurses (CTNs) spearheaded the return to in-person community outreach by adapting institutional workflows to the community setting, while ensuring safety for participants and staff. During restoration planning, there was limited guidance on resuming activities in the field. CTN in collaboration with the Nurse Leader adapted institutional restoration guidelines for use at the Mexican Consulate. A COVID-19 symptom screening tool was created and performed before participants were permitted onsite. Screening appointments were scheduled to avoid crowding the waiting room. Furniture was rearranged to allow for social distancing. Safety measures were put in place such as use of personal protective equipment, temperature checks, proper ventilation and limiting time the CTN spent per participant. Onsite staffing was limited to one nurse, only performing activities that could not be completed remotely, such as screening tests. Intake forms and referrals for social and health-related services were completed virtually. The workflow was submitted to the Hospital Incident Command System (HICS) for approval to resume community cancer screenings. In December 2020 we were approved by HICS to resume outreach activities and did so without any known transmission of COVID-19 to staff or participants. We screened 246 participants and recruited 113 new participants to outreach studies since returning onsite. Resuming in-person activities in the community is crucial to connecting at-risk communities with preventative screenings. Nurses can advocate for resuming screening and outreach activities to ensure that vulnerable populations are not overlooked post-pandemic. Institutional protocols can be safely adapted to community settings and set a standard for safe nursing practice.

P57 RADIATION ONCOLOGY NURSES IMPROVE PATIENT EDUCATION FOR CYBERKNIFE ROBOTIC RADIOTHERAPY

Kathleen Maloney-Lutz, MSN, RN, OCN[®], CNRN, NYU Winthrop Hospital, New York, NY; Lorelyn Tirado, RN, NYU Langone Long Island Hospital, Mineola, NY; Jennifer Gillespie, BSN, RN, NYU Langone, Mineola,

NY; Shannon Cleary, RN, NYU Langone Long Island Hospital, Mineola, NY; Rosanna Schifilliti, RN, NYU Langone Long Island, Farmingdale, NY; Maureen Oliveri, MSN, RN, NYU Winthrop, Mineola, NY

Patient Education and Safety

Prostate cancer is the second leading oncologic cause of death in men in the US. One treatment option is Cyberknife Robotic Radiotherapy; this delivers precise radiation to targeted areas to destroy tumors, while limiting the radiation delivered to surrounding healthy tissue. To achieve precise dosing and without damaging surrounding tissue, patients must undergo a planning CT scan. Ensuring the patient follows a detailed bowel preparation is essential to obtaining the planning CT scan. An excel spreadsheet was developed and maintained by nursing noting patient name, date of birth, doctor, date of CT and if preparation was successful. If the CT is unsuccessful, stool and gas still in the rectum, the patient would need to repeat the bowel preparation and schedule another scan. Improper bowel preparation was the leading cause of the unsuccessful CT scans interfering with the planning process and leading to a delay in treatment. June to December 2020, 42 of 215 (19.5%) CT scans were unsuccessful and required repeating. A review of the patient education material performed by the radiation oncology RN's demonstrated the need for improvement. Discussions with patients regarding the education currently provided further emphasized the need for a revision of the educational packets. During the fiducial marker appointment, the patient and nurse have a one-on-one education session. The patient is provided an individual education packet containing clear instructions for each day of the preparation. To further clarify any instructions regarding the bowel preparation, radiation oncology nurses call patients 72 hours prior to the scheduled CT scan. There was a significant improvement in successful planning CT scans. January-June 2021, the rate of unsuccessful CT scans decreased to 5% (16/282) from 19.5% June-December 2020. Patients also verbalized a better understanding of the bowel preparation required. Patient education is of utmost importance in the provision of quality care. The individualized education sessions with the nurse utilizing the revised educational materials demonstrated the increased compliance with the bowel preparation as evidenced by successful CT scans.

P58 AMBULATORY METHOTREXATE

Kelli-Ann Mancini, MSN, RN, OCN[®], Smilow Cancer Hospital, New Haven, CT; Catherine Sumpio, PhD, RN,

**AOCNS®, Smilow Cancer Hospital, New Haven, CT;
Kirsten Pedersen, MSN, RN, Smilow Cancer Hospital
at Yale New Haven, New Haven, CT**

Coordination of Care

High-dose methotrexate (HDMTX) is a complex regimen requiring aggressive alkalinizing hydration, timely leucovorin rescue and vigilant methotrexate level monitoring, urine pH, and renal function post treatment. At our cancer center, the regimen is routinely given in the inpatient setting, but when a young adult patient with sarcoma and an anxiety disorder refused admission, we were challenged to quickly develop a feasible ambulatory treatment protocol. The purpose of the project was to safely administer high dose Methotrexate in the ambulatory setting. Utilizing an interdisciplinary team comprised of the attending oncologist, oncology pharmacist, infusion nurse, and nursing educator, criteria were developed to determine the patient's eligibility for ambulatory HDMTX. Approval depended on a patient's cognitive, physical and emotional capacity to comply with all critical elements of care. A calendar was designed with times pre-filled in to ensure oral leucovorin was taken at the exact times. Worksheets were designed for the patient to track and document urine output and pH, and sodium bicarbonate taken twice daily with extra doses as needed. A patient education handout was created to provide care rationale and meticulous instructions for pre-treatment, Day 1 in clinic, and Days 2, 3 and beyond as needed. The patient was also set up with daily appointments for lab work and the alkalinizing hydration bag change until Methotrexate was cleared. Clinic nursing staff were inserviced on the new ambulatory regimen, their responsibility to review and assess patient's compliance with home care, and discuss any concerns with appropriate team member. Two patients were successfully treated in the ambulatory setting as demonstrated by absence of toxicity, patient adherence to instructions, and no reported adverse events. Staff voiced overall confidence with the process and adequate support throughout. Treating patients in the ambulatory setting saves an estimated three inpatient days, opening these beds to more acute admissions. Identifying an appropriate patient population to safely administer HDMTX in the ambulatory setting is key. Development of documentation tools for patients that are easy to understand, along with scheduled ambulatory monitoring visits, allow patients to receive an inpatient regimen in the outpatient setting safely. Utilizing the interdisciplinary team to create a safe process has helped

our institution move to the next level in ambulatory care.

P59

REDUCING THE NUMBER OF MISSED ON-TREATMENT VISITS IN RADIATION ONCOLOGY

**Victoria Mancini, RN, NYU Langone Perlmutter
Cancer Center Long Island, Mineola, NY**

Coordination of Care

External beam radiation therapy usually requires daily treatments. While undergoing radiation therapy the patient will have a scheduled on-treatment weekly visit with the nurse and radiation oncologist. These appointments are an opportunity to discuss progress with treatment, and specific side effects they might be experiencing, however patients were forgetting to stay for their weekly visit. Missed visits may lead to a delay in the reporting of symptoms and subsequently delay the necessary supportive care. Weekly visits allow for timely intervention of symptom management. Patients who missed their on-treatment visits were more at risk for delayed treatment of symptoms. The purpose of this study was to decrease the amount of missed on-treatment weekly visits to improve symptom management and patient satisfaction. Through interdisciplinary collaboration with radiation oncologists, nursing, and support staff it was determined that providing a printed schedule, specific to the patient, would be of assistance in patient's remembering their weekly visits. White boards were placed in each dressing room and are updated daily with pertinent information such as; date, nurse, and MD seeing in person visits. The nurses also provided daily lists of the scheduled weekly visits to the radiation therapists. A 6 month matchup between the nurses and radiation oncologists was initiated to help reduce the quantity of missed weekly visits. From January–May 2021 there were 46 missed weekly appointments. Further breakdown of these missed appointments showed a marked improvement in the number of missed visits after implementation of the project. January and February alone accounted for 40 of the missed visits with only 6 occurring March - May. The radiation oncology departments' Press Ganey scores also demonstrated a marked improvement in patient satisfaction related to their experience during their radiation therapy treatment. This project not only increased the number of patients following through with on-treatment visits, it was also encouraging and empowering for the nurses who initiated the project. The data will continue to be followed to improve patient and staff satisfaction.

P60

LGBTQ+ ALLY FOR COMPASSIONATE CARE

Kim Marchand, RN, OCN®, UTSW, Dallas, TX; Steven Selter, BSN, RN, OCN®, UT Southwestern Medical Center, Dallas, TX

Oncology Nursing Practice

The journey of seeking medical care is stressful for all oncology patients, but there continues to be an added stress felt by LGBTQ+ patients. Many LGBTQ+ members do not seek medical attention because of fear of discrimination and a history of previous negative experiences with medical professionals. Though many programs and institutions are providing Health Care Providers with Cultural Sensitivity Activities, LGBTQ+ biases continue to be present. Providing compassionate care to LGBTQ+ patients requires an understanding of basic terms & definitions along with awareness of their barriers to care. As nurses and Ally's for our LGBTQ+ population we are passionate about finding ways to improve care for our LGBTQ+ patients. We have independently sought out information to educate ourselves, but how do we get this information disseminated across our organization? Identify: Where is the deficit in staff's knowledge? Where do we begin to educate staff, to improve patient care? How to implement annual training on Inclusion and Diversity? Medical professionals who are unaware that their biases affect their LGBTQ+ patients, contribute to the reasons LGBTQ patients delay seeking care. Interventions included researching Nursing Journal articles and completing courses by The Healthcare Equality Index, Oncology Nursing Society, National Comprehensive Cancer Network, National LGBTQ Cancer Network, Elsevier's Oncology Journal Network. Also consulted the Office of Diversity and Social Workers. A needs assessment questionnaire is being developed to identify the following topics related to care of LGBTQ patients: staff educational needs/deficits, staff comfort level in caring for LGBTQ patients, professional and personal biases, and understanding of barriers to care. In evaluation: review results of questionnaires and review feedback from LGBTQ patients, family members & staff. This project continues to be a work in progress. Educational resources addressing LGBTQ+ issues need to become more available. The goal is to implement annual training. Though many programs and institutions are providing Health Care Providers with Cultural Sensitivity Activities, LGBTQ biases continue to be present. To increase preventative care, early detection & treatment, all people need to feel safe and have a sense of security that their medical team will

provide an accepting and understanding environment for their care. As educated Oncology nurses, we can gear our thinking towards inclusion, not segregation and instill an environment where patients are comfortable receiving their care.

P61

AN ONCOLOGY CLINICAL NURSE SPECIALIST-LED FALL PREVENTION PROGRAM IN AN OUTPATIENT ONCOLOGY/HEMATOPOIETIC STEM CELL TRANSPLANT CLINICS AND INFUSION SETTING WITHIN AN ACADEMIC CENTER BUILDING A CULTURE OF FALL PREVENTION

Melinda Mayorga, RN, MSN, AGCNS-BC, OCN®, USC Norris Comprehensive Cancer Center, Los Angeles, CA; Gerardo Gorospe, RN, MSN, BMTCN®, PHN, USC Norris Comprehensive Cancer Center, Los Angeles, CA; Lilia Lopez, RN, USC Norris Comprehensive Cancer Center, Los Angeles, CA; Celia Jarquin, RN, USC Norris Comprehensive Cancer Center, Los Angeles, CA; Paulita Seno, RN, USC Norris Comprehensive Cancer Center, Los Angeles, CA; Ezekiel Murphy, Oncology Informatics, USC Norris Comprehensive Cancer Center, Los Angeles, CA

Patient Education and Safety

Oncology patients are at risk for falls due to neurologic deficits caused by multidrug treatment plans and cancer sites. Few examples of fall prevention approaches in outpatient oncology/hematopoietic stem cell transplant clinics with infusion centers were found. The purpose of the clinical nurse specialist (CNS)-led initiative was to create a fall prevention program for clinics with an infusion center of a comprehensive cancer center. A root cause analysis (RCA) was performed to identify contributing factors leading to falls and falls with injury. This revealed nursing knowledge deficits regarding fall metrics and nurse sensitive indicators, absence of clinician communication regarding fall risk, and outdated fall risk screening intervals. A committee was formed to review literature, unit-based goals and fall risk documentation, analyze policies, identify environmental fall risk areas and prevention strategies within the institution. Nursing participated in a national fall prevention campaign, created a clinician fall prevention communication tool and engaged multidisciplinary collaboration to evaluate environmental safety, documentation standardization and design of novel signage to identify patients at risk for falls. Unit specific fall prevention education was rolled out and evaluated. Nursing knowledge of fall risk and prevention

practices increased after education rollout. The rate of fall/falls with serious injury fell below benchmark levels of National Database for Nursing Quality Indicators (NDNQI) after adoption of fall prevention approaches for four quarters in the infusion center and five quarters in the clinics. Institutional policy was amended to screen patients for falls at every visit to align with the institutional goal of zero patient harm. Chart audits revealed 88% (n: 273) documentation compliance. A culture of fall prevention was created as nursing gained knowledge and engaged in all areas of fall prevention. Aligning with the National Association for Clinical Nurse Specialist (NACNS) spheres of impact, the oncology CNS targeted fall prevention outcomes within patient direct care, nurses and nursing practice, and organizations and systems. This focus informed the fall prevention approaches for both units using RCA findings. The oncology CNS aligned spheres of impact to target fall prevention outcomes in a combined clinic and infusion areas. The CNS mentored staff and implemented patient education on fall prevention strategies while articulating the value of fall prevention at the organizational level.

P62 **ASSESSING NURSING KNOWLEDGE, ATTITUDE, AND CURRENT PRACTICES ON MEDICAL CANNABINOIDS**

Alyssa Ridad, RN, UCLA Health, Santa Monica, CA;
**Monica Mikhael, RN, UCLA Health, Los Angeles,
CA; Kathy Pardes-Green, RN, UCLA Health, Santa
Monica, CA**

Evidence-Based Practice

Prior to the legalization of marijuana, oncology patients did not feel comfortable having discussions about cannabis use to help with symptom management such as pain, nausea, decreased appetite, anxiety, and depression. Since the legalization in California, there has been a significant increase in oncology patients seeking advice from healthcare providers, particularly nurses, on safety and usage of cannabis in relation to symptom management. In the past 20 years research has shown the anti-inflammatory benefits of cannabis and its connection to the reduction of common oncologic associated symptoms. Oncology healthcare providers have reported lack of knowledge about making recommendations to cannabis use and have expressed interest in receiving education or training about medical cannabis. At our current academic healthcare, there are no policies in place that allow the use of medical cannabis within the hospital setting, excluding use of low dose marinol. The pur-

pose of this project is to assess the knowledge, attitudes, beliefs, and comfort level of registered nurses around the use of medical cannabinoids within the oncology population. Survey responses will assist in identifying gaps in healthcare providers' knowledge around cannabinoid use for symptom management during treatment. This will enhance the comfort level around, and increase exposure to, conversations about use within a medical setting. There is a need for education and training on the risk and benefit of cannabis use, especially reducing barrier for patients to share their experiences with medical professionals. A qualitative electronic survey will be distributed to registered nurses in three acute oncology units within an academic healthcare system. The questions are designed to explore the nurses' comfort level and knowledge of medical cannabis use for the oncology population. Currently, data is still being collected from both academic medical centers. There is an increased need for awareness and education around cannabinoids use in the oncology population. Healthcare discrepancies can result in misinformation and/or hesitance from patients due to negative stigma associated with medical marijuana. Recent discoveries on the endocannabinoid system have helped support the expansion of research on therapeutic properties of cannabinoids. Nursing staff need to remain current on these new ways to support the oncology community and stay up to date on the latest scientific research within this topic on medical cannabinoid use.

P63 **EMPOWERING NURSES THROUGH USE OF TELEPHONE TRIAGE**

**Kerry-Ann Newell, BSN, RN, OCN®, BMTCN®, Memorial
Sloan Kettering Cancer Center, New York, NY; Marci
Andrejko, DNP, APRN, FNP-C, Memorial Sloan Ketter-
ing Cancer Center, New York, NY; Faye Inumerables,
MSN, RN, ACNS-BC, OCN®, Memorial Sloan Kettering
Cancer Center, New York, NY**

Oncology Nursing Practice

Improved supportive care services have allowed organizations to transition patients from inpatient to outpatient settings. Telephone triage is essential to optimizing outpatient care by ensuring access to clinical resources and promoting continuity of care. Nurses are vital members of the multidisciplinary team in an ideal position to aide in transformational changes and assist patients in navigating complex levels of care. The purpose of this project is to implement an interdisciplinary team approach to telephone triage in an Outpatient Cellular Immunotherapy Unit by lever-

aging the role of the Charge Nurse. Patient outcomes and nurse's perception of empowerment and support were explored. A multidisciplinary task force of nurses developed a new telephone triage workflow to cultivate triage skills of the Charge Nurses and foster collaborative relationships with the Advanced Practice Providers (APP). To facilitate training, a standardized tool to guide evidenced-based care was implemented, and an algorithm to determine escalation of care was utilized. Surveys were administered 6-months post implementation to participating nurses (N= 7) to evaluate perception of support and empowerment. A total of 108 triage calls were documented, almost half were either handled by the nurses only (45%) or collaboratively with the APPs (45%). The most common calls were for symptom management (62%), care coordination (20%) and prescriptions (14%). Nausea, vomiting and pain were the most frequently reported symptoms. Among the calls requiring escalation of care, 41 required an in-person visit and 20 were referred to the institution's urgent care center. Nurses reported up to 10 calls per week, requiring, on average 5-10 minutes per call. They reported high confidence in their ability to practice to the fullest extent of their education and training. All nurses endorsed adequate preparation. However, less than one third of nurses did not feel supported by the multidisciplinary team. Implementing the new workflow empowered nurses to practice at their full potential. This innovative change required additional training, which nurses identified as valuable in promoting confidence in triaging care. The interdisciplinary approach reduced the triage burden on the APPs allowing time for other responsibilities. An ongoing effort to strengthen the collaborative relationship continues to be explored with the goal of promoting safe, high quality outpatient care.

P64 **IMPROVING INFUSION CENTER EFFICIENCY WITH INFUSION TIME REDUCTION**

Sophie Ou, MS, RN, BSN, OCN[®], UCSD Koman Outpatient Infusion Center, San Diego, CA
[Coordination of Care](#)

The demand for patient services in infusion continues to increase while the resource for this service remains limited. At UCSD Koman Outpatient Infusion center we only have twelve infusion chairs. Managing the limited infusion chairs becomes a challenge as patient needs exceed capacity. To tackle this challenge, we changed the administration route of chemotherapy from intravenous infusion to subcutaneous in-

jection. We reviewed the medication administration and updated the new administration guidelines by reducing intravenous administration time, which also resulted in decreasing unnecessary pre-medications and the post-infusion observation hour. There was an 8% increase on daily capacity from 19 pts per day (January–April 2020) to 21 pts per day (May–August 2020). Through a series of small changes to our infusion practices starting in May/2020, we were able to increase our daily capacity by 8 percent. This project required support from the entire multidisciplinary team: physicians, pharmacists, schedulers, and infusion nurse staff. The gains have been sustained. We will continue to review the medication administration and update practice to follow newest guidelines, and the nursing workflow to increase efficiency.

P65 **CHANGING PRACTICE: SWITCHING FROM HEPARINIZED SALINE TO NORMAL SALINE PULSATILE FLUSHING TO MAINTAIN CENTRAL VENOUS ACCESS DEVICE (CVAD) PATENCY**

Theresa Patrick, RN, OCN[®], Sarah Cannon Cancer Institute at Johnston-Willis Hospital, Richmond, VA
[Oncology Nursing Practice](#)

Heparin is currently being administered at our facility on all CVADs to maintain patency. Research indicates that heparin flushing is not superior to Normal Saline (NS) flushing in reducing occlusions. NS only flushing appears to be a safe and effective way to care for patients with CVADs. This has been a hot topic of discussion on the Oncology Nursing Society Member Community Digest. In addition, further benefits include: decreased cost; decreased need to access CVADs resulting in potential decrease in Catheter-Associated Blood Stream Infections (CLABSIs); elimination of drug/heparin incompatibility reactions; decreased risk of Heparin-Induced Thrombocytopenia (HIT). The purpose of this project is to ensure current practice for maintaining CVAD patency is evidence-based. This led to evaluating whether NS flushing is as effective as heparin flushing in maintaining patency. First, an evidence-based practice research review was completed. This review was then presented to our pharmacy department and nursing leadership. A multidisciplinary committee was formed which changed our policy guidelines to reflect this practice change. The research and proposed policy amendments were presented to the Oncology Quality Committee and members of our Pharmacy and Therapeutics Committee for their consideration. The proposed policy

changes were approved. Plans are moving forward to update the policy after educating staff on the new practice, including the NS pulsatile flushing technique. The effectiveness of this change in practice will be evaluated by monitoring the number of central line occlusions and the doses of alteplase use required to declot CVADs. We will review the use prior to and after this change. Addressing the need for clinicians and patients to unlearn traditional teachings and accept changes to practice is essential in making way for this process to be adopted and sustained. In addition, the use of NS will decrease costs and may reduce adverse events. Starting as a single idea for an evidence-based practice project to fulfill clinical ladder requirements, this work has led to practice change at my hospital and now a possible presentation at a national level.

P66 ARMS OUT, IMMUNITY UP! INTERDISCIPLINARY COLLABORATION IN THE DEVELOPMENT OF AN OUTPATIENT ONCOLOGY COVID-19 VACCINATION CLINIC

Kim Peterson, MSN, APRN-CNS, ACCNS-AG, OCN[®], Greenebaum Comprehensive Cancer Center at the University of Maryland Medical Center, Baltimore, MD; Kirsten Tomaschefskey, BSN, RN, CCRN, Greenebaum Comprehensive Cancer Center at the University of Maryland Medical Center, Baltimore, MD; Suzanne Cowperthwaite, DNP, RN, NEA-BC, University of Maryland Greenbaum Comprehensive Cancer Center, Baltimore, MD; Tracy Douglas, DNP, RN, BMTCN[®], NEA-BC, Greenebaum Comprehensive Cancer Center at the University of Maryland Medical Center, Baltimore, MD; Meghan D'Angelo, MSN, RN, University of Maryland Medical Center, Baltimore, MD; Heather Thomas, MA, Greenebaum Comprehensive Cancer Center at the University of Maryland Medical Center, Baltimore, MD COVID-19

The COVID-19 pandemic wreaked havoc on physical, mental, and emotional health worldwide. The first COVID-19 vaccine approved for Emergency Use Authorization in December 2020 offered a glimpse of pandemic defeat. Access to vaccines is complicated for patients with cancer due to their immunocompromised state, complex treatments requiring oncologist consultation and frequent appointments. A single location for patients to receive coordinated outpatient and preventative care in a familiar setting is beneficial for the overall patient experience. The purpose of this project was to create a COVID-19 Vaccination Clinic in an NCI-Designated Comprehensive Cancer Center through a collabora-

tive, interdisciplinary partnership. Our goal was not only to vaccinate and boost immunity for oncology patients, but also for the general public. On March 9, 2021 oncology leadership received approval for a COVID-19 vaccination clinic. Executives, leadership from nursing, operations and ambulatory, IT, and pharmacy met daily for one hour between March 11 and March 19 to create infrastructure and develop an implementation plan. Through collaborative planning efforts an electronic health record department and vaccine clinic schedule were created, new workflows developed, oncology resources reallocated to support operations, exam rooms and waiting areas modified, staff educated to new processes, patients identified for scheduling, and a data tracking Smartsheet[®] developed. A 34-page handbook outlined steps of the process and resource for clinical staff. Severely immunocompromised patients were approved by their oncologists, nurses called patients to screen for vaccine eligibility and schedule appointments, pharmacists managed preparation and distribution of vaccines to minimize waste, and medical assistants administered vaccines and monitored patients post injection. Between March 22 and July 9, there were 507 vaccines administered, 46 cancellations, 24 same day add-ons, and one vaccine wasted due to expiration. Smartsheet[®] data collected the first week showed a total of 242 telephone calls in which 40% declined or deferred vaccination, 23% already vaccinated, 22% did not answer, and 15% scheduled. No adverse reactions were identified during post monitoring period in the clinic. The success of the COVID-19 Vaccination Clinic can be attributed to the collaborative partnership between the interdisciplinary group. Expertise from members led to a rapid, efficient and organized implementation of the clinic. Immunocompromised oncology patients have received benefit from vaccination services in a familiar location during their already scheduled oncology appointments.

P67 KEEPING THE DOORS OPEN TO AVOID DELAYS IN CANCER CARE: NURSE-LED INNOVATIONS FOR ONCOLOGY PATIENTS DURING COVID-19

MaryPat Porinchak, BSN, RN, OCN[®], Memorial Sloan Kettering Cancer Center, New York, NY; Donna Marie Curran, MSN, RN, OCN[®], Memorial Sloan Kettering Cancer Center, New York, NY; Nancy Heffernan, BSN, RN, OCN[®], Memorial Sloan Kettering Cancer Center, New York, NY; Melissa O'Dell, BSN, RN, OCN[®],

Memorial Sloan Kettering Cancer Center, New York, NY; Salima Rafikh, BSN, RN, OCN®, MSKCC, New York, NY; Karen St-Cyr, BSN, RN, OCN®, Memorial Sloan Kettering Cancer Center, New York, NY

COVID-19

Travel restrictions and fear of exposure to COVID-19 are barriers that contribute to patients delaying vital cancer care. Access to non-emergent care at this NCI-designated Cancer Center was constrained at the height of the pandemic to ensure the safety of patients and employees. Nurses in the Patient Access Department redesigned workflows in collaboration with physicians and hospital leadership to prioritize new appointments. Patient Access Nurses coordinate new visits to ensure that patients have access to appropriate specialty providers in a suitable timeframe based on clinical criteria. During the pandemic, nurses collaborated with hospital leadership to design and implement new workflows prioritizing in-person appointments consistent with the patient's presentation. New routes of access to oncology care were created to mitigate delays in diagnosis and treatment. Nurse-led interventions included the development of Access Frameworks which utilize clinical criteria to direct patients toward in-person vs virtual consults. The Rapid Biopsy Program expedited care for undiagnosed patients. Patients who could not take advantage of these options had access to an Oncology Nurse to ensure they were directed to reliable care locally. This presentation will include data to demonstrate the positive impact of these interventions, which allowed patients to receive cancer care during unprecedented times when many barriers existed. At the start of the COVID-19 crisis, there was a 150% increase in calls that were triaged to a nurse. Telehealth visits grew from less than 1% to 85% of scheduled new visits. A total of 83 patients were scheduled in the Rapid Biopsy Program to date and 64 of these patients went on to receive further care at our hospital. Patient Access nurses played a vital public health role during COVID-19 by preventing delayed cancer care. Patients valued clinical guidance from Oncology nurses during distressing times after learning they had a cancer diagnosis or progression of disease. As a result of this collaboration, hospital leadership has requested ongoing nursing input to create expanded access pathways for efficiency and growth during clinical restoration. Other centers may benefit from these interventions to prevent delays in care. Nurses developed novel workflows for patients across the US to safely obtain cancer care during the height of the COVID-19 pandemic.

P68

MOVING OUT: ONCOLOGY NURSES TRANSITION CHEMOTHERAPY DESENSITIZATION OUT OF THE INTENSIVE CARE UNIT

Denise Portz, MSN, RN, ACNS-BC, AOCNS®, Froedtert & Medical College of Wisconsin, Milwaukee, WI; Nancy Froggatt, MN, RN, CNL, Froedtert & Medical College of WI, Milwaukee, WI

Oncology Nursing Practice

Drug desensitization is a procedure by which patients can be safely reintroduced to medications that have previously induced infusion reactions. Desensitization with chemotherapy has important implications for patients who may have limited options to treat their cancer. In a large Midwest academic cancer center, patients historically were admitted to the ICU for chemotherapy desensitization for one to two days where trained inpatient oncology nurses would leave their unit to go to the ICU to administer the desensitization protocol. This process proved to be costly and inefficient. The purpose of this project is to establish a process to perform chemotherapy desensitization safely and efficiently on the inpatient oncology units and in the outpatient infusion area rather than in the ICU. In a large Midwest academic cancer network, a multidisciplinary team was formed, led by an outpatient clinical nurse specialist and an inpatient clinical nurse leader. Members included oncology nurses, pharmacists, and providers who developed a new desensitization guideline and inpatient and outpatient workflows. Nurses were educated on new treatment plans and refreshed in infusion reaction management in accordance with institution standards. Medications to manage infusion reactions were available near the bedside to promote timely treatment. In phase one, desensitization was conducted on the inpatient oncology unit with patients discharging the same day. In phase two, patients who tolerated inpatient desensitization received subsequent cycles in the outpatient setting. Fourteen desensitization treatments with four patients in the inpatient oncology unit were successfully completed in phase one with no infusion reactions. Nursing resources were reduced from two RNs to one RN and overnight admission was eliminated. Patients expressed satisfaction with not having an overnight ICU stay and inpatient nurses expressed satisfaction with caring for the patient on their unit. Three desensitizations in the outpatient setting were also completed, where 340B drug pricing and eliminating inpatient admission is demonstrating cost savings. It is intended to complete seven more outpatient desensitizations before evaluating the outcomes for

future standardization of care. The benefits to moving chemotherapy desensitization out of the ICU include better nursing resource utilization, cost savings, and patient and staff satisfaction. Other organizations may wish to evaluate their approach and adopt a plan to provide chemotherapy desensitization to their patients outside the ICU.

P69 DISSEMINATION OF A GENETIC NAVIGATION FRAMEWORK FOR HEREDITARY CANCERS TO INCREASE MUTATION CARRIER IDENTIFI- CATION AND TO IMPROVE OUTCOMES

**Kathryn Pratt, BSN, RN, OCN[®], CBCN[®], ONN-CG,
University of Texas Southwestern Medical Center,
Harold C. Simmons Comprehensive Cancer Center,
Dallas, TX; Sayoni Lahiri, MS, CGC, University of Texas
Southwestern Medical Center, Fort Worth, TX; Sara
Pirzadeh-Miller, MS, CGC, University of Texas South-
western Medical Center, Dallas, TX**

Screening, Early Detection, and Genetic Risk

Approximately 5 to 10% of cancers are due to an inherited, pathogenic genetic mutation. The UT Southwestern Cancer Genetics Program (UTSW CGP), part of a National Cancer Institute-designated comprehensive cancer center, has identified 5,600 germline mutations over twenty years. Our program has developed population-based screening programs to increase identification of individuals with hereditary cancer. The UTSW CGP developed the unique nursing role of Genetic Patient Navigator (GPN), who follows up with mutation-positive patients to assess cancer risk-management compliance, with the ultimate goal of cancer prevention. The UTSW CGP developed a hereditary cancer-focused population screening and navigation toolkit (Cancer Genetics Toolkit/ CGT) through funding awarded by the Cancer Prevention Research Institute of Texas (CPRIT). The CGT compiled resources critical to the implementation of successful and sustainable cancer genetic screening and navigation programs. Our goal was to disseminate this free, web-based toolkit (available at utswmed.org/geneticstoolkit) to Texas cancer programs looking to implement similar initiatives. Focus groups were held with key stakeholders to modify the CGT. We disseminated the CGT to key stakeholders in Texas. The CGT contains: implementation tools for screening and navigation; resources for clinician education; resources for providing clinical services and patient follow-up, including genetic patient navigation resources for underserved patient populations; and tools for identification of high-risk patients. The

GPN regularly shared components of the CGT with oncology nurses and oncology patient navigators within Texas. Between March 2020 to September 2021, 1,966 individuals accessed the main CGT landing page 2,507 times. The portion of the CGT which the GPN contributed to (Clinical Services and Patient Follow-Up) was accessed by 377 individuals 641 times. Over this same time period, the GPN shared a total of 177 CGT resources with 19,659 Texas individuals of the Oncology Nursing Society (ONS), the Academy of Oncology Nurse & Patient Navigators (AONN+), and a local oncology patient navigation networking group. A CGT with resources on genetic navigation for clinicians, oncology nurses/ navigators and breast navigators serves as a starting point for change for large cancer programs, small oncology groups, and mammogram centers. Our goal is to continue to provide a free, up-to-date resource.

P70 STANDARDIZATION AND IMPLEMENTATION OF A CRYOTHERAPY GUIDELINE FOR MELPHALAN ADMINISTRATION ACROSS INPATIENT AND OUTPATIENT CARE AREAS

**Jessica Radicke, RN, MSN, OCN[®], BMTCN[®], CCCTM,
Thomas Jefferson University Hospital, Philadelphia,
PA; Jill Cristiano, RN, BSN, OCN[®], BMTCN[®], Thomas
Jefferson University Hospital, Philadelphia, PA; Felicia
Rivera, RN, BSN, OCN[®], BMTCN[®], CCRN, Thomas
Jefferson University Hospital, Philadelphia, PA; JoAnn
Silcox, RN, MSN, CCCTM[®], Thomas Jefferson Univer-
sity Hospital, Philadelphia, PA; Ellen Sweeney, RN,
MSN, OCN[®], Thomas Jefferson University, Broomal,
PA; Claudia Thomas-Nembhard, RN, MSN, Thomas
Jefferson University Hospital, Philadelphia, PA**

Coordination of Care

Many individuals who have been treated with chemotherapy have subsequently faced challenges in their recovery because of side effects and symptoms they have developed from the chemotherapy that they have received. The chemotherapy, Melphalan, is well-known for its use in hematopoietic stem cell transplants (HSCT), as is its adverse effect of causing mucositis. The utilization of cryotherapy with Melphalan has been seen to reduce the development and severity of mucositis in patients. Healthcare institutions use Electronic Medical Records (EMR) to order treatment plan regimens and to communicate drug administration instructions to providers. The HSCT order sets that contained Melphalan at our institution had the following instruction embedded in the order set: the patient should chew ice during the medication infusion. This

communication was not evidence based. Additionally, it was interpreted differently among the staff and led to inconsistent patient education. The purpose of this project was to create an evidence-based cryotherapy practice guideline for Melphalan administration that could be implemented in the inpatient and outpatient care setting. A literature review was completed to determine an effective timeframe for cryotherapy. The proposed guideline was approved by an interdisciplinary team. The updated cryotherapy guideline was: patients should be educated to complete cryotherapy with ice chips starting fifteen minutes prior to receiving their Melphalan chemotherapy. Patients should continue with the cryotherapy during the entire infusion (fifteen minutes) and for an additional ninety minutes after the infusion has completed. The total duration of cryotherapy should be two hours. The nursing leaders collaborated with the EMR team to update the appropriate order sets to reflect the guideline change. Additionally, the nursing leaders educated their teams about this change using various methods of communications. Regular meetings with the staff were utilized to monitor compliance with the change. Scheduled outpatient appointment times posed an issue for cryotherapy compliance, not all patients are in the infusion center for ninety minutes post infusion. This concern led the team to purchase insulated bottles that could be used to house ice chips to ensure that patients had the necessary materials to comply with the guideline. Cryotherapy is a cost-effective intervention that can reduce the occurrence of mucositis. The EMR can assist in providing consistent evidence-based medication administration instructions across different care areas.

P71 AN EVIDENCE-BASED REVIEW OF OUTCOMES IN PATIENTS WITH ULTRASOUND GUIDED PERIPHERAL IV PLACEMENT

Lillian Reilly, MSN, RN, OCN®, Memorial Sloan Kettering Cancer Center, New York, NY; Kerry King, MSN, RN, OCN®, Memorial Sloan Kettering Cancer Center, New York, NY; Caroline Clark, MSN, APRN, OCN®, AGCNS-BC®, Memorial Sloan Kettering Cancer Center, New York, NY; Erica Fischer-Carlidge, DNP, CNS, CBCN®, AOCNS®, Memorial Sloan Kettering Cancer Center, New York, NY

Oncology Nursing Practice

Oncology patients are known to have poor venous access and may require treatment with caustic drugs, worsening vein health and increasing extravasation risk. The need to explore alternatives to traditional

methods of visualization and palpation for peripheral intravenous (PIV) insertion is becoming more necessary. The patient population at an NCI-designated Comprehensive Cancer Center frequently experienced multiple PIV stick attempts or central venous catheter (CVC) placement for chemotherapy treatments. Reducing the number of attempts can preserve vein health and improve patient outcomes and satisfaction. CVCs are less desirable due to the increased risk of infection. The purpose of this project is to determine best practice for utilizing vein visualization technology and evaluate outcomes. The PICO(T) question, "In patients requiring vascular access, how does use of vein visualization technology compared to no vein visualization technology affect patient outcomes?" guided an extensive literature search in CINAHL, PubMed, Joanne Briggs, EMBASE, Scopus, and Cochrane Library. 732 articles resulted; 66 articles were critically appraised; 40 were considered high quality and relevant to the clinical inquiry. An additional 7 articles were found through citation searching. Of the 47 articles, 39 supported use of ultrasound (US) guidance for PIV placement. Synthesis found US guidance reduces infection, number of IV attempts, delays in treatment, CVC placement and improves successful cannulation and patient satisfaction. Additional synthesis found the most common operator for US guided PIV placement is nurses. Criteria to define a difficult stick was synthesized across all articles. The 6 most common criteria to define a difficult stick were identified in the literature. None of the articles discussed chemotherapy extravasation or the oncology population, however criteria for difficult sticks include this population as one to benefit from US guidance for PIV placement. Final presentation will review a full synthesis of the evidence and associated institutional changes made based on these findings. Using the outcomes and difficult stick criteria, as well as the clinical expertise of oncology nurses, an algorithm was created to determine when US guidance should be used for PIV placement. This evidence-based algorithm will be used for future implementation of US guided PIV placement at the cancer center and can be applied in other settings for decision making.

P72 PREVALENCE OF SINGLE NUCLEOTIDE POLYMORPHISMS IN BREAST CANCER PATIENTS WITH ACUTE RADIODERMATITIS: SYSTEMATIC REVIEW AND META-ANALYSIS

Paula Reis, RN, PhD, University of Brasília, Brasília;
Beatriz Aguiar, RN, MSc, University of Brasilia, Brasil-

ia; Ana Normando, MSc, University of Campinas, São Paulo; Eliete Guerra, PhD, University of Brasília, Brasília; Elaine Ferreira, RN, PhD, University of Brasília, Brasília

Oncology Nursing Practice

Acute Radiation Dermatitis (RD) is a very common adverse skin reaction in breast cancer patients undergoing radiotherapy. Depending on the severity, this reaction can lead to treatment interruption. The Radiogenomics Consortium was created to develop large cohorts that assess the ability of Single Nucleotide Polymorphisms (SNPs) to predict radio-toxicities. The purpose of the study was to verify the prevalence of the SNPs in breast cancer patients that presented RD. The Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) criteria were used for this systematic review. A search was performed in the CINAHL, Cochrane CENTRAL, EMBASE, LILACS, PubMed, Scopus, and Web of Science databases. A search was performed in the Google Scholar, OpenGrey and PROQUEST Thesis & Dissertations. The risk of bias of the included studies was assessed using the Joanna Briggs Institute's Critical Appraisal Checklist for Cohort Studies tool. Meta-analysis of the prevalence of SNPs in breast cancer patients who had RD was performed in MetaXL[®] 5.3 software. Sixteen cohorts were included in this review. Thirteen studies had a low risk of bias, and 3 had a moderate risk of bias. However, only 10 studies presented sufficient data on the frequency. Twenty-two SNPs were included in the prevalence meta-analysis using a random-effects model. The prevalence ranged from 24% to 41% for all SNPs evaluated. The three most prevalent SNPs in breast cancer patients who had RD were rs1800469 in the TGFβ1 gene (41%; 95% CI: 23-60), rs3957356 in the GSTA1 gene (36%; 95% CI: 24-48) and rs4880 in the SOD2 gene (33%; 95% CI: 22-44). The inconsistency (I^2) was greater than 92% in all meta-analyses. The assessment of the prevalence of SNPs had high inconsistency and heterogeneity. However, high heterogeneity is expected in prevalence assessments. Evaluation of SNPs rs1800469 in the TGFβ1 gene, rs3957356 in the GSTA1 gene and rs4880 in the SOD2 gene may be promising to predict the occurrence of RD. These meta-analyses were performed with few studies, which decreases the possibility of recommendation. We suggest that studies continue to be performed to confirm the data in this review. Identifying SNPs prevalent in breast cancer patients who present with RD can help to predict this reaction and to aid in individualized treatment planning and nursing care.

P73

A DEDICATED DISCHARGE CALL NURSE TEAM CAN REDUCE READMISSION RATES

Leslie Renner, RN, Karmanos Cancer Institute, Detroit, MI; Clara Beaver, MSN, RN, AOCNS[®], ACNS-BC, Pittsburgh, PA; Robin Veicelli-Fowler, RN-BC, BS, Karmanos Cancer Center, Detroit, MI

Patient Education and Safety

Reducing readmission rates is on the forefront of every hospital's agenda and oncology patients have an increased risk for readmission due to their complex diagnosis and treatment. Research has shown that discharge follow up phone calls have decreased readmission rates when completed in a timely manner. At Karmanos Cancer Institute, discharge phone calls were originally assigned to the staff RNs to complete when they had down time on the floor. This led to many missed discharge phone calls in the time allotted (10 days). In 2020, a new position was created to address the need of placing discharge phone calls to all patients in a timely manner. The purpose of this initiative was to increase the number of completed discharge phone calls and decrease readmissions of oncology patients. In 2020 a new position was created for a discharge call nurse. This was created to provide structure to the discharge phone call process, increase the number of calls being completed and to decrease readmissions. Two part-time RNs were hired for the position using a script to provide structure to the discharge call. The expectations of the role were three-fold: to call 100% of the discharged patients, to reach patients within 3 days of discharge, and to increase the number of completed calls. During the discharge call the RNs reinforce education, verify supplies have been received, assist with follow-up appointments, and remind patients who/when to call in the event of an emergency. Prior to the dedicated discharge call nurse approximately 35% of discharge patients were being called within ten days of discharge and only 18% of these calls were completed. Since the discharge call nurse position has been created 100% of discharge patients have been called within three days. 77% of these calls included a discussion with the patient/caregiver. The discharge calls have answered patient questions, referrals have been made as well as follow-up clinic visits and there has been an overall decrease in readmission rates. A structured discharge call program can decrease readmission rates and improve patient satisfaction. Having a dedicated team that calls patients allows the patient/caregiver another resource to use if there are issues following discharge.

P74 THE DEVELOPMENT OF A STREAMLINED AND STANDARDIZED APPROACH TO ONCOLOGY CHARGE NURSE HANDOFF

Nadeen Robinson, MSN, RN, OCN®, New York Presbyterian, New York, NY; Nicole Turkoglu, MSN, RN, OCN®, BMTCN®, New York Presbyterian, New York, NY; Lorie Ann Magno, MSN, RN, OCN®, New York Presbyterian, New York, NY; Nataly Young, BSN, RN, OCN®, New York Presbyterian, New York, NY; Archana Shenoy, DNP, RN, FNP-C, OCN®, New York Presbyterian, New York, NY

Oncology Nursing Practice

Inpatient oncology charge nurses expressed a need for a streamlined approach to handoff that focuses on the needs of the unit. Charge nurses stay late to give handoff resulting in feelings of burnout, job dissatisfaction, and accumulation of incidental overtime. The purpose of the study was to use an oncology charge nurse tool to create an efficient handoff, decrease incidental overtime, and increase job satisfaction. An oncology specific streamlined handoff tool and new approach to utilizing the electronic medical record (EMR) was implemented. Handoff was based on acuity and quality (step-down, chemotherapy, research, hospice, fall risk, central lines, psycho/social needs, isolation), staffing, patient flow (census, admissions, discharges, barriers), and equipment/supply needs. Charge nurses communicated with staff through huddle messages and receiving report from staff. At baseline the incidental OT was 4.29 hrs and during implementation 3.54 hours. A spike was seen in incidental OT for the 6 main charge nurses in the first (7.16hrs) and second (8.16hrs) schedule periods post implementation of the project. This could be related to adjusting and becoming more familiar with the process. There was a steady decrease in the third (5.75hrs), fourth (5.38hrs), and fifth (3hrs) schedule periods post implementation. This might be related to the new charge handoff method becoming the standard practice to conduct charge handoff. The standardized oncology charge nurse handoff allowed for: (a) focused handoff concentrating on the most pertinent needs of the unit, (b) ability of charge RN to retain most important information, (c) charge RN to be readily available to meet the needs of the unit, (d) charge RN to start environment of care and patient rounds early in shift, (e) better ability of charge nurse to understand how to best help RNs on shift, and (f) potential decrease in charge RN incidental overtime and increase in charge RN satisfaction. Oncology patients have a high acuity and complex needs.

The oncology charge nurse needs a tool specific to the needs of an oncology unit to create an efficient method of giving and receiving charge report. The oncology charge RN has many roles including leader, mentor, expert, communicator, and mediator. An oncology charge nurse handoff tool enables the oncology charge RN to achieve nursing excellence and create a more favorable work environment.

P75 CREATION OF A SURGICAL STEP-DOWN UNIT DURING THE COVID-19 PANDEMIC

Melody Rosamilia, MSN, RN, OCN®, CNL, Memorial Sloan Kettering Cancer Center, New York, NY; Patricia McTague, DNP, RN, FNP-BC, Memorial Sloan Kettering Cancer Center, New York, NY; Kelly Palazzolo, MSN, RN, CNS, AGCNS-BC, PCCN, Memorial Sloan Kettering Cancer Center, New York, NY; Patricia Spellman-Foley, MSNed, RN, CNML, MSKCC, New York, NY

Coordination of Care

Like many health care facilities significant changes were made to care for patients during the COVID-19 pandemic. At this Magnet recognized 514 bed cancer center based in New York City, changes included halting elective surgeries, redeploying or uptraining staff and converting the step-down unit (SDU) into an ICU. Nursing was at the forefront of these changes and the care provided. As time progressed, surgeries resumed to perform necessary interventions for our oncology population. When these resumed, it was necessary to create a new surgical SDU for the critically ill postoperative patients as the previous SDU remained an ICU. The unit designated to become a surgical SDU had expertly trained nurses, primarily in head and neck surgical oncology, head and neck medical oncology, melanoma, sarcoma, and telemetry. To become a SDU these nurses required uptraining of additional knowledge and skills. A collaborative approach between nurse educators, clinical nurse specialists, and nursing leadership was used to provide training to the staff and safely transform the unit. Initially, there was a unit-to-unit collaboration in which SDU nurses cross covered until uptraining was completed. A blended approach of didactic and hands on training was used to uptrain 63 RNs to ensure competency. The didactic education involved an in-depth review of arterial line monitoring, vasopressors, titration, and case studies. The nurses spent time in the post-anesthesia care unit (PACU) or ICU to cross train. In addition, nursing partnered with biomedical engineering to install new monitors with enhanced capabilities as well as upgrading the remote alarm sys-

tem to notify nurses of clinical changes. From January to September 2021, a total of 202 patients admitted to the surgical SDU. Of the SDU patients admitted, 36% were hepatopancreatobiliary surgical patients, followed by thoracic and gastric mixed tumor surgery, 38% and 24%, respectively. The COVID-19 pandemic showcased adaptability across the care continuum, allowing swift action to provide highly skilled patient care. By upgrading this unit thoughtfully with future implications in mind, upgrades in monitoring, ventilator capability, and patient visibility affords us the capability to quickly transform if a pandemic or natural disaster warranted it.

P76 NURSING INTERVENTIONS FOR FEMALE PATIENTS UNDERGOING VULVAR CANCER RADIATION

Jennifer Rosbough, BSN, RN, CHPN, OCN®, Cleveland Clinic, Cleveland, OH

Research

Radiation treatments to patients with vulvar cancer is challenging due to the significant physical side effects of treatment to this sensitive area. It is imperative for oncology nurses to guide these patients on symptom relief to minimize pain related to radiation therapy in order to successfully complete their course of treatment with minimal to no breaks in order to optimize outcomes. Reviewing multiple research articles to determine best practice was paramount in my research. Skin reaction was the number one treatment stopping side effect of radiation to the vulvar region, followed by bladder cystitis and gastroenteritis. For this project, I focused on skin reaction symptoms. Interventions for radiation related skin reactions were vast and included various topical ointments, creams, lotions, soaps or powders. The first step agreed upon by the majority of research articles was to cleanse the treatment area with lukewarm water, although how that is done differs. Some say shower, some say bath but most say sitz bath is the best way to do this. Sitting in a sitz bath for 15 minutes several times daily keeps the skin clean of toxins like urine or stool. This also serves to remove any ulcerated tissue paving the way for healthy tissue to grow. No soap was most often recommended followed by mild soap like Dove. The types of topical creams, lotions and ointments vary but one thing is consistent; no perfumes, dyes or artificial ingredients. The most recommended product is Aquafor, moderna or pure aloe vera (no alcohol) over the counter. Many physicians will switch over to prescription Silvadene if over the counters are

ineffective in soothing pain. Our job as nurses is to repeatedly provide education regarding skin care regimens including cleansing and topical agents as well as doing sound pain assessment. Sometimes, oral pain relievers may be needed in order to treat pain, again in order for the patient to successfully complete the full treatment. This poster will present the best practice treatments for radiation skin reaction. Optimizing education to this patient population is the number one job for the oncology nurse. Much has not changed in skin care for radiation over the years with the simpler the better being considered best practice.

P77 RADIATION ONCOLOGY–PROFESSIONAL DEVELOPMENT IN BRACHYTHERAPY THROUGH EXPANSION OF SERVICES

Victoria Bradford, RN, BSN, MBA, UC San Diego Health Cancer Services, La Jolla, CA; Monette Santos-Moss, RN, BSN, MSN, UC San Diego Health Cancer Services, La Jolla, CA

Oncology Nursing Practice

With a high volume, high acuity brachytherapy service, focusing primarily on patients undergoing therapy for gynecological cancers, the Brachytherapy RNs and physicians identified an opportunity to expand services, as well as increase patient safety and well-being with the integration of the Anesthesia team. The purpose of this project was to provide deep procedural and/or general anesthesia to new patient populations previously not eligible for brachytherapy services due to patient acuity and/or inability to provide specific brachytherapy service within OR setting. To ensure patient safety and regulatory compliance, a multi-disciplinary work group, composed of Radiation Oncology staff RNs and leaders, MDs, Physicists and Anesthesiology leadership worked closely together and identified the following critical steps and interventions: (1) Determination of resources (budget, time, people) and timeline; (2) Physical environment: Creation of dedicated post-anesthesia care space; (3) Create standard workflows for pre-anesthesia assessment and education by Anesthesiologist, Radiation Oncologist and RN, intra-procedure care and roles, and post-procedure care and roles; (4) Implement EMR documentation system: RNs had previously documented delivery of care, including moderate sedation, on paper flowsheets; Radiation Oncologists, Physicists and RNs generally use the EMR associated with the linear accelerators. This department uses ARIA (documentation and planning system of Varian) which then moves to EPIC via a one-way feed every 24

hours. Expanding services gave us the opportunity to move into our systemwide EMR – EPIC; Collaborative work with IS team to develop and implement EPIC OpTime (procedural module) in Radiation Oncology, aligned with other procedural areas throughout healthcare system; (5) Development of Competencies, Patient Education and Policies and Procedures in alignment with other perioperative and procedural areas; (6) Ensure regulatory compliance with all state and federally mandated requirements for anesthesia care (be sure to include Regulatory Services from beginning of project and team planning for CDPH visit). Project management timelines and updates crucial to ongoing team engagement. Metrics: patient safety (airway management, reversal), staff engagement and satisfaction, and patient satisfaction – perception of comfort and wellbeing during brachytherapy. Look forward to reporting on launch by ONS Congress 2022! Radiation Oncology RNs are leading the way as part of an overall strategic department goal to clinical documentation within EPIC. Our department will be able to offer brachytherapy services to high acuity patients who previously could not safely have moderate sedation, positively impacting their outcomes

P78 AMBULATORY ACUITY-TOOL: TAKING IT UP A NOTCH

Brooke Schrameck, RN, BSN, Smilow Cancer Hospital Care Centers in Derby, Waterbury and Torrington - Yale New Haven Health, Derby, Waterbury and Torrington, CT; Krista Bello, BSN, RN, OCN®, Smilow Cancer Hospital Care Centers in Orange, Guilford and Old Saybrook - Yale New Haven Health, Orange, Guilford and Old Saybrook, CT; Sandy Morgan, MSN, RN, OCN®, Smilow Cancer Hospital - Yale New Haven Health, New Haven, CT; Mandeep Smith, BSN, OCN®, Smilow Cancer Hospital Care Center in North Haven - Yale New Haven Health, North Haven, CT; Roberta Sterling, RN, MSN, MPH, CNML, Smilow Cancer Hospital Care Centers in Derby, Waterbury and Torrington - Yale New Haven Health, Derby, Waterbury and Torrington, CT
[Oncology Nursing Practice](#)

At a large comprehensive cancer center with fifteen ambulatory oncology sites, different acuity tools were being used and applied inconsistently. Assignments were often based on total patient volume and treatment time. When patient complexity was considered, there was not an objective standard to define that complexity. This led to perceived disparity among nurse patient assignments which affected overall nursing satisfaction. The purpose of this project was to cre-

ate and implement a standardized, objective patient acuity tool to drive the daily nursing assignment with an intended result of improving nursing satisfaction. An existing acuity tool was implemented for charge nurses in six ambulatory locations to improve safety, equality and objectivity within nursing assignments. Post-implementation, nursing feedback regarding the tool was reviewed and showed highly complex patients often went unidentified. The tool was modified to incorporate specific elements that drive complexity including ECOG, distress thermometer score and interpreter needs. Each element was assigned a different weight of 1-2 points. The modified tool was implemented in the same locations and the acuity value per patient was documented in a new field in the electronic medical record. Acuity values were totaled for each nurses' daily assignment to ensure the total acuity value did not exceed a pre-determined threshold. A pre-survey using a 5-point Likert scale was created to assess nurse satisfaction with patient assignments using the pre-existing acuity tool. Eighty-five surveys were completed across 6 clinics, with nurses rating their daily assignments from bored to chaotic over a two-week period. After implementing the revised acuity tool with complexities, eighty-five post surveys were completed over an additional two-week period. When compared with the pre-survey results, the post-survey results showed a shift from too busy to just right. Our project has demonstrated that assignment standardization with added consideration to psychosocial and physical needs, leads to increased nursing satisfaction with their daily assignment. This novel approach that includes numeric identification of acuity allows the charge nurse to continuously provide the infusion team with a safe and equitable daily assignment. Identified barriers included varying definitions of each visit type across offices and the acuity calculation was done at the beginning of the day, and not re-evaluated with changes that happened in the schedule throughout the day.

P79 THE AMBULATORY ONCOLOGY CLINIC VISIT: ESTABLISHING WORKFLOWS TO ENSURE PATIENT VISIT READINESS

Mandeep Smith, BSN, OCN®, Smilow Cancer Hospital Care Center in North Haven - Yale New Haven Health, North Haven, CT; Christina Matousek, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT; Justin Persico, MD, Smilow Cancer Hospital - Smilow Trumbull/Fairfield, Trumbull, CT; Monica Fradkin, BSN, MPH, OCN®, CNML, Smilow Cancer Hospital at Yale

New Haven Hospital, New Haven, CT; Jeremy Kortmansky, MD, Yale School of Medicine / Smilow Cancer Hospital, New Haven, CT; Constance Engelking, RN, MS, CHE Consulting Group, Inc., Old Lyme, NY
[Oncology Nursing Practice](#)

Return patient visit readiness is essential to efficient daily clinic flow and patient safety. “Visit readiness” encompasses completion of previously prescribed consultations, laboratory/imaging studies, placement of treatment orders, consents and authorizations before the patient’s visit. Lack of adequate preparation can result in deficient information, last minute cancellations with increased rescheduling workload, delays in care, and decreased patient satisfaction. The purpose of the study was to standardize proactive pre- and post-visit workflows customized to medical, surgical, and radiation oncology. A team was convened to identify process improvement opportunities for optimizing clinic flow. A current state assessment of pre-clinic preparation practices, utilization of the electronic medical record (EMR) and staff roles was accomplished using clinical practice observations and staff surveys. Group member ideas for efficiency improvements were gathered. Workflow mapping beginning with post-clinic wrap huddles followed by pre-clinic review processes were generated for review and refinement. During post-clinic huddles, each patient’s plan of care is discussed; outstanding items are a trigger to action. Two specific EMR tools to facilitate pre-clinic reviews were developed and tested for workability: consolidation of review elements in one EMR location and a flag indicating visit readiness. Additionally, a huddle checklist to guide daily clinic preparation and post clinic wrap was developed. Staff and provider training sessions were executed before the pilot launch. This project is being piloted for 6 weeks. Metrics to evaluate effectiveness of new clinic preparatory processes include: provider interruption time study, clinic preparation time studies, automated reporting of physician compliance with disposition completion, and selected nurse-sensitive Press Ganey indicators specific to team communication and plan of care. Weekly team multidisciplinary meetings will gather information on best practices and barriers. Additional pilot sites are planned for sequential rollout. Pre-clinic preparation ensures that all orders have been executed and testing is resulted ahead of visits. EMR tools streamline and simplify clinic preparation by nurses. Engagement by all team members has been facilitated by incorporating shared best practices in process mapping activities. A two-step clinic preparation that begins with post clinic huddle allowing for

sufficient lead-time and ending with pre-clinic review allows staff time to confirm readiness. The introduction of EMR tools coupled with proactive multidisciplinary huddling to ensure patient visit readiness is an innovative approach to oncology clinic preparation.

P80 UNIT-BASED MID SHIFT HUDDLES TO PROVIDE TO IMPROVE OUTCOMES: FEASIBILITY AND IMPLICATIONS

Nicole Smith, MSN, RN, Roswell Park, Buffalo, NY
[Patient Education and Safety](#)

There is significant evidence that unit-based huddles improve safety by increasing communication and improving overall team performance. Traditionally unit-based huddles occur during the initiation or termination of a shift. There is emerging data that doing the huddle during the shift may improve nursing sensitive indicators on the unit including hand hygiene scores, and patient falls. The purpose of this pilot project was to evaluate the feasibility and implications when implementing unit-based mid-shift huddles in a surgical floor of a dedicated oncology hospital. Following the Agency for Healthcare Research and Quality “Daily Huddle Component Kit” rubric the clinical nurse manager provided education to the charge nurses on how to implement the huddles. There are two components of the huddle including “patient first” and “temperature check”. The focus of “patient first” is patient safety and bed management. This is a time to discuss pending unit admissions, transfers, and discharges. Patients that are at high risk for falls, require an in-person sitter due to cognitive deficiencies, and declining/unstable patients are also discussed. The “temperature check” focuses on staff members workload, stress level, and resiliency including ensuring staff wellbeing, workload, and potential obstacles in providing care. Subjective data was overwhelming positive, and within three weeks, the mid-shift huddles became engrained in the daily unit operations. Given the positive feedback from staff, other units requested to initiate mid-shift huddles. Staff from the initiating surgical unit served as coaches in implementing the huddles. Mid-shift unit-based hospitals were overwhelmingly supported by staff. Moderate term results are currently being collected to assess the impact on employee engagement, nursing satisfaction, and nursing sensitive indicators.

P81 ONCOLOGY NURSES AND ADVANCED PRACTICE PROVIDERS TEAM UP TO JUMP

TO THE VERY FRONT OF THE FRONTLINE IN THE WAR ON COVID-19

Carolina Starr-Manning, MSN, RN, OCN[®], Baystate Medical Center, Springfield, MA; Janea Barrett, BSN, RN, HN-BC, Baystate Medical Center, Springfield, MA; Paula Brooks, DNP, FNP-BC, MBA, RNFA, Baystate Health, Springfield, MA; Susan Hunt, DNP, ACNP-BC, Baystate Medical Center, Springfield, MA

Coordination of Care

In November of 2020, the Food and Drug Administration (FDA) approved the emergency use of monoclonal antibody therapy to treat individuals considered at high-risk for complications, hospitalization and mortality due to COVID-19. By December of 2020, Baystate Medical Center (BMC) launched a task force comprised of organizational leaders, infectious disease providers, advanced practice providers, pharmacists and oncology nurses at the forefront. Subsequently, the oncology nurses have had to adapt swiftly to help serve the surrounding susceptible community while adhering to the stringent guidelines established by the FDA and Massachusetts Department of Public Health (MA DPH). The monoclonal antibody therapy itself continues to evolve as outcomes data is gathered, resulting in a rapid adjustment to differing drug recommendations, formularies and supplies. Since implementation we have treated over 600 patients and many report improvements of COVID-19 symptoms as quickly as 24-48 hours from the time of infusion. Based on anecdotal data, this program has shown to decrease hospitalization of those with mild to moderate symptoms, leaving beds open for more critical care patients. In addition, we believe our program has helped patients recover faster and has significantly impacted positive outcomes for individuals in our most vulnerable communities.

P82 ORAL CHEMOTHERAPY AND IMMUNOTHERAPY DOCUMENTATION

Victoria Bradford, RN, BSN, MBA, UC San Diego Health Cancer Services, La Jolla, CA; Cathleen Sugarman, RN, MSN, AOCNS[®], UC San Diego Health Cancer Services, La Jolla, CA; Shelly Kane, MPH, UC San Diego Health Cancer Services, La Jolla, CA

Oncology Nursing Practice

Proper management of oral chemotherapy dosing and side effect management contribute significantly to both the overall health and wellbeing of the cancer patient but also the overall survival. Documentation in the patient medical record correctly is essential to management in busy clinic and inpatient environments where several providers and nurses interact with a patient. Oral che-

motherapy and immunotherapy documentation also becomes an integral part of the patient's Survivorship Plan. In 2016, a major performance improvement project, driven by oncology RNs and in collaboration with Pharmacy, Information Services and Oncologists, established a section of the EMR (EPIC) for documentation of medications and side effects. Consistent use of the tool, however, decreased over time. We put together a small workgroup to collect feedback from the users and improve the tool. The purpose of the project was to increase reliable, standardized, and useful documentation of oral chemotherapy in the EMR to improve patient care coordination and outcomes. Interventions were (a) a small workgroup with oncology RNs, informatics specialists, pharmacists, physicians and quality leaders to determine how we could create user-friendly, meaningful PO Chemotherapy and Immunotherapy Documentation Tools, (b) development and implementation of physician and staff education on use of the tool, including rationale for use—why it's so important, and (c) development of metrics by disease team/department for monthly reporting, tracking and trending. Evaluation: Comparison of pre-intervention and post-intervention revisions in utilization of the oral chemotherapy tab in EMR through monthly reporting, tracking and trending by disease team and department. Oral chemotherapy and immunotherapy is an increasingly frequent part of cancer therapy. Because the patients themselves mostly manage it, close monitoring of side effects and their management is essential to ensure that it provides the maximum benefit to the patient. The ever-growing number of medical providers that interact with patients can further complicate this. The EMR ideally contains all the pertinent information needed, and collected in a standard way, to manage oral chemotherapy with patients at any point in their trajectory. As oral chemotherapy has become a more common part of cancer care, the EMR now encourages the collection of all information, in an easy to view way, needed to assist patients in achieving the maximum benefit from these therapies.

P83 DEVELOPING AN OBJECTIVE PATIENT NEEDS- BASED ACUITY TOOL FOR A BONE MARROW TRANSPLANT/HEMATOLOGY-ONCOLOGY UNIT

Jill Trzaska, MSN, RN, BMTCN[®], OCN[®], Northwestern Memorial Hospital, Chicago, IL

Oncology Nursing Practice

Assessing the right number and type of nursing staff to meet patient care needs is fundamental to inpatient

care. Correctly identifying specific patient care needs per shift and equally balancing nursing workload increases nurse satisfaction and optimizes resources needed to provide appropriate levels of care. Subjective acuity grading results in perception of unbalanced assignments, increased nursing workload, frustration, and inaccurate representation of patient needs per shift on a stem cell transplant (SCT) inpatient unit. The goal of this project was to develop and implement an objective acuity tool to accurately define patient acuity based on specific needs and care required for SCT patients, appropriately balance nursing workload, and increase nurse satisfaction with patient acuity in their assignments. Observation and pre-survey feedback on the existing process and tool supported the need for a more defined grading approach. An objective acuity tool was designed to the needs of the SCT population. Educational materials were created for staff in-services and a bulletin board was displayed in the break room. Paper copies of the tool were completed by every nurse and collected each shift by the charge nurse. The total number for acuity was utilized by the charge nurse when creating assignments. Revisions were made based on staff feedback and a post survey was completed following initial roll out. 87% of staff perceived the objective acuity tool as accurately reflecting their patient care needs, compared to 26% with the subjective tool. 74% of staff felt there was an equal distribution and balanced nursing workload, compared to 26% with the subjective tool. 65% satisfaction with the patient acuity in assignments was also seen, an increase of 45%. The development and implementation of an objective patient needs-based acuity tool was successful on the SCT inpatient unit, with 97% of staff feeling the new acuity tool has been beneficial, and 94% rating they would like to continue using the tool. Literature supports the use of a tailored tool in specialized patient populations for it more accurately reflects necessary levels of care and leads to improved patient outcomes. Since the SCT population comes with its own specific set of needs that creates complexity in care, it is vital that they are accurately represented to provide the safest and highest quality nursing care.

P84

LET'S TAKE A BREAK! INTERVENTIONS TO DECREASE NURSING BURNOUT ON A MEDICAL ONCOLOGY STEP-DOWN UNIT AFTER THE HEIGHT OF THE COVID 19 PANDEMIC

Nicole Turkoglu, MSN, RN, OCN®, BMTCN®, New York Presbyterian, New York, NY; Christine Yany, BSN, RN,

CHPN, NYP/Columbia, New York, NY; Juliet Hernandez Henriquez, BSN, RN, NYP/Columbia, New York, NY; Anu Chempola, BSN, RN, NYP/Columbia, New York, NY; Archana Shenoy, DNP, RN, FNP-C, OCN®, New York Presbyterian, New York, NY

COVID-19

Oncology nurses are exposed to many stressors while caring for the complex needs of cancer patients, which leads to burnout. The nurses on an inpatient medical oncology unit at an NYC academic medical center expressed many feelings of burnout in the work environment post the height of the COVID 19 pandemic. Nurses often expressed the inability to take a break. The purpose of the project was to decrease oncology nurses' perception of burnout through providing a system for encouraging nurses to take a break. Charge nurses utilized the electronic medical record (EMR) messaging system each shift to assign breaks with a buddy system. Nurses emailed staff, mentioned at unit meetings, and were encouraged and supported by the nurse manager to take a break. Pre (n=51) and post (n=43) test survey evaluating nurses taking breaks and level of burnout. Nurses were assigned a number for confidentiality and to track the level of burnout (n=38). Burnout was measured with a 1 item question on a 5-point Likert scale validated previously in nurses to measure burnout. Nurses were also asked how often they skip breaks on a 5 point Likert scale with 5 being "strongly agree." The baseline level of perceived burnout was 3.2368 and post it increased to 3.6053 (Sig. = <.001). Nurses' agreement with having to skip breaks prior was 4.6053 and post intervention it decreased to 4.2895 (Sig. = <.001). Post intervention, nurses significantly decreased skipping breaks, but the level of perceived nursing burnout increased. This suggests that there are other factors involved in perceived burnout. The post test asked "what is the main reason contributing to your perceived burnout?" Nurses mentioned lack of adequate staffing (n=20), increase in patient acuity (n=9), and increase in workload (n=6). Continued socialization and acceptance of taking a break is important to maintain the nurses' well being on the oncology unit. Nursing burnout in the current environment post the COVID 19 pandemic is an uphill battle, due to staffing and the general consensus of nurses feeling exhausted and worn-out. Some further interventions being conducted are providing mentoring, shared governance council participation, and methods to increase staff morale. Further study on the reasons nurses do not take a break and feel burnt out is in development.

P85 **STEPS TOWARDS RESTRUCTURING** **ORIENTATION IN AN AMBULATORY CARE** **ONCOLOGY SETTING**

Allison Ward, RN, MSN, OCN®, CCRN-K, RN-BC, Fox Chase Cancer Center, Philadelphia, PA; Vanessa Carrion, MSN, Fox Chase Cancer Center, Philadelphia, PA; Sarah Porzig, MSN, RN, OCN®, Fox Chase Cancer Center, Philadelphia, PA

Oncology Nursing Practice

Orientation of nursing staff in an outpatient oncology setting is complex. The development of a comprehensive orientation program is crucial for staff to succeed in their new role. The goal is to identify strategies to restructure the current new hire orientation for nurses and assistants in an ambulatory clinic that is composed of 65 staff members and 75 health care providers. Based on verbal feedback, observations, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements, the current orientation model needs to be improved. Orientation paperwork is incomplete, novice staff have difficulty working independently, and professional duties as defined by the job description are not being performed. The initial intervention for this project was the development of a unit-based committee that includes nursing staff who hold master's degrees with a focus in nurse education. The committee meets bi-weekly with the main intent to improve orientation. Committee members have begun to identify gaps with the current orientation model and areas for improvement. Preceptors in the department were surveyed. Questions pertained to orientation paperwork, the new hire schedule, and the development of goals. Novice unit staff who completed orientation in the department within the past 6 months are also being surveyed. 6 unit preceptors, which included 3 nurses and 3 clinic assistants, were surveyed about the current orientation model. 67% of preceptors agreed that orientation paperwork is unclear and inconsistent; goal-setting is variable. There were mixed results pertaining to the new hire schedule. Survey data from new hires is in the process of being collected. The survey focuses on novice staff opinions about the current orientation model and knowledge gaps after they completed orientation. This is an ongoing unit-based project with the goal of restructuring the orientation program in an ambulatory clinic. Involvement of the unit-based committee in the orientation process promotes shared governance for this Magnet facility. Based off of data collection methods and evidence-based research, a new orientation model will

be developed. Current thoughts include orientation binders with new hire paperwork, developing a standardized orientation schedule, and holding an initial meeting with the new staff member, preceptor, and committee member followed by consistent meetings with the committee member or department manager every 2 weeks.

P86 **A PROPOSED STUDY OF THE EFFECTS** **OF EARLY END OF LIFE DISCUSSIONS ON** **QUALITY OF LIFE IN PATIENTS WITH** **TERMINAL LUNG CANCER**

Virginia Whetstone, MSN, RN, OCN®, Memorial Sloan Kettering Cancer Center, New York City, NY

Symptom Management and Palliative Care

Metastatic non-small-cell lung cancer (NSCLC) is the leading cause of death from cancer worldwide. It is a debilitating disease that results in a high symptom burden, leading to patients receiving aggressive care at the end of life. The estimated prognosis is less than 1 year after diagnosis. Studies show that early end-of-life discussions and palliative care can lead to significant improvements in quality of life, mood, and even pulmonary function. The purpose of the study was to examine the effect of introducing early palliative care with standard tumor management on patient-reported outcomes and quality of life among patients with metastatic non-small-cell lung cancer (NSCLC). In patients between the ages of 45 to 70 years old with terminal lung cancer, what is the effect of end-of-life discussions versus no discussions regarding quality of life upon diagnosis? A prospective, quasi-experimental, correlational design to examine the effects of early end-of-life discussions on quality of life in terminal lung cancer patients from a cancer hospital in New York, New York. Fifty metastatic NSCLC patients between ages 45 to 70 will be recruited for this study. Twenty-five of the patients will be assigned to the experimental group and the remaining 25 patients to the control group. Measures: Quality of Life Rating Scales: Measuring the Quality of Life of Seriously Ill Patients: QUAL-E 2005 Questionnaire with 26 questions and the Functional Assessment of Cancer Therapy-Lung (FACT-L) Scale Version 4 measuring five different parameters. Depression Rating Scale: Patient Health Questionnaires (PHQ-2 and PHQ-9). Pulmonary Function Tests: Peak Expiratory Flow (PEF) and Functional Residual Capacity (FRC). Descriptive statistics to determine frequency distributions and inferential statistics will be used to test the hypothesis. Our findings can guide practitioners to

understand the importance of having early end-of-life discussions and palliative care interventions to better care for these patients and improve their quality of life at the end of life.

P87 **PHYSICAL ACTIVITY AND CANCER** **REHABILITATION: SAFELY GETTING OUR** **ONCOLOGY PATIENTS UP AND MOVING**

Kimberly Willford, BSN, RN, OCN[®], ProMedica Cancer Institute, Sylvania, OH; Debra Reis, MSN, RN, CNP, ProMedica Cancer Institute, Hickman Cancer Center, Sylvania, OH

Patient Education and Safety

Research findings support significant benefits of physical activity for patients with a cancer diagnosis and those going through cancer treatment. Exercise is the only evidence-based intervention research supports to address cancer-related fatigue. Additionally, research has indicated that patients with cancer who are physically active experience decreased anxiety and depression, improved sleep, and maintained flexibility, mobility, and strength. Exercise also lowers the risk of the development, as well as recurrence, of multiple cancers. Patients are often concerned about engaging in activity during and immediately post-cancer treatment. On average, only 10% of patients diagnosed with cancer report that their health care practitioners discussed physical activity as part of their treatment plan. Our purpose for this project was to assess and safely increase the physical activity of our patients, evaluate and refer appropriate patients for cancer rehabilitation, and increase awareness and educate staff on the benefits of this initiative. The overall goal was to increase the frequency in which oncology nurses recommend individualized, evidence-based physical activity to cancer patients. A multidisciplinary team was established, including members of the cancer rehabilitation team (e.g., physical therapists), oncology nursing educator, advanced practice provider for complementary therapies, and a cancer survivor. Administration, medical and radiation oncology providers, nursing, and cancer rehabilitation services all supported this project. A literature review was conducted. The *ONS Physical Activity Recommendation Toolkit* was used as the basis for the project. An innovative approach was needed to facilitate and standardize workflow throughout our health-care system. Our team created an electronic medical record (EMR) flow sheet that incorporates a checklist to assess medical clearance, physical activity level, patient education, goals, and need and order process for

cancer rehabilitation referral. The Oncology Nursing Society pamphlet *Walking—A Step in the Right Direction* was incorporated into the flow sheet, and copies were available for patients. Mandatory education via an online module was developed and assigned to oncology RNs and Advanced Practice Providers. Follow-up discussions with oncology nurses in various roles revealed overall support for this initiative. Educational gaps were identified and corrected. The evaluation process is in place to determine if there is an increased frequency in which oncology nursing recommends individualized physical activity to patients and if referrals increase to cancer rehabilitation.

P88 **CANCER SCREENING IN THE LAO AMERICAN** **POPULATION: AN INTEGRATIVE REVIEW**

Melissa Wong, BSN, BS, RN, Washington State University, Spokane, WA, and Sharp Memorial Hospital, San Diego, CA

Screening, Early Detection, and Genetic Risk

Asian Americans immigrants are one of the fastest growing ethnic groups within the United States. Asian American immigrants also have a high incidence and mortality related to cancer along with the lowest cancer screening rates. This higher incidence of cancer is partially due to the lack of appropriate screening due to lack of health knowledge, English language proficiency, or access to appropriate healthcare services. In addition, Asian Americans contain many diverse cultural groups with different languages and traditions which is not often represented in cancer statistics. Community health nurses can help bridge this gap in cancer screening by developing culturally specific research and interventions, especially in minority populations such as the South East Asian immigrant population. The purpose of this integrative review to explore the current research in the Lao American population in regards to cancer prevention and screening. CINAL, Embase, MEDLINE, and PubMed databases were searched using the keywords *Lao American, cancer prevention, and cancer screening*. MeSH terms were used to search the current literature. A nursing research librarian and content expert nurse researcher were used for added rigor. The articles were then screened for relevance and content. Articles were not limited to a specific type of cancer due to the limited amount of research in the Lao American population. Of the studies identified, only six studies specifically focused on cancer prevention measures. Two studies focused on cancer incidence trends among the Asian American subpopulations. Breast and cervical can-

cer were the main types of cancer screening studies identified. Evaluation of the research also showed that there was a disconnect between communication between healthcare providers and this population in regards to screening recommendations. There is a limited amount of research focused on the Lao American community in terms of cancer screening and prevention. Nurses play an essential role among this population by recommending cancer screening measures during annual exams and health screenings. There is also a need for nurses to focus on cancer prevention by focusing human papilloma virus and hepatitis B vaccinations, as the vaccination rates in this population have historically been low. By developing interventions specific to this population, nurses will be able to improve cancer prevention and screening measures leading to better health outcomes.

P89 **RECOGNIZING RISK: IMPLEMENTING A** **SUCCESSFUL CHG BATHING PROTOCOL FOR** **HEMATOLOGY/ONCOLOGY PATIENTS**

Melissa Wright, BSN, RN, OCN®, Huntsman Cancer Hospital, Salt Lake City, UT; Mai See Xiong, MS, RN, Huntsman Cancer Institute, Salt Lake City, UT; Jamie Fendler, BSN, RN, CIC, Huntsman Cancer Hospital, Salt Lake City, UT; Jennifer Jones, BSN, RN, OCN®, Huntsman Cancer Hospital, Salt Lake City, UT; Megan Dolim, MS, RN, OCN®, Huntsman Cancer Hospital, Salt Lake City, UT

Patient Education and Safety

As an inpatient medical oncology unit, we recognize the increased risk of hospital acquired infections (HAIs) when caring for a large population of immunocompromised patients. This became an especially pressing concern to our 25 bed mixed hematology/oncology unit, when between August–September 2019, we had a cluster of three Central Line Associated Blood Stream Infections (CLABSIs) and two Catheter Associated Urinary Tract Infections (CAUTIs) in two months. In reviewing these cases in detail, we looked closely at identifying trends between patient infections, recognizing there were interventions we could offer as a nursing staff to decrease the risk of HAIs for our patients. A literature review provided overwhelmingly convincing data to support the use of daily CHG bathing on our patient population, which has been a CDC recommendation for the reduction of CLABSIs since 2011 but is likely underutilized across hospital systems nationwide. Acknowledging that daily bathing has previously been a challenge to complete consistently on 25 patients, we focused our efforts on

identifying our most at-risk patients for our initiation of a CHG protocol. In again reviewing the commonalities between the five patient cases, we identified that the most consistent shared risk factor was patient age. In January of 2020, our unit implemented a 3 month pilot of a CHG bathing protocol on all patients with a central line or Foley catheter, who were age 60 or above. In this pilot, which included a total of 528 patients, there was an 80% compliance rate on bathing and zero occurrences of HAI. The protocol was adopted as a unit standard and since implementation in January 2020, we have had a total of two CLABSIs and zero CAUTIs over 21 months. Our Fiscal Year 2021 CLABSI Standardized Infection Ratio (SIR), which is the comparison of the actual number of infections to the predicted number of infections, decreased to .218 from a FY2020 CLABSI SIR of .632. Our CAUTI SIR decreased to 0.00 from 2.324 in the same time frame. The key factors to our success included frequent and comprehensive education for patients and staff on the risk of HAI, focusing our efforts on the most at-risk population, reviewing staff feedback often to identify barriers and modify our strategies, and continued review of audits to maintain compliance.

P90 **MONOCLONAL ANTIBODY INFUSIONS FOR** **COVID + PATIENTS IN THE OUTPATIENT** **SETTING**

Michael Wuckovich, MSN, RN, NYU Langone Health, New York, NY; Christina Distefano, MPH, NYU Langone Health, New York, NY; Sarah Mendez, EdD, RN, AOCNS®, NYU Langone Health, Laura and Isaac Perlmutter Cancer Center, New York, NY; Kurt Pinto, MSN, RN, PMHNP-BC, NYU Langone Health, New York, NY; Katie Weathers, MA, RN, OCN®, NYU Langone Health, New York, NY; Fabienne Ulysse, DNP, AOCNP®, NYU Langone Health, New York, NY

COVID-19

November 9, 2020 the Food and Drug Administration (FDA) granted emergency use authorization (EUA) for the investigational monoclonal antibody bamlanivimab for outpatients with a Covid + test. Casirivimab and imdevimab given in combination was granted EUA on November 21, 2020. Monoclonal antibodies have a high risk for hypersensitivity reactions, require specific checks and administration considerations. Oncology nurses administer this category of medication and are well-equipped to manage patients receiving them. Due to the contagious nature of Covid-19, leaders and clinicians within the organization gathered to determine a plan for opening 3 des-

igned units outside of the oncology infusion units. The combination of bamlanivimab and etesevimab was granted EUA on Feb 9, 2021. Safely treat Covid + patients in an ambulatory setting without putting oncology patients at increased risk. A general overview of monoclonal antibodies, identifying patients as high risk for severe illness due to Covid-19, and considerations for each medication was developed into an educational module and placed on our electronic educational platform. A checklist was developed to assist in ensuring appropriate documentation occurred. Patient education handouts were developed and available in the patient portal, and were approved by the Patient Education Department, and uploaded to our electronic resource section. Education was available to all clinicians, with a focus on the oncology nurses rotating through the unit. In order to maintain patient and staff safety, nursing worked closely with patient services in determining best workflow for patient notification of treatment approval, scheduling appointment, and patient arrival. The patient population included pediatrics (>12y.o.) and adults, who met the criteria were successfully treated at our different campuses to date: 865 on Long Island, 578 in Brooklyn, and 701 in Manhattan. Every patient case had been evaluated by physician and nursing leadership to ensure they met the criteria for treatment. Nursing played a critical role in identifying any issues prior to patients arriving for treatment. The education provided and the workflow developed with patient services were key in ensuring patients were well cared for during this trying time. Collaboration amongst disciplines, especially when there is a single goal, ensures all aspects of patient care were addressed. The overall goal of keeping our oncology patients safe while providing this valuable care to Covid + patients was a success.

P91 **LOST IN TRANSLATION**

Michael Wuckovich, MSN, RN, NYU Langone Health, New York, NY; Phebe Chiang, BSN, OCN®, NYU Langone Health, New York, NY; Erin McCaffrey, MHM, MPH, BSN, RN, NE-BC, NYU Langone Health, New York, NY; Caressa Valdueza, MSN, AGNP-C, NYU Langone Health, New York, NY; Ginelle Lamella, BSN, OCN®, BMTCN®, NYU Langone Health, New York, NY; Jessica Mayer, MA, RN, CPHQ, NYU Langone Health, Laura and Isaac Perlmutter Cancer Center, New York, NY
[Coordination of Care](#)

With the expansion of an urban clinical cancer center, doubling square footage and infusion bays, along with the amalgamation of a robust practice, it was immedi-

ately evident that communication within the infusion center and to the office practice with patients deteriorated. Patients were experiencing delays in their care due to inconsistent communication between infusion and office practice areas. Nurses could not locate peers for dual verifications, reactions and other patient care needs. The question at hand was apparent; how can we stream line patient-related information to improve communication? Never established within an outpatient center within the health system, thinking outside the box, the decision made, was to incorporate the Clinical Mobile Companion (CMC) within the infusion center. This device integrates care into the hands of nurses and medical assistants, enabling them to access the patient's medical record, monitor vital signs, review lab results, send secure text messages, call another nurse and scan identification barcodes. The purpose of the project was to improve and stream line communication within a large cancer center infusion floor, ultimately to eliminate patient safety issues, decrease delays in care and improve nursing satisfaction. Interventions: (a) Established communication with our Information Technology (IT) department to understand the CMC feasibility within the outpatient setting. (b) Generated an online survey, distributed to nurses and medical assistants to understand pain points in communication and current trends. (c) Worked with our IT training department to develop a robust training for all staff. (d) Identified super users from all disciplines to champion the integration of the CMC. (e) Develop post survey on whether communication and patient care has improved. Evaluation is ongoing. Go-live set for early November 2021. While implementation of the CMC device is expected to augment communication and patient care within the outpatient infusion area, there are limitations to its functionality since this device design was established is for an inpatient setting. The hope, in the future, is to establish a more outpatient focus on the CMC and make it more oncology/infusion focused.

P92 **ENSURING PATIENTS' ACCESS TO QUALITY CARE DURING THE PANDEMIC: AN ENHANCED PRE-CHEMO THERAPY EDUCATION VIA TELEHEALTH BY ONCOLOGY NURSES IN THE INFUSION CENTER**

Chermaine Wulff, BSN, RN, OCN®, UW Medicine |
Valley Medical Center, Renton, WA
[Patient Education and Safety](#)

Pre-chemotherapy teach appointment prior to initial chemotherapy visit is recommended best practice for

patients with newly diagnosed cancer or patients about to receive a new medication in the Infusion Center. Traditional in-person teaching is usually set a few days to one week prior to initial treatment and given by a chemotherapy certified nurse in the Infusion Center. COVID-19 restrictions inhibited access to traditional in-person visits to reduce the risk of exposure to patients and families. The purpose of this project was to develop a way to continue to provide quality pre-chemotherapy education to newly diagnosed cancer patients without risk or exposure. When the pandemic started, we had to change our practice protect patients from unnecessary infectious exposure. Pre-chemotherapy teaching had to be provided on the first day of treatment to reduce the number of appointments in the Infusion Center. This resulted in increased patient anxiety, increased nursing and chair time, and overall decreased patient and staff satisfaction. When clinics started telehealth visits with their providers, we asked the question if the pre-chemo visit could also be offered via telehealth. (a) Added visit type in EPIC for scheduling and made it a billable service. (b) Trained and certified a core group of Oncology Certified Nurses (OCN) in Telehealth visits. (c) Ordered necessary equipment. (d) Trained Schedulers. (e) Established one day each week for Pre-chemo teach with assigned OCN nurse. (f) Ensured new billable service was value-added for patient and facility. (g) Rounded with new patients during first treatment to assess for efficacy of the service. Initially, four patients were scheduled for pre-chemo teach telehealth visits to assess scheduling, RN time, needs and effect on the patients. The results were very positive. Nurses verbalized satisfaction in preparing the patients for their first day of treatment. Patient also voiced reduced anxiety as they received answers to their questions during the telehealth visit. After three months, telehealth visits increased to 7-10 patients per week. With each increase in patient visits, more problems were identified and resolved which allowed for a more seamless process.

P93 **DEVELOPING AN ONCOLOGY SPECIFIC PATIENT ACUITY SCALE**

Cynthia Ydrogo, MSN, RN, OCN®, Karmanos Cancer Institute, Detroit, MI; Jesse Martinovich, BSN, RN, Karmanos Cancer Institute, Detroit, MI; Carly Williams, BSN, RN, Karmanos Cancer Center, Detroit, MI; Clara Beaver, MSN, RN, AOCNS®, ACNS-BC, Pittsburgh, PA
[Oncology Nursing Practice](#)

Matching oncology nurses' assignments with patient acuity has critical implications for providing safe, ef-

fective, and efficient care. Despite this, there is a lack of well-established methods for accurate assessment of oncology patient acuity. Valid and reliable patient acuity scales are needed to accurately assess acuity of oncology patients. The purpose of this pilot study was to evaluate the psychometric properties (reliability and validity) of the Karmanos Cancer Institute Patient Acuity Scale (KPAS). The Karmanos Cancer Institute (KCI) nurse practice committee charged a small group of nurses to develop a patient acuity scale. Representatives from each inpatient unit were invited to join the acuity scale task force with the goal of developing and proposing a standardized patient acuity scale that could be used across all KCI non-ICU inpatient-nursing units to facilitate making equitable nurse-patient assignment and staffing decisions. The KPAS was developed and organized to rate patients across three levels of acuity (1=stable, 2=complex, 3=high risk) and two domains (severity of illness and nurse workload). Two inpatient units were selected to trial the KPAS (1 bone marrow transplant unit and 1 post-operative surgical unit) for 60 days and would be required to complete the scale five times per day to coincide with daily staff scheduling. At the conclusion of the 60-day pilot, the acuity scale scores were assessed. The following information was also included on the data collection sheets: number of code blue events, number of rapid response events, and number of patient falls. Staff nurses on the two inpatient trial units completed an acuity scale survey. Survey results suggested minimal scale modification and led researchers to conclude that the scale was reliable and valid in capturing KCI acute care population. A standardized acuity scale provides a method to accurately assess all types of oncology patients. The KPAS provided a means for hospital leadership to adequately staff units based on patient acuity. The KPAS created a level playing field where different patient populations could be fairly compared for resource allocation.

P94 **BRIDGING KNOWLEDGE: TEXTBOOK TO CLINICAL SETTING**

Fatemeh Youssefi, PhD, RN, OCN®, UTSW, Dallas, TX;
Sandy Page, MSN, RN, OCN®, UTSW, Dallas, TX
[Oncology Nursing Practice](#)

The innovation and novel oncologic agents require oncology nurses to stay abreast and updated in order to deliver optimal patient care. Patients have access to electronic resources and support networks to find answers to side-effects and information on their

cancer journeys, and because oncology nurses are integral members of the treatment team, it is critical they can answer patients effectively and accurately. Oncology Nursing Society (ONS) and National Comprehensive Cancer Network (NCCN) are great resources, and oncology nurses need to translate learned knowledge to individual patient scenarios. In order to identify and tailor education sessions within large academic cancer centers, one infusion nurse recognized a gap in the ability to translate educational knowledge to clinical settings. A series of two-question surveys were developed and shared with nurses with different roles including infusion, clinic, research nurses and navigators with questions capturing chemotherapy/immunotherapy intuition and critical thinking. The structure of a “two-question” weekly survey included one demographic question as well as an option for response time. Version one of the survey included basic questions such as identifying categories of immunotherapy and identifying associated adverse effects. The survey started with its objective and an emphasis on voluntary participation. The purpose of the survey is to ascertain gaps and create a tailored inservice to educate and bridge those gaps. The second version of the survey in the following week included new questions and correct answers to previous questions. The initial survey revealed 54% of respondents accurately identified all classifications of immunotherapy, and 19% of respondents accurately selected all appropriate side-effects of immunotherapy. Only 11% of respondents answered both questions correctly. The low accuracy suggests after twelve weeks of gathering survey feedback, a customized inservice including small groups would be needed to discuss the content and application of knowledge in patient scenarios. Many reliable resources are available for oncology nurses to ascertain answers to the clinical settings; however, an assessment within an institution is the initial requirement to identify gaps followed by educational components. Cancer treatments are based on concepts of customized and unique oncology agents which require recognizing side-effects and exploring in-depth nursing assessment. In order to master the concept, nurses must be able to bridge their knowledge to the clinical setting.

P95
A CAREGIVER SUPPORT PROGRAM FOR CAREGIVERS OF PATIENTS AFTER SURGICAL TREATMENT OF EARLY-STAGE NON-SMALL CELL LUNG CANCER: A STUDY

PROTOCOL OF A RANDOMIZED CONTROLLED TRIAL

Song Zhu, Master, the Second Xiangya Hospital, Central South University, Changsha; Jina Li, Master, the Second Xiangya Hospital, Central South University, Changsha; Lu Kang, Bachelor, the Second Xiangya Hospital, Central South University, Changsha
Oncology Nursing Practice

The prevalence of early-stage (stage I or II) non-small cell lung cancer (NSCLC) has continuously increased as a result of widespread screening programs. Surgical resection remains the standard treatment for early-stage NSCLC. However, patients receiving surgical treatment and their caregivers frequently experience a considerable burden both physically and emotionally. Family caregivers are usually not well-prepared to assume their new roles, which can negatively impact their health and quality of life and patient outcomes. This study will evaluate the effectiveness of a caregiver support program for reducing their caregiving burden, anxiety and depression, and improving quality of life. This study will be guided by the Stress and Coping Model. Family caregivers of patients diagnosed with early-stage NSCLC and scheduled for lung resection treatment will be invited to participate in this trial. Participants will be randomized to either receive the caregiver support program or usual care (control). The intervention consists of two nurse-led tailored face-to-face intervention sessions (one pre-surgery and one post-surgery) and one telephone follow-up session at one week after discharge. The intervention is designed to provide cancer-related information and pulmonary rehabilitation skills, address caregivers' concerns, and provide positive coping strategies for managing emotional problems. Therapeutic communication techniques will be used in the intervention program, including the use of open-ended questions, acknowledge and acceptance, active listening, reflecting, and summarizing. Primary and secondary outcomes will be assessed at baseline, 1 month and 3 months after the intervention. The primary outcome will include caregiver burden, while secondary outcomes will include quality of life, coping style, social support, anxiety, and depression. GEE model will be used to analyze the intervention effects. The early caregiver support program will help caregivers build the capacity to assume new roles and cope with negative experiences. It may have long-term potential to reduce caregiver burden, improve quality of life, and reduce anxiety and depression symptoms. If proven effective, the support program will be adopted and implemented as a family-centered care strategy in lung cancer clinical practice.

INDUSTRY-SUPPORTED

P96

OPTUNE LUA™ (NOVOTTF-100L™) FOR MALIGNANT PLEURAL MESOTHELIOMA: CONSIDERATIONS FOR ONCOLOGY NURSES WORKING WITH DEVICES APPROVED VIA THE HUMANITARIAN DEVICE EXEMPTION PATHWAY

Andrea Armstead, PhD, Novocure, New York, NY; Kelly Stone, BS, MT (ASCP), Novocure, New York, NY; Joe Davis, BS, Novocure, Inc, New York, NY; Lindsay Rain, BS, Novocure, Inc, New York, NY; Melissa Shackelford, RN, MSN, MPPM, Novocure, Inc, New York, NY

Oncology Nursing Practice

Malignant pleural mesothelioma (MPM) is a rare lung cancer linked to asbestos exposure. MPM typically occurs 2-4 decades after exposure to asbestos and most patients present with advanced disease not amenable to surgical resection. Recently, Optune Lua received approval from the FDA via the Humanitarian Device Exemption (HDE) pathway for first-line treatment of patients with unresectable MPM in combination with pemetrexed and a platinum agent based on the results of the Phase II STELLAR trial. Optune Lua delivers Tumor Treating Fields (TTFields), electric fields with antimitotic effects on cancer cells, via arrays placed on the skin at the tumor site. The goal of this abstract is to raise awareness amongst oncology nurses regarding the HDE pathway and how this impacts access to therapeutic advancements, such as TTFields therapy, for patients with rare malignancies. The purpose of the HDE pathway is to encourage the discovery and use of devices intended to benefit patients with rare diseases affecting < 8000 people/year in the US, such as MPM, with an accelerated review. This process is unique in that the approval standard is not demonstrated efficacy and safety, but rather that the probable benefit to the patient outweighs the potential risk of harm. With this type of approval comes additional regulatory oversight that must be considered before patients initiate therapy. In order to fill a prescription for an HDE-approved device such as the Optune Lua, a valid institutional review board (IRB) or local committee (LC) approval must be received by the manufacturer from the prescribing physician's institution. Oncology nurses may have experience with TTFields as Optune®, following FDA approval in 2011 for recurrent Glioblastoma (GBM) and in 2015 for newly diagnosed GBM. TTFields therapy for MPM is unique in that additional regulatory oversight must be in place

before treatment is initiated in the clinic. As the use of TTFields expands to other therapeutic areas, it is important for oncology teams to build awareness around this new treatment modality including special considerations, when appropriate for new indications. Oncology nurses drive transformative patient care, so it is critical that they stay informed on emerging therapies such as TTFields and understand key regulatory pathways that impact patient access.

P97

THE PHASE 2 CAPTIVATE STUDY: PRIMARY ANALYSIS OF A FIXED-DURATION COHORT FOLLOWING FIRST-LINE TREATMENT WITH IBRUTINIB PLUS VENETOCLAX FOR CHRONIC LYMPHOCYTIC LEUKEMIA/SMALL LYMPHOCYTIC LYMPHOMA

Maria Dela Rosa, NP, City of Hope National Medical Center, Duarte, CA; Blanche Anderson, RN, Department of Leukemia, University of Texas MD Anderson Cancer Center, Houston, TX; Joi Ninomoto, PharmD, Pharmacyclics LLC, an AbbVie Company, Sunnyvale, CA; Gabe Krigsfeld, PhD, Pharmacyclics LLC, an AbbVie Company, Sunnyvale, CA; William Wierda, MD, PhD, Department of Leukemia, University of Texas MD Anderson Cancer Center, Houston, TX; Tanya Siddiqi, MD, City of Hope National Medical Center, Duarte, CA

Oncology Nursing Practice

CAPTIVATE (PCYC-1142; NCT02910583) is a multi-center, phase 2 study of first-line ibrutinib+venetoclax (I+V) for chronic lymphocytic leukemia (CLL). The purpose of this project is to present results from a fixed-duration cohort of I+V-treated patients and share nursing experience-based insights on adverse event (AE) management with these agents and patient education regarding this novel fixed-duration regimen. Eligible patients were ≤ 70 y with previously untreated CLL/small lymphocytic leukemia. Patients received 3 cycles of single-agent ibrutinib followed by 12 cycles of I+V (ibrutinib, 420mg/d orally; venetoclax, ramp-up to 400mg/d orally). Rate of complete response including CR with incomplete recovery (CR/CRi) in patients without del(17p) mutation was the primary endpoint, with supporting analyses in the all-treated population. Secondary endpoints included undetectable minimal residual disease (uMRD) rate, PFS, tumor lysis syndrome (TLS) risk reduction, and safety. 159 patients were enrolled (median age, 60y). High-risk features included unmutated IGHV (56%), complex karyotype (19%), del(11q) (18%), and del(17p)/TP53 mutation (17%). 92% of patients completed all planned treatment. Median time on study

was 27.9 months (range, 0.8–33.2). Of 136 patients without del(17p) treated with fixed-duration I+V, 76 (56%) achieved CR; of these, 66 (87%) had CR lasting ≥ 12 cycles. Among all patients, ORR was 96%; CR/CRi was 55%. 77% and 60% of patients achieved best uMRD response in peripheral blood and bone marrow, respectively. 24-month OS and PFS were 98% and 95%, respectively. CR rates were similar in patients with del(17p)/TP53 mutation. Among patients with high TLS risk (n=34) at baseline, 94% (n=32) downgraded to medium-to-low TLS risk categories after ibrutinib lead-in; no TLS occurred. AEs were primarily grade 1/2. Most common grade 3/4 AEs included neutropenia (33%), hypertension (6%), and neutrophil count decreased (5%). AEs led to discontinuation of ibrutinib in 4% and venetoclax in 2%. Nurses can provide education and support to patients regarding AE management and TLS prevention, thereby reassuring them of ibrutinib's safety, which may increase treatment adherence. TLS prevention through education may reduce emotional/psychological burden of inpatient hospital stays. In CLL, first-line I+V—an all-oral, once-daily chemotherapy-free, fixed-duration regimen—provided durable responses, including in patients with high-risk genomic features. Efficacy appeared favorable; safety was consistent with known AEs for each agent. Nurses are essential to providing treatment-related support and helping patients identify and manage AEs, thereby maximizing clinical benefit.

P98 ONSET, DURATION, AND MANAGEMENT OF EDEMA AND EFFUSION IN PATIENTS TREATED WITH LONCASTUXIMAB TESIRINE FOR R/R DLBCL: UPDATED RESULTS FROM THE LOTIS-2 CLINICAL TRIAL

Claudia Grandas, RN, BSN, CCRP, Sylvester Comprehensive Cancer Center, Miami, FL; Lindsey Hendrickson, NP, Division of Hematology and Medical Oncology, Department of Medicine, Medical University of South Carolina, Charleston, SC; Juan Pablo Alderuccio, MD, Sylvester Comprehensive Cancer Center, University of Miami, Miami, FL; Brian Hess, MD, Division of Hematology and Medical Oncology, Department of Medicine, Medical University of South Carolina, Charleston, SC; David Ungar, MD, ADC Therapeutics America, Murray Hill, NJ; Melhem Solh, MD, Blood and Marrow Transplant Program, Northside Hospital, Atlanta, GA

Treatment Modalities

Loncastuximab tesirine (loncastuximab tesirine-lpyl; Lonca), an FDA-approved antibody drug conjugate

(ADC) comprising a CD19-targeted antibody conjugated to a pyrrolbenzodiazepine (PBD) dimer cytotoxin, is indicated in relapsed/refractory diffuse large B-cell lymphoma after ≥ 2 prior systemic therapies. Several adverse events (AEs), including edema and effusion, are likely related to the PBD cytotoxin. The objective of this project was to characterize the onset and management of edema and effusion in the pivotal LOTIS-2 trial (NCT03589469). Lonca was administered intravenously every 3 weeks (0.15 mg/kg for 2 cycles; 0.075 mg/kg for subsequent cycles). Dexamethasone premedication was administered to reduce the incidence and severity of PBD toxicities. Lonca was held for patients with Grade ≥ 2 edema/effusion (as defined by the Common Terminology Criteria for Adverse Events version 4.0) and spironolactone was recommended for initial management of edema or effusion. In this analysis (data cutoff: March 1, 2021), missing AE end dates were imputed using the date of new anticancer therapy, end of study, or data cutoff. In LOTIS-2 (N=145), edema occurred in 27.6% of patients; median time to onset was 40.0 days (min, max: 1, 277); and median duration was 50.5 days (2, 676). Grade ≥ 3 edema occurred in 3.4% of patients; median time to onset was 106.0 days (9, 183); and median duration was 5.0 days (3, 112). Effusion occurred in 11.7% of patients; median time to onset was 52.0 days (3, 234); and median duration was 20.0 days (4, 581). Grade ≥ 3 effusion occurred in 2.8% of patients; median time to onset was 118.0 days (17, 277); and median duration was 20.5 days (6, 411). In the total trial population, dose delays, reductions, and withdrawal occurred due to edema in 4.8%, 0.7%, and 2.8% of patients, respectively, and due to effusion in 1.4%, 0%, and 2.8% of patients, respectively. The median time to onset of any grade edema and effusion was approximately 2 and 3 treatment cycles, respectively. Incidence of Grade ≥ 3 edema and effusion was low and typically occurred later in therapy, with a median time to onset of approximately 6 treatment cycles. Edema and effusion were generally manageable with dose delays and modifications, which are recommended for Grade ≥ 2 events.

P99 THE ROLE OF THE ALLIED HEALTH PROFESSIONAL IN PHARMACEUTICAL ADVISORY BOARDS: IDENTIFYING EDUCATIONAL NEEDS TO IMPROVE CARE DELIVERY

Margaret Karas, MSN, RN, OCN®, CMSRN, AVEO Oncology, Boston, MA; Lisa Berge, PhD, DNP, FNP, Clear-

Choice MD, New London, NH; Kimberly D. Allman, MSN, CNP, AOCNP®, AVEO Oncology, Boston, OH
[Oncology Nursing Practice](#)

Nurses and advanced practice providers, or allied health professionals (AHPs), play a critical role in the triage, assessment and management of treatment related adverse events (TRAEs). Inadequate identification or suboptimal management of TRAEs can lead to poor quality of life (QoL) and early therapy dose reduction or discontinuation, which have a negative impact on efficacy outcomes. Preemptive and comprehensive education of AHPs can lead to greater confidence in their ability to provide high-quality patient education, early recognition of TRAEs and implementation of evidence-based interventions for symptom mitigation. In March 2021, an AHP advisory board was conducted following FDA approval of the drug FOTIVDA® (Tivozanib) for relapsed/refractory advanced renal cell carcinoma following two or more prior systemic therapies. This vascular endothelial growth factor receptor (VEGFR) tyrosine kinase inhibitor (TKI) presents a somewhat unique ‘on target’ side effect profile, given its high level of specificity for VEGFR 1,2,3. Participants overwhelmingly expressed a lack of resources for new clinical trial data and drug approvals, as well as a desire and need for a dedicated educational resource for AHPs. An Allied Health Initiative proposal was developed and submitted by nursing members of the AVEO Oncology medical affairs team with an overarching goal of improving patient outcomes through the creation and dissemination of a comprehensive AHP educational resource. This resource deck serves to enhance AHPs understanding of FOTIVDA® mechanism of action, data from the pivotal phase 3 TIVO-3 trial, dosing and administration and expansive information on TRAEs and management strategies. This resource can be reviewed with the AVEO Oncology medical affairs team as of mid-June 2021. To date, the AHP educational deck has been delivered to multiple AHPs and nursing staff. Limitations to dissemination include nursing shortages and reduced access to AHPs secondary to COVID-19 restrictions/obligations. Feedback regarding the resource has been positive with participants reporting utility in the sections dedicated to toxicity onset and duration, as well as AE-associated dose modifications/discontinuations. AHPs play a pivotal role in the success of patient care and outcomes. Developing and disseminating an AHP-specific educational deck, AHPs expressed increased confidence in their care of patients receiving FOTIVDA®.

P100 **PATIENT-REPORTED OUTCOMES IN THE GARNET TRIAL IN PATIENTS WITH ADVANCED OR RECURRENT MISMATCH REPAIR DEFICIENT SOLID TUMORS TREATED WITH DOSTARLIMAB**

Rebecca Kristeleit, MD, Guy’s and St. Thomas’ Hospital NHS Foundation Trust, London; Cara Mathews, MD, Women and Infants Hospital of Rhode Island, Providence, RI; Andrés Redondo, MD, Hospital Universitario La Paz, IdiPAZ, Madrid; Kathryn Pennington, MD, Gynecology Oncology at UW Medical Center Montlake, Seattle, WA; Susan Boklage, MS, MPH, GlaxoSmithKline, Philadelphia, PA; Jubilee Brown, MD, Levine Cancer Institute, Atrium Health, Charlotte, NC

[Psychosocial Dimensions of Care](#)

Regulators increasingly use patient-reported outcomes (PROs) to inform the risks and benefits of new drug therapies. Dostarlimab is a programmed death receptor 1 (PD-1)-blocking antibody that is approved in the US as a monotherapy in adult patients with mismatch repair deficient (dMMR) recurrent or advanced endometrial cancer (EC) that has progressed on or following prior treatment with a platinum-containing regimen or with dMMR recurrent or advanced solid tumors that have progressed on or following prior treatment and who have no satisfactory alternative treatment options. Here, PROs from the GARNET trial in patients with dMMR solid tumors treated with dostarlimab are reported. GARNET is a phase 1, multicenter, open-label, single-arm study conducted in 2 parts: dose escalation and expansion. Expansion cohort A1 enrolled patients with EC, and cohort F enrolled patients with non-EC solid tumors. Patients received dostarlimab 500 mg IV Q3W for 4 cycles, then 1000 mg Q6W until disease progression or discontinuation. PRO assessment, an exploratory endpoint, was measured using the EORTC-QLQ-C30. PROs were collected at baseline, each dose cycle, and after discontinuation. Multi-item and item-level analyses were collected to understand response distribution and change from baseline. PRO data were available for 94/126 patients in cohort A1 and 138/144 patients in cohort F who received ≥1 dose of dostarlimab. Questionnaire completion rates were consistent across domains in both cohorts. Improvements from baseline for pain and fatigue were observed for both cohorts A1 and F starting at cycles 2 and 3, respectively. Improvements in physical functioning were maintained above baseline from cycle 4 for cohort A1 and from cycle 3 for cohort F. Symptomatic AEs were experienced by a minority of patients; <25% of patients in cohort A1 and <26% of patients in

cohort F experienced 1 category or greater worsening. Improved scores were reported in 5%–33% of patients in cohort A1 and 9%–39% of patients in cohort F. PROs from the GARNET trial show dostarlimab was generally well tolerated and that disease-related symptoms were improved or maintained while on treatment. PRO results were consistent between patients with dMMR EC and those with dMMR non-EC tumors. These data, with previously reported efficacy and safety profile of dostarlimab, support the use of dostarlimab in patients with dMMR solid tumors.

P101 A POST-MARKET ANALYSIS OF SAFETY DATA IN PEDIATRIC PATIENTS TREATED WITH TTFIELDS (2015-2021)

Francisco Mercado, MS, PhD, Novocure, Portsmouth, NH; Sara Gause, PA, Novocure, Portsmouth, NH; Julia Stindl, PhD, Novocure, Portsmouth, NH; Carly Mooney, ND, Novocure, Portsmouth, NH

Oncology Nursing Practice

Cancers of the central nervous system are the most common solid tumors in childhood. As with adults, Glioblastoma (GBM) remains an equally devastating disease in children, with substantial morbidity and mortality. The reported median survival in pediatric GBM ranges from 13 to 73 months with a 5-year survival of less than 20%. Tumor treating fields (TTFIELDS) are a loco-regional, intermediate frequency (200 kHz), low intensity (1-4 V/cm), non-invasive antimitotic therapy delivered via transducer arrays placed on the patient's skin and connected to the portable device. TTFIELDS demonstrated safety and efficacy in Phase 3 studies of adult patients with GBM, which led to FDA approval for recurrent use as monotherapy and in newly diagnosed GBM with adjuvant temozolomide. NCCN Guidelines also support the use of TTFIELDS with Category 1 recommendations for newly diagnosed GBM and category 2b for recurrent GBM. A post-market analysis examined the safety data in pediatric patients treated off-label with TTFIELDS (Optune®, Novocure) from January 2015 – August 2021. 81 pediatric (<18 years) patients received TTFIELDS therapy during this period. Of those, 54 were male and 27 female, median age of 13 years (range 3-17 years). The most common diagnosis was newly diagnosed GBM (49%) followed by recurrent GBM (33%). 63% of patients reported at least one adverse event (AE), 170 AEs in total, during the observation period. There were 28 serious AEs reported by 14% of patients, the most common being seizures (5%). No serious AEs were considered related to device use. Of the 170 AEs, 99 were considered potentially

related to TTFIELDS including heat sensation (12%), electric sensation (10%), and headache (12%). As has been observed in the adult population, the most common AE related to TTFIELDS use reported in pediatric patients was medical device site reactions of the skin reported by 36% of patients. Oncology nurses play an important role in the early detection, prevention, and effective management of AEs, which are critical to optimizing patient adherence to therapy. The post marketing surveillance data shown here support the safety and tolerability of TTFIELDS in pediatric patients, while published recommendations for the care of TTFIELDS dermatologic AEs may assist nurses in minimizing AEs in these patients receiving TTFIELDS.

P102 RECOMMENDATIONS FOR MANAGEMENT OF PI3K ALPHA INHIBITOR-INDUCED HYPERGLYCEMIA BASED ON ALPELISIB TREATMENT EXPERIENCES FROM TWO ACADEMIC INSTITUTIONS

Janie Metsker, RN, BSN, CN-BN, ONN-CG, Saint Luke's Hospital Koontz Center for Advanced Breast Cancer, Kansas City, MO; Odessa Williams, RN, AGPCNP-BC, Memorial Sloan Kettering Cancer Center, New York, NY; Timothy Pluard, MD, Saint Luke's Hospital Koontz Center for Advanced Breast Cancer, Kansas City, MO; Neil Iyengar, MD, Memorial Sloan Kettering Cancer Center, New York, NY

Oncology Nursing Practice

Alpelisib plus fulvestrant is approved for the treatment of *PIK3CA*-mutated hormone receptor-positive (HR+), human epidermal growth factor receptor 2-negative (HER2-) advanced breast cancer (ABC). Hyperglycemia, an on-target effect of PI3K alpha inhibitors such as alpelisib, was the most frequently observed adverse event (AE; 63.7%) in the SOLAR-1 trial. A protocol amendment updating the study eligibility criteria (excluding patients with glycosylated hemoglobin [Hb1Ac] $\geq 6.5\%$) and AE management guidelines led to reduced treatment discontinuations due to any-grade hyperglycemia (9% vs 3.6%, before and after amendment, respectively). Therefore, strategies that optimize management can play a role in keeping patients on therapy and may have an impact on outcomes. The purpose of this project was to provide recommendations for managing PI3K inhibitor-associated hyperglycemia to reduce incidence/severity—particularly for patients at risk of experiencing high-grade events. Authors reviewed AE management strategies implemented in the SOLAR-1 and BYLieve trials of alpelisib-based treatments in ABC.

Recommendations are also based on experience from healthcare providers (HCPs) from 2 institutions specialized in the treatment of cancer. Preparation and early intervention are essential. Educate patients and optimize lifestyle (eg, diet) prior to starting alpelisib to prevent/mitigate hyperglycemia. Initiate lifestyle optimization before administering alpelisib (possibly while patient with a *PIK3CA*-mutated tumor is still receiving another agent). Consider adding a nutritionist to the care team. Perform a thorough baseline assessment of patients' personal medical history, diet/exercise habits, and risk factors for developing hyperglycemia. For patients with prediabetes/diabetes (fasting plasma glucose ≥ 100 mg/dL; HbA1c $\geq 5.7\%$), consultation with an endocrinologist/diabetologist is advised; do not assume these patients have received prior education per their condition—refer to an educator (nurse practitioner). For patients with BMI ≥ 30 , subclinical insulin resistance may be present; advise weight loss. For patients aged ≥ 75 years, closely monitor as patients may not notice hyperglycemia-associated symptoms. Consider at-home glucose monitoring. Continuous glucose monitoring devices are preferable over traditional prick glucometers based on ease of use and ability to share results remotely with HCPs. Identifying patients at risk of developing alpelisib-associated hyperglycemia and proactively tailoring management to the individual will likely result in increased patient compliance and better outcomes of this AE. These recommendations for nurses may help optimize hyperglycemia management in patients treated with alpelisib, a relatively new agent.

P103 CHARACTERIZATION AND MANAGEMENT OF CUTANEOUS REACTIONS IN PATIENTS WITH RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA TREATED WITH LONCASTUXIMAB TESIRINE IN THE LOTIS-2 TRIAL

Julie Pruett, APNP, Medical College of Wisconsin, Milwaukee, WI; Katie Zellner, MS, PA-C, Medical College of Wisconsin, Milwaukee, WI; Brad Kahl, MD, Department of Medicine, Oncology Division, Washington University, St. Louis, MO; David Ungar, MD, ADC Therapeutics America, Murray Hill, NJ; Luqiang Wang, PhD, ADC Therapeutics America, Murray Hill, NJ; Mehdi Hamadani, MD, Medical College of Wisconsin, Milwaukee, WI

Treatment Modalities

Loncastuximab tesirine (loncastuximab tesirine-ly-pl; Lonca), an FDA-approved antibody drug conjugate

comprising a CD19-targeted antibody conjugated to a pyrrolbenzodiazepine (PBD) dimer cytotoxin, is indicated in relapsed or refractory diffuse large B-cell lymphoma after ≥ 2 prior systemic therapies. Several adverse events (AEs), including cutaneous reactions, are likely related to the PBD cytotoxin. Knowledge of potential adverse cutaneous reactions that may impact a patient's quality of life is necessary for healthcare professionals to effectively counsel and manage patients on treatment. The objective of this project was to describe the onset and management of cutaneous reactions, including photosensitivity and non-photosensitivity reactions, in the pivotal LOTIS-2 trial (NCT03589469). The methodology for LOTIS-2 has been published (Caimi, et al 2021). For this analysis (data cutoff: 01 March 2021), the number (%) of photosensitivity and non-photosensitivity cutaneous reactions, time to treatment-emergent AEs (TEAEs), action taken, and duration of cutaneous reactions were included. Non-photosensitivity reactions include rash and pruritus. To determine duration of cutaneous reactions, missing AE end dates were imputed using the date of new anticancer therapy, end of study or data cutoff date. Of the 145 patients who received Lonca in LOTIS-2, 15 (10.3%) had photosensitivity reactions (3 [2.1%] patients experienced Grade ≥ 3) and 44 (30.3%) had non-photosensitivity reactions (3 [2.1%] patients experienced Grade ≥ 3). The median (min, max) time to onset was 37.0 (13, 150) days for any-grade and 32.0 (13, 35) days for Grade ≥ 3 photosensitivity reactions; and 30.5 (1, 104) days for any-grade and 56.0 (8, 89) days for Grade ≥ 3 non-photosensitivity reactions. Dose modifications to manage Grade ≥ 3 cutaneous reactions (dose delays, modifications, or withdrawals) occurred in $<5\%$ of patients. The median (min, max) duration of any-grade photosensitivity reactions was 119.0 (35, 357) days and 38 (12, 88) days for Grade ≥ 3 events. The median (min, max) duration of any-grade non-photosensitivity reactions was 85.5 (1, 689) days and 7.0 (2, 10) days for Grade ≥ 3 events. In LOTIS-2, the incidence of Grade ≥ 3 cutaneous reactions was low, typically occurred within 60 days of starting treatment, and were managed by dose delay. Patients should be advised to minimize and protect skin from sun exposure.

P104 PRACTICAL CONSIDERATIONS WITH CRIZANLIZUMAB USE

Charlene Sylvestre, MSW, RN, MSN, NP-C, Sickle Cell Center for Excellence, Boston, MA

Oncology Nursing Practice

Sickle cell disease (SCD) is a common genetic inherited blood disorder, characterized by sickle shaped

red blood cells. Vaso-occlusive crises (VOCs), the hallmark of SCD, can cause sudden and unpredictable pain along with other complications. The cell adhesion molecule P-selectin plays a key role in the multicellular interactions that can lead to VOCs. Crizanlizumab, a monoclonal antibody that binds to P-selectin, is indicated to reduce the frequency of VOCs in patients ≥ 16 years or older with SCD. Many infusion centers may not be familiar with the SCD population and should consider implementing these best practices to ensure successful crizanlizumab infusion visits. Prior to infusion the patient should be comfortable, hydrated, and warm to prevent potential VOC triggers. Provide a blanket and ensure the patient is not in a prolonged sitting position. Assess for venous access in patients without a port, using a warm compress or ultrasound if needed. Ensure intravenous access prior to releasing the medication order from the pharmacy. Evaluate for any pain (current or prior 48 hours), weight changes, recent VOCs or illnesses, and pregnancy status. Review the patient's medical record for a specific SCD care plan. Finally, use an open-ended question to confirm what medication(s) the patient is currently receiving. Administer crizanlizumab intravenously over 30 minutes (or as per your institutional protocols or guidelines) with a sterile, nonpyrogenic 0.2-micron inline filter. It's important to note that infusion-related reactions (IRRs) can occur during or within 24 hours of administration. Most IRRs have occurred during the 1st and/or 2nd infusions. Monitor for and advise patients of signs and symptoms of IRRs, which may include pain in various locations, headache, fever, chills, nausea, vomiting, diarrhea, fatigue, dizziness, pruritus, urticaria, sweating, and shortness of breath or wheezing. After administration of crizanlizumab, flush the line with at least 25 mL of 0.9% sodium chloride or 5% dextrose injection. It is important to counsel patients on the most common adverse events (incidence $\geq 10\%$) which are nausea, arthralgia, back and abdominal pain and pyrexia. Verbalize key follow-up points such as scheduling their next appointment and who to call if they experience AEs or IRRs. These best practices for nurses can help manage AEs and IRRs and limit patient discomfort.

P105
EQUIPPING ONCOLOGY NURSES TO
NAVIGATE NOVEL TERRAIN IN
NEUROFIBROMATOSIS TYPE 1:
THE IMPACT OF A LIVE, VIRTUAL
EDUCATIONAL SYMPOSIUM ON NURSE

CONFIDENCE, KNOWLEDGE, AND
PERFORMANCE

Bryan Taylor, PharmD, Creative Educational Concepts, LLC, Lexington, KY; Susan Gitzinger, PharmD, MPA, Creative Educational Concepts, LLC, Lexington, KY; Vanessa Carranza, PharmD, Creative Educational Concepts, LLC, Lexington, KY; Joni Fowler, PharmD, BCPP, Creative Educational Concepts, LLC, Lexington, KY; Jessica Hall, Creative Educational Concepts, LLC, Lexington, KY; Shannon Langmead, RN, MSN, CRNP, Johns Hopkins, Baltimore, MD

Oncology Nursing Practice

Neurofibromatosis type 1 (NF1) has historically been a disease with a paucity of treatment options, limited primarily to a trimodal combination of surgery, radiation, and surveillance. Unfortunately, surgery is often morbid and complete resection is rarely achievable, while radiation has been found to increase the risk for malignant transformation. As such, the recent emergence of novel targeted medical therapies, including the very first FDA approval of a MEK inhibitor for NF1 in April 2020, has been paradigm-shifting. Given the rapidity of the data revolution taking place in NF1, educational initiatives are exigently needed to help clinicians stay abreast of the latest data and clinical utility of targeted medical therapies. Oncology nurses, as the preeminent patient educators and providers of social support on the interprofessional NF1 treatment team, must maintain a current knowledge base to effectively counsel patients, mitigate toxicity, and confidently manage patients receiving targeted medical therapies. This educational initiative was strategically designed to equip nurses across the totality of the NF1 treatment continuum, from diagnosis through longitudinal patient assessment. Activity learning objectives focused on clinical presentation, pathophysiology, the evolving clinical trial evidentiary base for targeted medical therapies, toxicity management, and appropriate patient/family education and support. Knowledge and confidence were objectively assessed by analyzing pre- and post-test results before and after the ONS symposium. Statistical testing between pre- and post-participation was conducted via chi square analysis with a priori significance set at 0.05. Performance metrics were assessed using a follow-up survey six weeks post-activity. 100% of participants stated they would make a change in practice as a result of attending. Top change: "Educate patients, caregivers, and colleagues." There was a 63% increase in participants who felt either "Very confident" or "Confident" managing NF1 patients receiving targeted therapies. Statistically significant advancements in knowledge

($P < 0.05$) were achieved for questions related to plexiform neurofibromas and recognition of MEK inhibitor toxicities. Participant performance at follow-up exceeded pre-test for questions related to NF1 diagnostic criteria, plexiform neurofibromas, and MEK inhibitor toxicities. Our educational outcomes analysis illustrates demonstrable impact on oncology nurse confidence, knowledge, and performance in NF1. We also identified residual gaps, which will be strategically targeted with future initiatives: recognition of newly-published diagnostic criteria and real-world, case-based management of MEK inhibitor toxicities.

P106 IMPACT OF COVID-19 ON TTFIELDS THERAPY MANAGEMENT: MAINTAINING OPTIMAL PATIENT TREATMENT BY SHIFTING TO VIRTUAL MANAGEMENT AND SUPPORT OF PATIENTS WITH GLIOBLASTOMA (GBM)

Anne Thomas, BS, RN, OCN[®], Novocure, Inc, New York, NY; Gage Gwyn, PhD, APRN-BC, OCN[®], Novocure, Portsmouth, NH; Peggy Frongillo, RN, BSN, Novocure, Inc, New York, NY; Connie Wagenknecht, MSN, ANP-BC, AOCNP[®], Novocure, Portsmouth, NH

Patient Education and Safety

A treatment option for newly-diagnosed GBM may include a multi-disciplinary approach involving maximal safe surgical resection, followed by concomitant temozolomide with radiotherapy, and maintenance temozolomide with Tumor Treating Fields (TTFields; Optune[®]; Novocure[®], device manufacturer). TTFields is a portable, noninvasive, antimitotic cancer therapy that locoregionally delivers intermediate-frequency (200 kHz), alternating electric fields through arrays to target GBM tumor. Immunosuppressed cancer patients face higher risks from Covid-19 infection than the general population, necessitating rapid adjustments to access and care delivery to prioritize patient health and safety. Oncology nurses are positioned to educate and include patients/caregivers in shared decision making regarding self-protection strategies (ie, to limit exposure to viruses/COVID-19). The purpose of this real-world study is to evaluate whether virtual TTFields management is comparable to live support for GBM patients. Treatment strategies to overcome restrictions and limitations to TTFields access and care during COVID-19 were implemented by Novocure[®], starting April 2020, by offering virtual patient treatment starts and ongoing follow-up/support. 314 GBM patients chose virtual initiation of TTFields therapy. A subset of patients in Hawaii (n=16) were supported 100% virtually. Data suggest no differenc-

es between virtual and live management. Data for virtual vs live, respectively were comparable: duration of TTFields therapy, usage, number of calls to care center, and early discontinuation rates. Surveys captured patient feedback showing patient/caregiver confidence and satisfaction as comparable between groups. The small Hawaiian GBM patient cohort managed solely via telehealth demonstrated feasibility of future virtual support of patients initiating TTFields and ongoing treatment. Responding to the pandemic, patient care has been transformed with adoption of telehealth resulting in quality outcomes for GBM patients treated with TTFields that were comparable to live interactions. Oncology nurses play a key role in advocating for patients and ensuring optimal care/outcomes are not compromised by shifts in care delivery to telehealth. These data may provide confidence for oncology nurses that patient care/outcomes were maintained virtually. Given these positive results and need for virtual access, a pilot program will be initiated examining the feasibility of exclusive virtual management to serve the growing number of GBM patients on TTFields therapy.

P107 SAFETY OUTCOMES OF OLAPARIB AS MAINTENANCE THERAPY FOLLOWING FIRST- LINE PLATINUM-BASED CHEMOTHERAPY FOR PATIENTS WITH BRCA-MUTATED METASTATIC PANCREATIC CANCER: RESULTS FROM THE POLO STUDY

Katelyn Van Kuiken, BSN, RN, OCN[®], University of Chicago Medicine & Biological Sciences, Chicago, IL; Talia Golan, MD, Institute of Oncology, Sheba Medical Center, Tel Aviv University, Tel Aviv; Karen Cui, MD, PhD, AstraZeneca, Gaithersburg, MD; Neil Brickel, MD, AstraZeneca, Cambridge; Charu Gupta, MSc, MS, AstraZeneca, Gaithersburg, MD; Hedy Kindler, MD, University of Chicago Medicine, Chicago, IL

Treatment Modalities

Olaparib is a PARP inhibitor that has been approved for the treatment of ovarian, breast, pancreatic and prostate cancers in patients who have a mutation in the DNA damage repair genes *BRCA1* or *BRCA2*. In pancreatic cancer, olaparib is approved for use as maintenance therapy in such patients following first-line platinum-based chemotherapy, based on the results of the phase 3 POLO study (NCT02184195) in which maintenance olaparib was demonstrated to have a significant progression-free survival benefit relative to placebo (median: 7.4 months vs 3.8 months; hazard ratio: 0.53; 95% confidence interval: 0.35–0.82; $p = 0.004$). Nurses

are often a primary point of contact for patients experiencing adverse events (AEs), and it is important that they are able to provide timely, appropriate support. Here, we present safety data from POLO at the data cut-off for the overall survival analysis (July 21, 2020), and guidance for AE management. The randomized patient population in POLO constituted 154 patients, 151 of whom received study treatment and were included in the safety analysis (olaparib [300 mg tablets twice daily]: n = 90; placebo: n = 61). Treatment-emergent AEs were recorded in 98.9% of patients receiving olaparib and 91.8% of patients receiving placebo, falling to 48.9% and 24.6%, respectively, for grade ≥ 3 AEs, and 31.1% and 16.4%, respectively, for serious AEs. There were no incidences of acute myeloid leukemia or myelodysplastic syndrome, and no deaths from an AE that was causally related to study treatment. Common AEs included fatigue/asthenia (olaparib: 63.3%; placebo: 36.1%), nausea (olaparib: 48.9%; placebo: 24.6%), anemia (olaparib: 32.2%; placebo: 16.4%) and vomiting (olaparib: 25.6%; placebo: 16.4%). In the olaparib arm, the median time to first onset of these AEs ranged from 8.5 days (nausea) to 56.0 days (vomiting), and the median duration of the first event ranged from 0.9 days (vomiting) to 132.1 days (fatigue/asthenia). AEs in the olaparib arm were managed by treatment interruption in 41.1% of patients, dose reduction in 17.8% and treatment discontinuation in 8.9%. AEs were otherwise managed through supportive care. Guideline-recommended strategies for the management of AEs observed in POLO, including fatigue/asthenia, nausea, anemia and vomiting, will be presented alongside study safety data.

INTERNATIONAL

P108 THERAPEUTIC ITINERARY AND QUALITY OF LIFE OF WOMEN WITH POST-MASTECTOMY PAIN SYNDROME

Edvane De Domenico, PhD, Escola Paulista de Enfermagem, Universidade Federal de São Paulo (UNIFESP), São Paulo; Luana Bonfim, RN, Universidade Federal de São Paulo, São Paulo; Kelly Nishimura, RN, Universidade Federal de São Paulo, São Paulo; Ana Maria Pires, RN, Escola de Enfermagem da Universidade Federal de São Paulo, São Paulo; Simone Elias, MD, Universidade Federal de São Paulo, São Paulo
Symptom Management and Palliative Care

Post-mastectomy pain syndrome (PMPS) is defined as a chronic neuropathic pain, located in the anterior

chest, armpit and/or upper half of the arm, which begins after surgery for breast tumor resection. Therapeutic Itinerary (TI) comprises a successive description of events that occurred from the perspective of the individual or group for the maintenance or recovery of the health-disease state. The objective of the project was to identify the path taken by women with PMPS and to assess the QoL of these patients. This was a cross-sectional study, mixed nature, with patients being followed up at the Outpatient Mastology Unit of Hospital São Paulo - Universidade Federal de São Paulo, UNIFESP, in the city of São Paulo, São Paulo, Brazil. Data were collected in the second half of 2020, consisting of: sociodemographic and clinical characterization, semi-structured questionnaire and Functional Assessment of Cancer Therapy - Breast plus Arm Morbidity (FACT B + 4). For data analysis, descriptive statistics, content analysis (Bardin) and ATLAS.ti 8.0® software were used. Results: 11 participants, median age 56 years (SD: 9.4), 90.9% live accompanied, 63.6% had 2 or more children, 65.2% ≥ 9 years of education, 72.7% unemployed or retired, 55.2% with monthly income of up to 2 minimum wages (equivalent to US\$ 417,00), 9.1% smokers, 63.6% in overweight or obese status; 72.7% diagnosed 3 years ago or more. The TI of the participants revealed an initial picture of PMPS after any type of breast surgery, aggravated by radiotherapy. The initial symptoms were: pain, with throbbing characteristics, radiating, burning, tightening, stabbing; plus tingling, numbness, swelling and heaviness in the arm. These symptoms have remained until today. The medication trajectory of women with PMPS revealed frequent use of non-steroidal anti-inflammatory drugs, most with medical indication, but with little efficacy. The non-pharmacological trajectory showed, mainly, motor physiotherapy and acupuncture as mitigating agents for a period of time. As for QoL, the overall FACT B+4 score (range 0-148) was 96.1 (SD 18.8), with lower scores for the social/family and functional domains. TI revealed symptoms that were not controlled over time and impaired QoL, especially in the social/family and functional domains of women with a profile of social and clinical vulnerability. These data will contribute to the implementation of a new continuum of care for these cancer survivors.

P109 ADHERENCE TO ORAL ANTINEOPLASTIC CHEMOTHERAPY, SOCIAL SUPPORT, SYMPTOMS AND WELL-BEING OF PATIENTS

WITH BRAIN CANCER AT A BRAZILIAN UNIVERSITY HOSPITAL

Edvane De Domenico, PhD, Escola Paulista de Enfermagem, Universidade Federal de São Paulo (UNIFESP), São Paulo; Barbara de Alencar, RN, Universidade Federal de São Paulo, São Paulo; Bárbara Stéphanie Macedo, Student, Escola de Enfermagem da Universidade Federal de São Paulo, São Paulo; Eliana Teraoka, RN, Escola de Enfermagem da Universidade Federal de São Paulo, São Paulo; Adrialdo Santos, MD, Universidade Federal de São Paulo, São Paulo

Treatment Modalities

Oral antineoplastic chemotherapy is the main clinical therapeutic choice in brain cancers, requiring comprehensive care. This was a cross-sectional, quantitative study with patients diagnosed with brain cancer, undergoing treatment with oral antineoplastic chemotherapy, treated at the outpatient clinic of a Brazilian University Hospital, from February 2019 to August 2020. Five instruments were used: socio-demographic and clinical variables; Social Support Scale (MOS-SSS), WHO Well-Being Index (WHO-5), Morisky Medication Adherence Scale (MMAS) and MD Anderson Symptom Inventory Scale (MDASI). Results: 26 participants, median age of 36.5 (SD 14.14), 61.5% male, 50% self-declared brown or black, 46.2% unemployed; 69.3% with 12 years of schooling or more; 53.9% diagnosed with glioblastoma; 73.1% received Temozolomide or Lomustine. By the MOS-SSS scale, most patients reported having a social support network, grouping the answers always and almost always, in relation to: going to the doctor (77%); preparing daily meals (61.5%), performing daily tasks (65.4%), showing love and affection (88.6%), trusting or talking about your problems (61.7%), helping to understand a certain situation (61.6%) and to do pleasant things (57.7%). In the WHO-5 scale data, the answers were grouped more than half the time all the time, showing that 65.4% feel happy and willing; 73.1% calm and peaceful, 61.6% feel refreshed and rested; 57.8% feel active and energetic and 53.9% fill the day with interesting things. According to the MDASI inventory, on the symptoms scale, the mean scores were 5.8 (range 2.2 to 7.4 points), with the worst score being for worry in its worst state. In the interference scale, the average was 5.6 points, and the biggest limitations were related to activities in general and walking. In the MMAS-8 scale, the score was of average adherence (6.9 points), highlighting that 19.2% attest to feeling uncomfortable for correctly following the treatment and having difficulties remembering to take them. In the analysis of multiple correspondence, the

highest adherence indexes were associated with affective and emotional support, information support and positive social interaction. Despite the fact that the majority declare positive levels of well-being, social support and symptoms, adherence to treatment is unsatisfactory. The level of adherence and possible intervening factors must be constantly evaluated for effective educational action.

P110 SEXUALITY APPROACH IN SEXUAL AND GENDER MINORITIES ONCOLOGY PATIENTS IN: SCOPING REVIEW

Daniela dos Santos, RN, PhD, Hospital Sírio Libanês, São Paulo; Tassia Rodrigues, Hospital Sírio Libanês, São Paulo; Ingrid Jensen, Hospital Sírio Libanês, São Paulo; Ricardo Santana, T, São Paulo

Oncology Nursing Practice

Cancer diagnosis brings changes in several dimensions which include the sexual behavior with impact on the patient's quality of life, include patients who are part of sexual and gender minorities (SGM) and who have specific demands that require a different approach. Objective: Analyze the sexuality approach of SGM cancer patients. It was performed a Scoping Review based on the Joanna Briggs Institute methodology between September and October 2020. It was used descriptors as sexuality AND sexual gender minorities AND medical oncology in the following databases: Pubmed, Science Direct, Scopus, Web of Science, Virtual Library of Health and Embase. It was considered as inclusion criteria the research topic in Portuguese, English and Spanish, full article and publications between 2005 and September 2020. The search revealed 295 articles which 11 were aligned with the inclusion criteria. The first group called situational diagnosis pointed out that the majority of professionals do not collect any information about gender identity or sexual orientation, and the available tools don't offer opportunity to questioning on the topic, the sexual effects from the treatment was not explored, few professionals felt that they didn't have the right skills to address sexual orientation issues, but they were interested in receiving education around SGM health, and finally they perceived the need of sexology in specific educational and practical training programs. The other group, called improvement strategies, revealed interventions such as the elaboration of institutional policies, research development, implementation of educational plan through workshops and/or webinars addressing hard skills and diversity, as well as support messages in classrooms wait. In the scientific envi-

ronment, there are validated instruments and strategies to approach and evaluate cancer patient sexuality, such as BETTER MODEL, PLISSIT, SF36, however they were not applied in any of the analyzed studies. Potentially lack of training and technical-scientific skills of health care professionals are related to prevention, screening, treatment acceptance and future care challenges in the SGM. There are important gaps in the approach of the sexuality and gender identity in SGM cancer patients.

LEADERSHIP/MANAGEMENT/EDUCATION

P111 **WE WILL WEATHER THIS TOGETHER: HOW TEAM MEMBER ENGAGEMENT AND JOB SATISFACTION INCREASED PATIENT SATISFACTION SCORES**

Jamie Adams, BSN, RN, OCN[®], University of Maryland Kaufman Infusion Center, Bel Air, MD; Peyton Neilson, MSN, RN, OCN[®], University of Maryland Kaufman Infusion Center, Bel Air, MD

Oncology Nursing Practice

Consumers Assessment of Healthcare Providers System (CHAPS) surveys developed by the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services (CMS) measure patient experience. CHAPS scores are publicly reported, tied to reimbursement, and drive quality. Press Ganey assists organizations to implement CHAPS, monitor outcomes, and assist in benchmarking. The “Is Emotional needs of the patient addressed by staff”, question was reported as 65.52% in the Press Ganey Top Box Score at a suburban academic medical center. Many studies have strongly correlated employee engagement to patient satisfaction. The focus of the project was to increase staff engagement resulting in improved Top Box Scores for emotional needs addressed by staff and the overall CHAPS results. Staff were surveyed by a SurveyMonkey questionnaire developed based upon the CHAPS standards by the Infusion Coordinator and Nurse Manager to measure baseline staff engagement and job satisfaction. According to the results of the SurveyMonkey, staff believed that team work and morale had declined thus leading to poorer job satisfaction and less engagement. Activities were implemented to promote teamwork, boost morale, enhance engagement and increase job satisfaction. Examples of activities included: holiday celebrations, Halloween t-shirts (the

“Boo Boo Crew”), Thanksgiving decorated face masks and Ugly Sweater Day. Goodies (candy, small gifts) were consistently given to the staff to show appreciation and promote a fun work environment. Themed T-shirts were designed by staff and worn on t-shirt Fridays. One hundred percent of the staff participated in the SurveyMonkey questionnaire. All of the staff implemented center activities. A weather forecast themed dashboard was created to monitor progress: Press Ganey (CHAPS) scores and explanations, space for staff feedback and suggestions, and space to encourage other team members. Six months after starting the project, emotional needs addressed Top Box Score increased to 76.70% and there was an overall improvement CHAPS scores. Beyond patient satisfaction other benefits include staff anecdotally reporting a more positive atmosphere on the unit, improved teamwork and feeling happier at work. Some staff members have taken the initiative to implement their own strategies to continue to promote teamwork and staff satisfaction including monthly themed potluck lunches, community food drives, Infusion garden beautification, and increased acknowledgement of others.

P112 **IMPORTANCE OF PATIENT EDUCATION IN THE UTILIZATION OF LEE SYMPTOM SCALES IN PATIENTS WITH CGVHD FOR ANALYSIS OF SYMPTOM CONTROL**

Brittney Baer, BSN, RN, Vanderbilt University Medical Center, Nashville, TN; Katie Roberts, BS, RN, University of Minnesota, Minneapolis, MN; Hope Qamoos, MSN-NP, Syndax Pharmaceuticals, Waltham, MA; Kimberly Dishman, MSN-NP, Syndax Pharmaceuticals, Waltham, MA; Julianne Dunlap, MSc, Fred Hutch, Seattle, WA

Patient Education and Safety

Chronic graft versus host disease (cGVHD) remains the leading cause of non-relapse mortality in patients post-allogeneic transplant. Novel agents are becoming available for patients with cGVHD, increasing the need for a personalized approach and evaluation of symptom control to guide treatment decisions. The National Institutes of Health (NIH) Consensus Development Project on Criteria for Clinical Trials in cGVHD has proposed use of the Lee Symptom Scale (LSS) in clinical trials to measure efficacy. Patient understanding of this questionnaire is essential to accurately capture data, minimize the impact of survey fatigue, and evaluate evidence of symptom improvement. Here we provide methods utilized to educate patients enrolled in SNDX-6352-0503 evaluating the

use of axatilimab in patients with cGVHD. SNDX-6352-0503 is a Phase 1/2 study assessing the safety/efficacy of axatilimab in patients with active cGVHD despite ≥ 2 prior lines of systemic therapy. Key secondary objectives included improvement in LSS from baseline. LSS was assessed day one of each cycle and evaluates symptoms via 30-questions clustered by organ systems routinely affected by cGVHD. Total scores range from 0-120 and a 7-point improvement indicates clinical benefit. Study coordinators worked closely with participants to collect LSS data, used verbal instructions to educate on LSS value and addressed the sense of survey burden. Paper forms were provided with instructions to consider changes in their symptoms in the past 30-days. Ample time and a quiet space were provided with coordinators readily available to provide necessary clarifications. Areas typically requiring clarification included questions related to unintended weight loss and scoring of skin changes. Forms were then collected and scanned for completeness. The FDA and other regulatory bodies require an assessment of patient-reported symptoms when evaluating a new agent. Patients must receive appropriate education in the importance of the LSS questionnaire and completion to enable effective and reliable evaluation of novel agents in cGVHD. Applying these methods decreased questionnaire fatigue and led to the collection of a robust data set illustrating a 7-point improvement in 50% (n=19/38) of pts and contributing to axatilimab's continued development. AGAVE-201 and other studies in cGVHD will continue to utilize the original or modified LSS to assess symptom control, highlighting the importance of patient education in the utilization of these tools.

P113 **TRAIN THE TRAINER: VIRTUAL TO RECONNECT AFTER COVID-19**

Clara Beaver, MSN, RN, AOCNS[®], ACNS-BC, Karmanos Cancer Center, Riverview, MI
[COVID-19](#)

Related to the restrictions placed by COVID-19; the trainers that are assigned to the network cancer centers were unable to meet in-person in 2020. Since the inception of the train the trainer program in 2016, the group has meet in person yearly at the annual cancer meeting. In 2021, it was evident that the group needed to reconnect and discuss new regulations, staffing issues and reaffirm the competency check off, as well as train new trainers. Due to continued COVID-19 concerns and staffing issues; virtual training sessions were requested by leadership. The purpose of this project

was to find alternative means in which to meet with the trainers and reinforce the changes in standards, provide support related to staffing/practice issues and reaffirm the expectations of yearly competencies. In addition, a format to train newly identified trainers needed to be developed. Four sessions were scheduled via a virtual environment for trainers to join. Session times/dates were discussed with the leadership and set based on staff availability. On-line sessions were kept to 2 hours and all trainers were expected to join at least one session to receive information and provide feedback. The format of the virtual presentation was a powerpoint with changes in regulations and review of competencies evaluation; time was built in to discuss clinic challenges and lessons learned from COVID-19. The new trainers also received education of how to complete competency evaluations and expectations. An online document storage system was also put into place for trainers to be able to access documents when needed. All network trainers were able to attend a virtual session and receive information. The trainers reported that the virtual format and session was an effective way to communicate. Using the new virtual format, all trainers now have access to all the documents needed for new hire orientation, competency validation and content from the session presented. When faced with changes in the environment including not being able to meet in person, a virtual environment can help connect groups. Touch points with trainers/preceptors about changing expectations, regulations and discussing challenges is important in maintaining continued competence. Virtual formats allow groups to communicate with others about challenges they are having and have access to data needed to maintain competence.

P114 **NURSES ON BOARDS COALITION: PURPOSE, PILLARS, PROCESS, PROGRESS**

Laura Benson, RN, MS, ANP, Conversations In Care, LLC, New Rochelle, NY
[Professional Development](#)

The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity states that nurses have a critical role to play in achieving the goal of health equity, but they need robust education, supportive work environments, and autonomy. The report goes on the say: "The ultimate goal is the achievement of health equity in the United States built on strengthened nursing capacity and expertise." Nurses represent the largest segment of the healthcare workforce, are considered the most trustworthy of all professions and play an invaluable

role on the frontlines of care in our schools, hospitals, community health centers, long-term care facilities, and other places. Their perspective and influence must be felt more at decision-making tables. The Nurses on Boards Coalition's (NOBC) mission is to "improve the health of communities and the nation through the service of nurses on boards and other bodies". Building healthier communities in America requires the involvement of more nurses on corporate, health-related, and other boards, panels, and commissions. NOBC is committed to increasing nurses' presence and influence. In 2020, the Coalition registered more than 10,000 nurses serving on boards. There is now a focus on measuring the impact of nurses serving in board roles. A simultaneous goal is to help provide the opportunity for nurses education and advancement in leadership roles, by providing resources, identifying new opportunities, and facilitating mentorship of nurses on all levels of the experience spectrum. To that end both a Board Competency Model and Board Readiness Model have been developed and available to help guide nurses toward their leadership goals. As written in the Future of Nursing 2020-2030 report (recommendation #6) "All public and private health care systems should incorporate nursing expertise in designing, generating, analyzing, and applying data to support initiatives focused on social determinants of health and health equity using diverse digital platforms, artificial intelligence, and other innovative technologies." There is a call to action for all nurses to serve in leadership roles at every level of the spectrum. NOBC and our 25 plus member organizations want to provide all nurses with the tools and opportunities they require to improve the health of the nation.

P115 CLINICAL TRIAL OFFICE RESPONSE TO COVID-19 AT AN ACADEMIC COMPREHENSIVE CANCER CENTER

Edward Bentlyewski, MSN, APN, NP-C, AOCNP, CCRP, CUIMC Herbert Irving Comprehensive Cancer Center, New York, NY; Frances Brogan, MSN, RN, OCN, CCRP, CUMC Herbert Irving Comprehensive Cancer Center, New York, NY; Ryan Shelton, BS, Herbert Irving Comprehensive Cancer Center, New York, NY; Andrew Lassman, MS, MD, Herbert Irving Comprehensive Cancer Center, New York, NY; Joseph Jurcic, MD, Herbert Irving Comprehensive Cancer Center, New York, NY; Moshe Kelsen, MBA, Herbert Irving Comprehensive Cancer Center, New York, NY

COVID-19

The Covid-19 pandemic challenged our department to adapt existing workflows to maintain high quality can-

cer care and clinical trial compliance. Limited patient access to campus altered the way trial procedures were conducted. Clinical research staff, including Research Nurses, were redeployed to other departments within the institution. Limited hospital bed availability due to Covid-19 proved difficult for our cancer clinical trial patients. The purpose of this project was to evaluate practice alterations in response to the Covid-19 pandemic, including redeployment of research staff, decreasing research activities, utilizing telehealth, shipping oral study agents, and coordinating inpatient admissions for patients actively on trial who require hospitalization. Our department has staff of 25 research nurses and research nurse practitioners who work primarily in assigned disease-based teams and assume all clinical care for patients on study. One-third of the nursing staff were redeployed to other clinical departments. In response, remaining nurses filled these gaps in coverage. This was possible because of standardization of policies and procedures throughout our department. Many of our patients travel from out of state for clinical trial and had difficulties coming to New York. For these patients, we performed remote telehealth visits where feasible. If possible, we performed laboratory and other assessments locally and shipped oral study drugs directly to patients. This involved careful coordination to ensure investigational product stability and maintain patient safety. Cancer Center leadership recognized the continued need to provide excellent cancer care and access to clinical trials during the pandemic while mitigating risk. To reconcile these competing needs, we carefully decreased our study activities while maintaining care of active patients and still offering patients access to trials with potential therapeutic benefit. Enrollment to trials was paused with a review process implemented to request exceptions for accrual of new patients to existing studies. No exception requests were denied. The pandemic experience demonstrated that Clinical Trials Offices must remain nimble to adapt to large-scale disruptions. Standardized workflows, training, and competencies allowed the continued conduct of clinical trials while many staff members were redeployed to other departments. The use of telehealth and local assessments was beneficial and can be applied more widely to allow patient-centered care closer to their home.

P116 FOUNDATIONS FOR SUCCESS—PAVING THE WAY FROM NOVICE TO EXPERT

Tiffini Boyde, MSN, RN, OCN®, BMTCN®, CNL,

Mount Sinai Hospital, New York, NY; Sarah Middlekauff, MSN, RN, Mount Sinai Hospital, New York, NY

Professional Development

Oncology education during orientation establishes a foundation for the oncology nurse's professional practice and is essential to quality care, safety, nursing retention and satisfaction. Review of oncology quality data in relation to nursing practice identified a need for the development of an interactive course during orientation specific to oncology nursing. The purpose of this project was to develop an interactive online course for nurses on orientation to enhance novice nurse knowledge, understanding, critical thinking and team collaboration within a large ambulatory cancer center. A needs assessment was provided to oncology nurses on orientation. The assessment results assisted nurse educators in developing weekly one hour lectures via zoom. Oncology topics reviewed included oncological emergencies, activation and management of medical emergencies, telephone triage, care for central venous access devices, chemotherapy/immunotherapy treatment regimens, patient education, utilization of the electronic medical record and nurse documentation. All nurses on orientation within the ambulatory cancer center were invited to attend the classes to facilitate networking and collaboration among the various oncology clinical areas. Learners were asked to complete pre and post-tests for each class to assess knowledge and understanding on specific oncology topics. Case studies were utilized to facilitate critical thinking. Upon completion of orientation, nurses completed an exit survey to determine ongoing educational needs and improvements to the course. Pre and post-test knowledge assessments from each class revealed the learners' knowledge increased as a result of the didactic lecture content. Upon completion of their orientation, 100% of the nurses found the classes valuable and effective. The newly hired nurses reported support from their educator, increased knowledge of oncology, and the importance of collaboration and teamwork in the clinical oncology areas. Weekly, interactive oncology education is effective in increasing the newly hired nurse's knowledge, understanding and critical thinking. Future plans include offering the course to incumbent staff to improve professional practice of the novice and expert nurse. Educational support for newly hired staff and incumbent staff will enhance nursing knowledge, quality patient care, nursing retention and satisfaction. The COVID-19 pandemic has impacted orientation, learning and networking for newly hired oncology nurses. The utiliza-

tion of an interactive online platform has positively impacted nurses learning of oncology content as well as assisted in networking among nurses on orientation in various clinical areas.

P117 RESPONDING TO EMERGENCY SITUATIONS QUICKLY (RESQ) IN AMBULATORY ONCOLOGY

Tiffini Boyde, MSN, RN, OCN[®], BMTCN[®], CNL, Mount Sinai Hospital, New York, NY; Marceline Naude, MSN, NP, WHNP-BC, Mount Sinai Hospital, New York, NY; Adedayo Ogunfowora, MSN, RN, Mount Sinai Hospital, New York, NY; Caitlin Reich, MSN, NP, FNP-BC, Mount Sinai Hospital, New York, NY; Nicole Hall, MSN, RN, Mount Sinai Hospital, New York, NY; Lindsay Diamond, MSN, NP, OCN[®], Mount Sinai Hospital, New York, NY

Oncology Nursing Practice

Oncology patient care predominately occurs in ambulatory settings increasing the risk for medical emergencies. A rapid response team (RESQ) was developed to improve quality care, coordination, communication and patient outcomes during medical emergencies. A quality review revealed 4 cardiac arrests with poor patient outcomes in the ambulatory setting from 2019-2021. The leadership and clinical team identified a fragmented process for escalation of patient care during medical emergencies leading to poor communication, collaboration and transfer to the emergency department. The interdisciplinary RESQ team consisted of nurses, advanced practice providers, physicians and administration. Communication tools developed included an alert-paging system, streamlined and trackable documentation of events in the electronic medical record and event reporting system. Policy and process development included multiple disciplines and departments. Staff education was implemented from February 2020 to December 2020 to improve continuity of the quality improvement project regarding the emergency activation process, initial management of medical emergencies, communication and efficiency in the escalation and transfer of patient care. From August 2020 to August 2021, 24 RESQs were activated by staff. Of the 24 events, 63% (n=15) of patients presented with hypotension, 34% (n=8) mental status changes, 26% (n=6) potential sepsis, 26% (n=6) arrhythmias, 21% (n=5) hypoxia, 12% (n=3) anaphylaxis/hypersensitivity reaction, 8% (n=2) chest pain, 4% (n=1) seizures, 4% (n=1) hemoptysis, and 4% (n=1) hypoglycemia. All patients were stabilized or safely transferred to a higher

level of care. 12% (n=3) of the patients were stabilized within the ambulatory setting and discharged home. A multidisciplinary collaborative approach was utilized to develop the RESQ team and escalation process for patient care during medical emergencies. Collaboration between multiple departments and staff education was vital. Medical emergency event documentation has enabled clinical leadership to review and implement interventions to enhance staff and RESQ team processes and education improving management of medical emergencies and quality patient care. A rapid response team in an ambulatory setting is a novel approach to medical emergencies that has the potential to improve patient outcomes, quality care, safety, communication and collaboration among interdisciplinary care teams and departments.

P118 **THE COMMISSION ON CANCER 4.2** **STANDARD: AN INNOVATIVE APPROACH** **TO MONITOR COMPLIANCE**

D’Ana Brooks, RN, MSN, CMSRN, CNL, Smilow Cancer Hospital, New Haven, CT; Christina Matousek, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT; Elizabeth Gineo, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT; Kelli-Ann Mancini, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT

Professional Development

The Commission on Cancer (CoC) is a conglomerate of organizations committed to ensuring quality care for oncology patients through standard setting. In 2020, CoC released new standards requiring oncology nurses and advanced practice providers (APPs) without an oncology certification, to obtain thirty-six continuing education (CE) hours during the three-year accreditation survey cycle. Due to the vastness of our organization, this working group sought to establish an electronic method to allow staff to store their CEs and allow managers to efficiently monitor for compliance to ensure that this standard is met. The purpose of this project was to create an electronic process for oncology nurses to document their CEs and allow managers the ability to monitor employee progress and compliance. Our group collaborated with employee self-service (ESS) personnel to identify tracking and submission capabilities. Current expectations are for nurses to utilize ESS to document their nursing certifications. Information Technology (IT) analysts built an oncology CE section within ESS for nurses, advanced practice providers, and managers to upload CE certificates and track number of hours completed.

Managers have the ability to filter employee lists by department, date(s), total CEs, and/or name for reporting capabilities. Educational sessions were held for nurses and managers on how to use this new feature. This process will allow for efficient CE tracking for our institution. Oncology nurses will be responsible for obtaining thirty-six CEs for every three-year cycle or maintain an oncology certification. Nursing will be responsible for uploading proof of CEs in ESS for tracking purposes. Managers will be asked to complete a key survey to determine ease of monitoring compliance following staff’s upcoming annual review. CoC accredited sites must demonstrate high quality nursing care through maintaining CEs or oncology certification. Utilizing ESS, a tracking system was designed for nurses and managers. Nursing is now able to upload CE credits obtained. Managers can track these CEs utilizing appropriate filters by name and date to ensure requirements are met. The solution of modifying an existing electronic employee management system for nurses and managers to track CE progress is an innovative way to monitor compliance for this new standard. Using technology that is currently in place is a low cost, high efficacy way to adequately track and report CE status.

P119 **AN INNOVATIVE APPROACH TO** **CONTINUING EDUCATION AND** **PROFESSIONAL DEVELOPMENT**

Gean Brown, MSN, RN, OCN®, CNML, Smilow Cancer Hospital, Yale New Haven, Trumbull, CT; Christina Matousek, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT; Nicole Bocchetta, MSN, RN, OCN®, Smilow Cancer Hospital/Yale New Haven Health, New Haven, CT; Elizabeth Gineo, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT; Patricia Szabo, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT

Professional Development

In 2020, the Commission on Cancer (CoC) released their new standards outlining updated requirements for oncology nurses to achieve an oncology-specific certification or ongoing education evidenced by thirty-six continuing education (CE) hours over a three-year period. Our organization launched its revised clinical ladder advancement program called SPIRE: Scholar, Practitioner, Innovator, Researcher, and Educator. SPIRE encourages nurses to educate their peers utilizing current evidenced-based practice. Our team mentored bedside nurses to present in a “round robin” style virtual CE event to encourage participation in the clinical advancement process. The purpose of

this project was to mentor bedside leaders in their clinical advancement and promote access to CEs for all oncology nurses within our organization. Nursing professional development specialists (NPDS) chose evidenced-based articles that award free CEs from six different ILNA categories, including health promotion, treatment modalities, palliative care, symptom management, survivorship, and scientific basis for practice. Attendees were provided with the link to each article and were responsible for obtaining and reading articles on their own. Each topic was designated a breakout room that would transpire in four 20 minute sessions. Attendees chose four out of the six breakout sessions to attend. Managers and NPDSs recruited nurses who expressed interest in the SPIRE program to serve as presenters. An electronic survey was distributed at the conclusion of the event. The questions were a variety of Likert scale and open comment. Of 43 participants, 34 (79%) responses were recorded. 91% rated the event as “excellent” or “very good.” To meet the updated CoC Standard 4.2, all nurses providing direct care must hold an oncology certification or complete 36 CEs over three years. The CE event provided nurses an opportunity to improve their knowledge and clinical practice while obtaining CEs. This event also provided the speaker an opportunity to advance in the clinical ladder. This program was innovative in multiple ways. A virtual format allowed nurses across a large geographic region the opportunity to network. In addition, nurses working towards their clinical ladder were given the opportunity to lead this professional activity. Individuals learn in multiple ways; this was accomplished through reading, hearing, and discussing the article with their peers.

P120 PALLIATIVE CARE ON A MEDICAL ONCOLOGY UNIT

Bianca Carpenter-Marshall, MSN, RN-BC, NE-BC, Baylor University Medical Center, Dallas, TX; Samantha Stephenson, BSN, RN, OCN®, Baylor University Medical Center, Dallas, TX; Allison Steen, MSN, RN, OCN®, NE-BC, Baylor University Medical Center, Dallas, TX; Sasilekha Jyothik, MSN, RN, OCN®, Baylor University Medical Center, Dallas, TX

Symptom Management and Palliative Care

In 2010 the American Academy of Hospice and Palliative Medicine estimated need for 6,000 more physicians and a need for clinical staff education. Palliative care plays a crucial role in the continuum of health care delivery and the need to improve quality

of life for patients nearing end of life is a necessity. In 2021, the medical oncology unit in collaboration with the Palliative Care team developed a specialized area within the unit. The goal was to cohort a population of palliative care patients into a defined area with nurses trained in concepts of palliative care. The plan included admission of terminal patients who required symptom management and inpatient care. Goals of care were identified by providers and nursing. Nursing joined forces with palliative care providers to identify educational needs. A multidisciplinary approach was taken to formulate the education plan. Initially, bedside leaders were identified to champion the unit. Preliminary education involved Achievement for Excellence in Palliative Care modules followed by a short 5 question quiz. The modules were developed by the Palliative Care team. Nursing care, pharmacology, ethical dilemmas, and procedures that would impact the unit were reviewed. Utilizing an innovative approach to sustain ongoing educational opportunities, members of the care team presented selected topics on issues critical to palliative care. Open sessions were offered to staff to provide feedback. Information from the sessions was utilized to develop additional learning activities. Since implementation, approximately 34 patients were provided care in the palliative area. Family feedback has been positive and complimentary of the nursing staff. “They are all fantastic and wonderful. I can tell each of them were raised by wonderful family and by an exceptional nursing team.” From the chaplain, “The patient had done a lot of harm to his family. . . . The stories of compassionate care helped the family begin their healing. . . . The nursing staff were there to help him die and help him die well. Love can transformative to the hardest hearts.” A hybrid education approach utilizing both virtual and in person sessions contributed to its success. Resources were made available for staff to review as needed on a team site for the unit.

P121 A MEDICAL ASSISTANT APPRENTICESHIP PROGRAM IN AN ACADEMIC ONCOLOGY AMBULATORY CLINIC

Lyndsey Conway, MN, RN, BMTCN®, Seattle Cancer Care Alliance, Seattle, WA; Kathleen Shannon Dorcy, PhD, RN, FAAN, Seattle Cancer Care Alliance, Seattle, WA; Sharol Kidd, MBA, BSN, RN, Seattle Cancer Care Alliance, Poulsbo, WA; Naomi Heinecke, LPN, BHA, Seattle Cancer Care Alliance, Seattle, WA; Rikka Quinanola, MA-C, Seattle Cancer Care Alliance, Seat-

tle, WA; Loo Hilzer, MA, Seattle Cancer Care Alliance, Seattle, WA

Professional Development

The composition of care teams significantly influence quality of care provision for complexly ill oncology patients. In a National Comprehensive Cancer Network (NCCN)-designated cancer center treating 32,178 patients a year, a need was identified to build a specialized workforce of medical assistants (MA). The NCCN center partnered with a state-wide program to initiate a tuition-paid apprenticeship, where the center provided oncology specific training and learning in the ambulatory care setting. The purpose of this project was to enhance oncology clinical care with a focused recruitment and retention effort of MAs to build capacity for state of the science patient cancer care delivery. Clinic leaders assessed feasibility and implementation of an MA apprenticeship program in 2018. Apprentices commit to a two-year contract to work in the oncology clinic in exchange for program tuition (\$3750) and paid employment (2000 clinical hours). MAs were assigned preceptors who facilitated interdisciplinary collaboration of staff to train to the full capacity of MA licensure. Reflective journaling was used to track individual processing and achievement within the program and helped committee members gain insight on challenges and successes of the program. Since initiation of the first cohort in 2018, 9 graduates have completed the program and remain employed as certified medical assistants, and 11 individuals are current apprentices enrolled in the program. The clinical learning and achievement of apprentice graduates has enhanced center wide MA scope of practice to full extent of licensure and enhanced the quality of cancer care delivery. The apprenticeship program has been significant in the increase in hiring and retention of medical assistants in the ambulatory oncology clinic. The program has been an effective recruitment tool for both external candidates and incumbent staff. It has been utilized by internal employees to pursue MA certification and achieve personal professional growth within the organization. The program has also been effective as an equitable community workforce development tool with the opportunity for candidates to enroll in a tuition-benefit program and be paid while engaging in learning and skill acquisition. Collaboration with state program to bring highest quality of education and clinical practice possible. Serving equitable population for people professional oncology training and improving care outcomes for people with cancer.

P122

WASHINGTON STATE TO WASHINGTON DC: DYNAMIC DIALOGUE BETWEEN POLICY INFLUENCERS AND ONCOLOGY NURSES

Arlyce Coumar, RN, MN, OCN®, Seattle Cancer Care Alliance, Seattle, WA

Professional Development

In the Fall of 2020, with the US Presidential election pending and the COVID pandemic exposing racial and health access disparities, our Puget Sound chapter of the Oncology Nursing Society's (PSONS) Legislative and Health Policy Committee sponsored a conference on population health issues. COVID travel restrictions mandated the event transition to a virtual format. PSONS audience and panel Participation was significantly enhanced by the accessibility of virtual attendance. The purpose of this project was to facilitate oncology nurses in effective civic engagement, politics, and policy formation within a forum of local, state, and national level leaders in public health, education, and government. The committee organized a 2.5-hour virtual interactive webinar with a panel of eight speakers, moderated by Alec Stone, ONS Public Affairs Director. Panel presentations by health advocacy and policy subject matter experts from non-profit, government and academic settings engaged the oncology nurse audience in examination of complex current events. 40+ attendees with eight panelists on a Zoom platform exceeded attendance expectations for an in-person event and inspired an exceptional list of speakers presenting from across the USA. Evaluations revealed spirited engagement. In responding to the great interest, PSONS plans on hosting an annual event put on the Legislative and Health Policy committee. Leadership mentoring from ONS national level (Alec Stone) built capacity for motivation and initiative to organize the PSONS event. With the next event, techniques for providing increased opportunity for participant discussions with panel will be important. Our PSONS nurses are passionate about making a difference with effective political activism. ONS as a non-partisan entity exemplifies how to engage with issues and policies for health absent of polarizing opinions. Webinars such as this can inspire individual nurses to participate in civic engagement and this advocacy can improve overall public health well-being, access equity, cancer prevention, cancer care and research. Ultimately political advocacy will improve health care outcomes for our oncology patients and public health standards. Oncology nurses recognize they have a significant role as leaders and influencers of public health and policy formation to

decrease suffering related to cancer. Collaboration from Washington DC to Washington state exemplifies best processes for addressing divisive differences that produce stagnation on the issues of public health and ultimately decreasing quality oncology outcomes.

P123 **THE MORE YOU KNOW: USING SOCIAL MEDIA TO ENGAGE AND EDUCATE STAFF IN A SPECIALTY FIELD OF HEALTHCARE**

Nicole Crapser, MSN, RN, Hartford Hospital, Hartford, CT; Anna-Rae Montano, RN, PhD, OCN®, MED-SURG-BC, Hartford Hospital, Hartford, CT

Oncology Nursing Practice

Education modalities and platforms have rapidly adapted due to the effects of the COVID-19 pandemic and new social distancing requirements. There are constant updates in the field of oncology related to treatment plans, clinical trials and specialty skills that require additional training for all members of the healthcare team. A study used social media for surgical training and found that the educational content had a significantly higher rate of engagement by those who followed it. Social media provides an efficient, immediate, accessible and inexpensive platform for oncology education that can enhance engagement by all members of the healthcare team. The purpose of this project was to implement a social media presence to provide education, advertisement of class offerings, and recognition to all members of the oncology team. Instagram was chosen as the social media platform for its ability to post videos, pictures, conduct polls, quizzes and more. The content is updated and provided by the educators of the Hartford Healthcare Cancer Institute. Content includes weekly learning moments, chemotherapy flashcards, and updates in practice. Team recognition, trivia, inspirational quotes, and reminders of class offerings are posted weekly through the Instagram story. In one month the Instagram account has gained 52 followers with different healthcare roles who practice in different settings. Qualitative feedback from staff has been favorable with staff reporting an increase in knowledge of different chemotherapies and interest in obtaining OCN certification due to the content posted. It is challenging to provide education only through emails and policy updates that have limited staff engagement. Creating an educational oncology Instagram account allows oncology educators to provide real-time updates of clinical information to staff. Next steps involve increasing our follower count and gathering data from polls and quizzes to tailor educational

offerings and focus annual competencies on gaps that are identified from members of the HHC Cancer Institute team.

P124 **PATH TO SUCCESS: DEVELOPMENT OF AN ONBOARDING PROCESS FOR RN SPECIALTY CARE COORDINATORS**

Nancy Dalpiaz, RN, BSN, Cleveland Clinic, Cleveland, OH; Georgina Rodgers, BSN, RN, OCN®, NE-BC, Cleveland Clinic Health System, Cleveland, OH; Deborah Stack, RN, BSN, Cleveland Clinic, Cleveland, OH; Kelly Folk, RN, BSN, Cleveland Clinic, Cleveland, OH; Yolanda Curry, RN, BSN, Cleveland Clinic, Cleveland, OH; Jodi Ferrini, RN, BSN, Cleveland Clinic, Cleveland, OH

Oncology Nursing Practice

Care coordination is a model of care based on the management of high risk patients to assure their healthcare is optimized and focused on wellness and health promotion. It is a process and function that includes: management of high risk patients; a focus on disease management, health and wellness, patient activation, organized care with appropriate and complete transitions, and communication along the care continuum. Within our cancer center, it was noted that there is a lack of standardized approach to the on-boarding or our Oncology Specialty RN Care Coordinators. There are differing levels of education and training provided to new hires dependent upon the disease group and/or preceptor. The intent of this project was to develop a standardized, high level foundation for training and education to ensure that each new RNCC is equipped with the same building blocks for success. A core group initiated a plan that aimed to develop appropriate educational tools through a module based format that moves the orientee from novice to expert in a precepted orientation for 12 weeks. The team consisted of experienced specialty care coordinators, RNCC leadership and a clinical project manager scoping the project and creating module based collection of materials essential to the learner. Each module is a compilation of key resources which include policy and procedure resources, consistent reports available to RNCCs, recommended shadowing experiences, electronic health record job aids, standardized education and documentation templates, patient care and clinical development resource materials. The effectiveness of the on-boarding process and learning modules will be evaluated on a quarterly basis to determine if the modules are meeting the needs of the learners. Guidelines were written to outline a process for the review of existing materials and a mechanism

to update modules with new information, as appropriate. Future directions for modules may include disease specific content to support learners in their designated specialties. Content has been uploaded to a Care Coordination Department intranet site within the health system to allow for ease of access across the numerous oncology service line sites.

P125 PAIRING NOVICE NURSE WRITERS WITH EXPERIENCED NURSE WRITERS TO SHARE CANCER NURSING BEST PRACTICES THROUGH A FORMAL WRITING MENTORSHIP PROGRAM

Elaine DeMeyer, MSN, RN, AOCN®, BMTCN®, beyond Oncology, Rockwall, TX; Joni Watson, DNP, RN, MBA, OCN®, Self-Employed, Fate, TX; Stephanie DeMeyer, BA, BS, beyond Oncology, Arlington, VA; Courtney Leonard, BA, MashUp Media LLC, Piscataway Township, NJ; Vanessa Ira, MA, Mashup Media LLC, New York, NY

Psychosocial Dimensions of Care

All oncology nurses have something to write about in their roles, but many often have no idea where to begin. The thought of writing might seem scary, daunting, or overwhelming. Very few nurses receive instruction on writing beyond college. With online publications, it is easier for nurses to contribute to the body of nursing knowledge. The purpose of the writing mentorship program is to bridge the gap between the available training and encouraging nurse authors in order to develop or enhance nurse writing skills to improve dissemination of information that can change practice to improve patient outcomes. beyond Oncology pairs experienced writers (mentors) with novice writers (mentees) to write short (700-900 word) articles with three to five references for a new “Best Practices” section within the Cancer Nursing Today platform. This standing column focuses on both clinical and non-clinical emerging best practices in nursing. Topics range from chemotherapy safety issues and symptom management to strategies to improve communication, build resilience, and improve inclusivity. A special advanced practice provider (APP) corner includes topics of interest to APPs from a variety of positions including leadership, nurse practitioner, or clinical nurse specialist. Nurses apply to either role through the beyond Oncology website and then are paired to work through a topic of interest. Iterative feedback provides just-in-time coaching to support the mentee. Since the introduction of the Best Practices standing column in June

2021, both mentees and mentors share a positive experience. Mentee writing ability shows significant improvement and confidence, and one mentor stated she feels a “sense of giving back to their profession” and that “it is energizing and refreshing at this point in her career.” Formal mentee and mentor evaluation is planned at six months and one year. Mentorship can bridge the gap to help new nurse authors publish to meet their personal and professional goals. They get the encouragement, empowerment, and support they need to successfully write for early publication. While a mentoring relationship obviously benefits the mentee, it can be equally rewarding for the mentor.

P126 BRINGING NURSING RESEARCH TO THE BEDSIDE: SUPPORTING STAFF THROUGH THE PROCESS

Anne Delengowski, RN, MSN, AOCN®, CCCTM, Thomas Jefferson University Hospital, Gloucester, NJ

Professional Development

Nursing research is critical to the advancement of the profession. The process of nursing research from concept to fruition can often seem daunting due to the time commitment and commitment to all the steps in the research process. Despite this, the long term benefits far outweigh the intensity of the process. The benefits to staff include engagement in the research process, mentorship to the process, professional development and increasing morale. The oncology nursing staff of a large academic medical center set a goal to bring nursing research to the bedside. Initially, much education was done to support the knowledge base of the staff. The nurses completed IRB training. Each nurse has specific roles within the process including but not limited to literature review, designing the project and IRB submission. To date, two projects have been completed, one is about to begin and one is in the developmental phase. These projects were initiated in both inpatient and outpatient areas and included nursing staff from the various areas. Two projects were grant funded. Staff have presented outcomes at the local, regional and national level. Of note, this work continued throughout the pandemic and really improved morale during these challenging times. This session will describe successes and challenges of this project and an overview of the process for engagement of staff to research, roles of the staff nurse and outcomes.

P127 ADDRESSING OPPORTUNITIES FOR IMPROVEMENT FOR NUTRITIONAL

EDUCATION IN A LARGE OUTPATIENT ONCOLOGY NETWORK

Amy DiMaggio, MSN, RN, CMSRN, OCN®, 5150 Centre Avenue, Pittsburgh, PA; Joyce Diacopoulos, RD, LDN, UPMC Hillman Cancer Center, Pittsburgh, PA; Laura Edwards, MS, RD, LDN, UPMC Hillman Cancer Center, Pittsburgh, PA

Patient Education and Safety

The University of Pittsburgh Medical Center (UPMC) Hillman Cancer Center (HCC) is a large academic cancer center consisting of 70 medical and radiation oncology locations throughout New York, Pennsylvania, Ohio, and Maryland. On an annual needs assessment survey conducted by the UPMC HCC Professional and Patient Education Department, results indicated opportunities to improve patient education nutrition resources for oncology patients. Additionally, survey responses identified preferred learning methods of lectures and self-paced activities. Upon receiving feedback, the clinical nutrition and education department teams of UPMC HCC brainstormed to restructure nutrition education for the nursing staff. A five-question survey was distributed to help the teams to narrow the most desirable topics to be addressed. Shortly after results were received and an action plan to address these opportunities were created, a pandemic forced all educational efforts to be transitioned to virtual learning. Still adhering to preference, the teams quickly developed quarterly web-based lectures and a self-paced learning module on the network's enduring education website. The sessions, delivered by various key players in the network's nutritional service department allowed for feedback, networking, and troubleshooting key barriers in delivering nutrition education to patients. Based on post survey data, the workgroup will continue to address the needs of the nurses to ensure patients receiving care within the network's oncology setting are provided nutritional education information encompassing evidence based best practices.

P128 GROWING EVIDENCE-BASED PRACTICE CULTURE

Tracy Douglas, DNP, RN, BMTCN®, NEA-BC, Greenebaum Comprehensive Cancer Center at the University of Maryland Medical Center, Baltimore, MD; Kim Peterson, MSN, APRN-CNS, ACCNS-AG, OCN®, Greenebaum Comprehensive Cancer Center at the University of Maryland Medical Center, Baltimore, MD; Suzanne Cowperthwaite, DNP, RN, NEA-BC, University of

Maryland Greenbaum Comprehensive Cancer Center, Baltimore, MD

Professional Development

The Institute of Medicine identifies evidence-based practice (EBP) as a core competency for health care providers. Barriers to EBP among non-physician providers include lack of knowledge, lack of time, and lack of organizational support/awareness. EBP is supported at the institutional level through a central Nursing Research and Evidence-Based Practice Council, as a component of the professional advancement Model and as a requirement of the nurse residency program. As a way to invigorate EBP in the Cancer Center: a committee is formed, under the guidance of the central council, to provide support and guidance to Oncology EBP. The purpose of this project is to describe the committee's mission and goals, its early achievements, and its effect on EBP culture, as evidenced by scholarly work from the Cancer Center. Interventions included recruiting interdisciplinary staff interested in EBP for patients with cancer, creating a charter with a mission; activities, membership, reporting, and delegation of authorities. Monthly meetings with agendas and minutes are held to facilitate EBP projects, review scholarly work, create and provide EBP education, provide organizational support for EBP, and practice EBP together. The committee started in August of 2020, has 23 members, with an average of 15 members attending each meeting. The committee reviewed and approved eleven posters at the hospital's Clinical Practice Summit in 2021. The Cancer Center submitted 65% more posters than in 2019 representing an increase in scholarly work within the department. Education was also developed and disseminated to the staff. There was one session on literature search strategies and PICO question development. A second education topic demonstrated literature and guideline resources available to oncology staff and subsequently, the committee created an oncology-specific search portal highlighting important oncology-related journals and links to evidence-based national and international guidelines. The committee is currently working on an EBP project. The committee continues to provide organizational support, staff education, expert reviews of scholarly work, and a place to learn EBP as a group. This methodology can be repeated in other organizations to improve oncology nursing competency and culture for EBP.

P129 EDUCATION ON THE ONCOLOGY NURSE AND THEIR ROLE DURING INFUSION REACTIONS

Rayna Ewer, BSN, RN, OCN®, UCLA Medical Center,

Santa Monica, CA; Allegra Bell, MSN, RN, OCN®, UCLA Health Santa Monica, Santa Monica, CA; Patti Jakel, Los Angeles, CA

[Oncology Nursing Practice](#)

In the ever-changing world of oncology, it is vital that nurses stay up to date on the latest treatments and the symptom management of those treatments. Immunotherapy, clinical trials, and desensitization are innovative ways to provide groundbreaking treatment to our oncology population, however, these treatments are also accompanied by risk of reaction. Training nurses how to identify, monitor, and properly manage the variety of reactions that accompany these treatments is vital to patient safety. Simulation (SIM) training provides nursing staff with the ability to practice within a safe environment while having hands-on experience. There is an abundant amount of research on the safety and efficacy of desensitization procedures, however there is little to no research on maintaining competencies for front-line staff. Our purpose is to create an in-person simulation course on the process of chemotherapy desensitization and educate front-line nurses on the various reaction types and nursing management of those reactions. SIM training will be provided for staff using real case studies from past root-cause-analyses on patients who had anaphylactic reactions during chemotherapy desensitization. These simulations will include cytokine release syndrome, neuro toxicity, and the different types of hypersensitivity reactions. In addition, we will include how to differentiate these reactions from symptoms of sepsis within the oncology patient. The goal of this proposed project is to increase nurse confidence and knowledge in desensitization/reaction management and to create a standardized process on maintaining competency. A volunteer, anonymous, electronic survey was conducted to collect baseline data on RN's interest and need for simulation training to maintain competencies in the desensitization process. Data for this project is currently still being collected. Lastly, due to COVID-19 restrictions, implementation of SIM may be delayed until regulations are lifted.

P130 BRINGING THAT CALMING PRESENCE: AN INTRODUCTION TO CARING SCIENCE

Elizabeth Fernwood, RN, BSN, Huntsman Cancer Institute, Salt Lake City, UT

[Oncology Nursing Practice](#)

Caring Science, developed by Dr. Jean Watson (2008), provides nurses with new perspectives on

healing as a personal, moral and professional pursuit, delineating micro-practices to enhance care amidst stressful situations. This project introduces Caring Science and provides experiential learning that can be used to de-escalate frustrating situations, either between a nurse and patient, or for nurses in conflict with themselves. Situational stress experienced by patients and nurses managing cancer can lead to disconnection between the dyad, which impedes patient healing and can lead to nurse burnout. This offering is designed to coach participants how to breathe calmly, release emotionally, and develop their intuition. With these skills, nurses can recognize impediments and redirect situations towards healing. In the pilot presentation, participants will be a new graduate cohort of thirty oncology nurses. The presentation will be given in person, in a group setting. This presentation will be structured via Powerpoint®, including an overview of Caring Science and its most pertinent topics, to build foundational understanding. The topics will be extracted from the Caring Science theorem: self-growth, sacred caring, moments of authentic connection, intuitive knowing, and loving-kindness. Dispersed throughout the presentation I will teach box breathing, tapping, visualization, sharing gratitude, and pausing before caring. There will also be group discussions. The presentation will accomplish the goal of introducing Caring Science and teaching micro-practices to resolve situational conflict. It will also offer participants resources to promote nurse resiliency. I will evaluate using Watson Caritas Self-Rating Score®, pre- and post-presentation. The Self-Rating tool measures self-care practices, relationships, and how they promote caring. The presentation may be offered to nurse managers and current nurses, tailored for nurse resiliency in an oncology setting.

P131 DIVERSITY, EQUITY AND INCLUSION

Kimberly Foster, BSN, RN, OCN®, University of Texas MD Anderson Cancer Center, Houston, TX

[Professional Development](#)

In an outpatient ambulatory healthcare setting, the desire to cultivate Diversity, Equity and Inclusion principles among the healthcare team was initiated by Diversity Champions. In 2020 as diversity and race relations in the United States were brought to the forefront by media outlets, the Diversity Champions desired to have open dialogue among team members to better understand our colleagues and

the patients we serve. A group of seven Diversity Champion members from the ambulatory health-care building joined forces to receive extensive training and provide a forum for exploring cultural diversity, equity and inclusion on our campus. The purpose of this project was to create a Diversity Poster Fair to celebrate our diverse workforce and build cultural awareness among team members: (a) Promote Cultural Awareness. (b) Create healthy work environment. (c) Provide Innovative ideas to advance inclusion. (d) Present education. (e) Increase awareness of team dynamics with honest self-reflection on personal beliefs and unconscious bias. Identifying how unconscious bias impacts others. (f) Learn from other perspectives. Diversity Champions met monthly to develop a timeline, discuss objectives, and delegate assigned task to assure success of the Diversity Fair. Additionally, discussion at meetings included networking, exploring feelings and thoughts on courses attended. Sharing cultural beliefs and providing a platform to grow as Diversity Champions for the campus. Individuals and groups of interdisciplinary members submitted posters addressing topics of education, cultural awareness or innovative ideas to advance inclusion. Ninety eight percent of staff members surveyed indicated the poster fair increased awareness of diversity resources available to them as employees. Ninety Five percent of team members indicated they gained knowledge that could improve their customer interactions. Eighty percent of team members surveyed responded that the fair promoted open conversations between colleagues. All team members indicated the poster fair increased their awareness of diversity networks available to them. Diversity, Equity and Inclusion Poster Fair allowed team members to work individually and in groups to research and create educational posters regarding a variety of diverse topics which fostered learning. Implementing a Diversity Fair could contribute to a healthy work environment and improve patient relations.

P132 **VARIATION BELONGS IN THE GENOME, NOT IN HOW THE ONCOLOGY TEAM USES TERMINOLOGY**

Patricia Friend, PhD, APRN-CNS, AOCNS[®], AGN-BC, Loyola University Chicago, Maywood, IL; Kathleen Calzone, PhD, RN, AGN-BC, FAAN, National Cancer Institute, National Institutes of Health, Bethesda, MD; Suzanne Mahon, RN, DNS, AOCN[®], AGN-BC, FAAN, Saint Louis University, St. Louis, MO; Mary Schmitt,

MS, APRN, FNP-BC, AOCNP[®], St. Joseph Hospital, Nashua, NH; Erin Dickman, MS, RN, OCN[®], Oncology Nursing Society, Pittsburgh, PA

Oncology Nursing Practice

Modern science has deciphered the entire human genome and is even learning how to safely edit or alter the genome (e.g., CRISPR gene editing). Genomic applications to health focus on genomic variation and how genomic variants are associated with health and illness. The National Human Genome Research Institute (NHGRI) strategic vision boldly predicts that the clinical relevance of human genomic variants will be “readily predictable” and has launched a consortium (Impact of Genomic Variation on Function--IGVF) to study how human genomic variation impacts genome function, and how such variation influences health and disease. Despite these advances, the “language” of genomic variation has not been fully and uniformly adopted in cancer care. Using outdated terms such as mutation rather than pathogenic variant can lead to errors because the term mutation can mean benign, uncertain significance, and pathogenic genetic changes which have very different impacts on genomic function and disease risk. As a result, there have been misinterpretations by nurses resulting in unsafe care. The Genomics Advisory Board (GAB) of the Oncology Nursing Society is committed to uniform adoption of the three Cs of genomic terminology for oncology practice: current, correct and consistent. The GAB has developed a Call to Action that will be presented to the ONS Board for formal approval. The intended use of the Call to Action is to promulgate the statement for educative purposes as the oncology nursing profession transitions and fully integrates genomic terminology. The Call to Action addresses frequently used terms and provides correct terminology in an effort to reduce error and promote quality care for all. This document is part of a strategic approach to improve genomic literacy in all oncology nurses. As the genomic evidence base continues to expand influencing not just cancer care but all healthcare, it is not surprising that the terminology has also evolved. For example, because of evidence of confusion, in 2015 the American College of Medical Genetics and Genomics recommended the transition from mutation to variant with the associated five tier classification. Despite the challenge of learning and changing familiar terms, implementation of current terminology is essential to avoid misinterpretation which could result in error decreasing the quality of nursing care provided.

P133 IMPLEMENTATION OF A WELLNESS BOARD IN AN AMBULATORY SETTING

Deborah Gibbs, RN, MSN, NE-BC, Karmanos Cancer Center, Detroit, MI; Clara Beaver, MSN, RN, AOCNS®, ACNS-BC, Pittsburgh, PA; Ellen Dillard, MSN, APRN, FNP-C, Karmanos Cancer Institute, Detroit, MI
[Oncology Nursing Practice](#)

At Karmanos Cancer Center nursing care is delivered using the principles of the Relationship-Based care model. One of the principles in the model is care of self; one way organizations can promote a caring environment is by providing self-care initiatives through education. The COVID pandemic has placed additional stressors on staff not only at work, but also at home. Staff expressed an interest in learning more about self-care and requested additional information. At the time, the organization/unit did not have self-care specific information available for the staff. The purpose of this process improvement project was to provide staff resources on self-care initiatives and heighten the awareness of the importance of self-care. A wellness board was created next to the time clock for staff to view. The wellness board has areas to place information related to mindfulness, exercise, and healthy eating with a goal of changing out information monthly. Once created all staff were educated on development and purpose of the wellness board through email communication. The wellness board is updated by various members of the team and all team members are encouraged to add information they find helpful. After the wellness board was created, the staff were encouraged to discuss self-care throughout the day. Some staff have found the board helpful, but unfortunately it has not been as engaging as originally thought. It has been difficult to have additional staff members providing resources for the board as originally thought. The placement of the board is being evaluated to see if it includes all staff (including those that do not punch in with a time clock). Other units throughout the healthcare system are also looking at the use of a wellness board. Self-care is an important part of an oncology nurse's day especially as they deal with the complexity of care related to COVID and restrictions. A wellness board is a method to be able provide education related to self-care and can easily be replicated in other areas. With proper placement the wellness board can encourage staff to think about wellness and how it can easily be integrated into their busy lives. The wellness board can also promote an environment in which the staff feel supported and valued by leadership and other colleagues.

P134 EFFECTS OF CNE EDUCATION ON NURSE CONFIDENCE, KNOWLEDGE, AND PERFORMANCE IN BIOMARKER TESTING AND TREATMENT OF NSCLC

Susan Gitzinger, PharmD, MPA, Creative Educational Concepts, Lexington, KY; Bryan Taylor, PharmD, Creative Educational Concepts, Lexington, KY; Vanessa Carranza, PharmD, Creative Educational Concepts, Lexington, KY; Joan Fowler, PharmD, BCPP, Creative Educational Concepts, Lexington, KY; Jessica Hall, BA, Creative Educational Concepts, Lexington, KY; Vicki Sherry, DNP, CRNP, AOCNP®, University of Pennsylvania School of Nursing, Philadelphia, PA
[Professional Development](#)

The discovery of targetable oncogenes has prompted the development of targeted therapies for NSCLC. These novel treatments have dramatically changed the NSCLC landscape by impacting disease control, symptom palliation, and progression-free and overall survival rates in selected patients. Despite educational efforts to improve practice standards and outcomes in oncology, there remains a large gap between academic cancer centers and community practice, leading to disparities in care. Molecular testing is costly and resource-intensive, but critical to detect oncogenic driver mutations that may respond to targeted therapies. This educational initiative was targeted to oncology nurses and nurse practitioners attending six ONS Chapter meetings conducted in areas of testing disparities as identified per Medicare reporting. The education was designed to ensure an appreciation of the latest advances in NSCLC, including the nurse's role in comprehensive molecular testing strategies and biomarker-driven approaches. Activity participants also explored strategies to improve communication between nurses and patients/caregivers in an effort to promote shared decision-making, reduce adverse events, and improve adherence. Performance and confidence change were objectively assessed by analyzing pre- and post-test results before and after each ONS chapter presentation. Statistical testing between pre- and post-participation were conducted via chi square analysis with a priori significance set at 0.05. 85% of participants stated that they would make a change in practice as a result of attending these activities. There was a 67% increase in those who felt either "Very confident" or "Confident" about biomarker testing in NSCLC. Participants in community settings were twice as likely to have patients that felt uncomfortable waiting for biomarker testing results before starting therapy. Biomarker testing was a topic

nurses felt least comfortable talking to their patients about (43% community vs. 21% academic). Additionally, 44% of academic and 55% of community participants were unaware of how their facility approached biomarker testing at NSCLC diagnosis. This analysis demonstrates that future educational initiatives should also focus on appropriate timing of biopsy and re-biopsy. Baseline knowledge regarding the selection of appropriate targeted therapy based on patient genetic testing results was also fairly low. While there was robust, statistically significant improvement in knowledge for these topics, residual education gaps remain that would be optimally addressed in future educational initiatives.

P135 ONCOLOGY NURSING SHOWDOWN! ONLINE NON-HODGKIN LYMPHOMA GAMESHOW CLOSES KNOWLEDGE GAPS, IMPROVING NURSING MANAGEMENT, CONFIDENCE, AND COMPETENCE IN PATIENT CARE

Elizabeth Heller, PhD, i3 Health, Rochelle Park, NJ;
Keira Smith, BA, i3 Health, Rochelle Park, NJ; Kristin
Wright, PharmD, i3 Health, Rochelle Park, NJ; Sarah
Williams, MAT, i3 Health, Rochelle Park, NJ

Professional Development

The treatment of non-Hodgkin lymphoma (NHL) is constantly evolving, increasing the need for nursing professionals to regularly update their working knowledge in order to provide the best care to their patients. This study was conducted to determine if a live online case-based nursing continuing professional development (NCPD)-approved activity could identify and address gaps in oncology nurses' knowledge regarding the individualized treatment of patients with NHL. The *Oncology Nursing Showdown! Aggressive Non-Hodgkin Lymphoma Edition* at the Oncology Nursing Society 46th Annual Congress was an NCPD-approved 1-hour live online gameshow exploring the latest strategies in nursing management of advanced aggressive NHLs, including diffuse large B-cell lymphoma, mantle cell lymphoma, and peripheral T-cell lymphoma. Learners were given a matched pairs pre- and post-activity assessment consisting of case-based questions that gauged their ability to apply emerging data to clinical decision making. Knowledge gaps and learning gains were calculated based on percentages of learners obtaining correct responses. Significance was assessed using a chi-squared test. Baseline assessment data confirmed gaps in knowledge. Learners' competence increased in the following areas: (a) Risk factors for the development of tumor

lysis syndrome: 40% learning gain. (b) Management of cytokine release syndrome: 34% learning gain. (c) Cancer staging guidelines for mantle cell lymphoma: 32% learning gain. (d) Ibrutinib safety: 54% learning gain. (e) Brentuximab vedotin adverse event management: 64% learning gain. (f) Mogamulizumab safety: 20% learning gain. As assessed using Likert scale data, 89% of learners who completed the evaluation (n=95) felt more confident in treating their patients with NHL after the activity. In addition, 89% of learners who completed the evaluation felt that the material presented would be used to improve the outcomes of their patients with NHL. Responses on the pre-activity assessment demonstrate some notable areas of educational need, especially with regard to brentuximab vedotin adverse event management (12.50% correct responses) and ibrutinib safety (26.79% correct responses). The statistically significant improvements in competence seen on the case-based assessment questions, as well as gains in self-perceived competence and confidence in treating patients with NHL, show the importance of NCPD for oncology nurses and the educational benefits of a live, interactive online format.

P136 ORAL CHEMOTHERAPY ADMINISTRATION AT HOME: A LITERATURE REVIEW

Cynthia Huff, DNP, RN, MSN, OCN®, CRNI, CNL, University of San Francisco, San Francisco, CA, and Long Beach Medical Center/MemorialCare, Long Beach, CA
Patient Education and Safety

Oral chemotherapy agents require the same safe handling considerations in the home setting as in controlled health care settings. Effective home management strategies emphasize caregiver protections, proper storage, safe administration, spill management, and proper waste disposal to reduce the risk for hazardous drug exposure. A literature review was performed in the following databases: CINAHL, Cochrane Library, SCOPUS, and PubMed. The search terms included hazardous drugs (HD), safety standards, and oral chemotherapy. After reviewing 27 articles published from 2011 to 2019 using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses, seven articles met the inclusion criteria and were synthesized. Articles were excluded if they focused on HD administration in the hospital setting, other forms of chemotherapy, anesthesia HDs, or occupations outside of healthcare. Articles were included if they focused on (a) documented HD residue contamination in the home, (b) patient and caregiver

education on oral chemotherapy, and (c) standards of care for oral chemotherapy. An oral chemotherapy safe-handling checklist for healthcare providers to use when teaching patients and caregivers was developed by the author based on best practices found in the literature. The tool, "Oral Chemotherapy Home Safety Education," provides a framework for nurses to educate patients on HD administration and safe handling measures. A patient and caregiver teach-back tool was developed and named "TIPS for Administering Oral Chemotherapy at Home." Nurses may refer to the safe handling checklist and teach-back tool in all healthcare settings when demonstrating how to administer/properly dispose of an oral chemotherapy medication. Developing educational tools aimed at standardizing nurses' patient education content and increasing patients' and caregivers' knowledge of and skills and confidence in the safe handling of oral chemotherapy agents at home can also improve the safety of caregivers and the environment.

P137 **LEADING THE WAY TO EXCELLENCE THROUGH CLINICAL PRACTICE AND EDUCATION AT A COMPREHENSIVE CANCER CENTER**

Michelle Johann, MSN, RN, PHN, CPAN, City of Hope, Duarte, CA; Peter Hirsch, BSN, CNOR, City of Hope, Duarte, CA

Professional Development

Providing education to a multidisciplinary team can be challenging. Thereby supporting an area that encompasses various levels of expertise requires a multimodal approach in education. The many facets of an educational platform should be evaluated and adjusted to meet the needs of the staff. Hence, the development of an inclusive education calendar timeline. This calendar includes scheduled monthly educational topics that meet regulatory and mandatory requirements. The classes range from Code Blue, Medication/Drug Diversion, and Malignant Hyperthermia to Fire and Chemotherapy safety. Scheduled monthly educational programs for a multidisciplinary team in an acute Oncology Comprehensive Cancer Center are beneficial to both the learner and facilitator to promote priority and accountability. The purpose of the education calendar is to prioritize educational topics so that staff members can plan for and rely on clinical support for growth and development. Aligning current clinical practice with educational topics will ensure participants meet the needs of our complex oncology patient population. Education is a significant

component to evidence-based best practice is met and promoted. A clinical practice schedule that includes meaningful topics will guarantee the accountability of new knowledge compliance. Each month a clinical topic(s) is selected, prioritized, and scheduled. This department calendar provides staff with structure and a systematic method to meet educational needs. Periodically staff is required to submit an educational needs assessment survey. This survey identifies a variety of educational opportunities for staff. The educational topics that scored the highest level were listed to be at the forefront. Upon further evaluation of the data collected, the option that was clear to improve staff knowledge and clinical expertise were to create an education calendar with a delineated timeline that is necessary to target and meet the needs of staff to provide optimal care to our complex oncology patients. Education is a necessary component in developing knowledge and expertise for staff members to function with evidence-based-driven clinical practice. A calendar with scheduled monthly educational programs provides staff with consistency and repetition for generalized and specialized educational oncology care training. The new method of educating oncology nurses by developing a clinical practice calendar timeline supports professional growth for staff and creates an evidence-based-care environment for patient safety and centered care.

P138 **LEADERSHIP INSPIRED PSYCHOLOGICAL RESILIENCE FOR ONCOLOGY CLINIC NURSES DURING COVID**

Deborah Johnson, MNSc, NE-BC, UAMS Medical Center, Little Rock, AR; Rowena Garcia, BSN, MBA, CNML, UAMS Medical Center, Little Rock, AR; Haley Gass, MSN, RN, UAMS Medical Center, Little Rock, AR; Crystal Huddleston, MSN, RN, UAMS Medical Center, Little Rock, AR; Mallory Brown, BSN, UAMS Medical Center, Little Rock, AR; John Danny Payne, BSN, RN, UAMS Medical Center, Little Rock, AR

COVID-19

Covid has drastically changed healthcare delivery processes especially nurses. Covid impacts them psychologically, physically, and emotionally. They disassociate from the empathetic, caring nurses to provide the best care under abnormal times bringing about staffing shortages. Leaders have to be supportive both emotionally and physically (by staffing), along with other duties. This has taken a toll on leaders and staff nurses. Leaders have to display supporting attributes that lead to nurses being psychologically resilient

during the pandemic. The purpose of this retrospective quantitative study is to acknowledge specific staff identified attributes transformational leaders need to improve nurses' psychological resilience leading to retention. Using the data from a validated 360 Leadership evaluation yielded attributes that staff value as significant. Therefore, applying these attributes during staff exchanges such as huddles, rounding, staff meetings, and 1:1 interactions continues to show support during the pandemic. Furthermore, the adoption of transformational leadership remains a focus of the institution to help improve nursing resilience. Questions were randomized from the survey. Each participants' score from the questions were averaged to comprise the overall result indicating the value in transformational leadership attributes. The literature review regarding correlations between pandemic effects on staff morale and support interventions by institutional leadership was used in combination with data from an internal survey. The survey evaluated staff perception of leadership identifying the need for leadership driven strategies to support staff during and after pandemics. The study is substantiated by growing data showing nurse burnout, career changes, and early retirements, leading to nursing shortages during a pivotal time. Using information collected in the study, the need for support is more evident. Leaders using transformation support strategies also help with retention making psychological resilience achievable and necessary.

P139

ASSESSING HEALTH SYSTEM ONCOLOGY SERVICES DURING A PANDEMIC: VIRTUAL CONSIDERATIONS AND REDESIGN

Patricia Johnston, DNP, RN, OCN®, NEA-BC, The University of Texas MD Anderson Cancer Center, Houston, TX; Cynthia Powers, DNP, MS, RN, City of Hope, Duarte, CA; Julie Segovia, DNP, RN, NEA-BC, The University of Texas MD Anderson Cancer Center, Houston, TX; Marvetta Walker, MHA, BSN, RN, The University of Texas MD Anderson Cancer Center, Houston, TX; Shauna Choi, PharmD, The University of Texas MD Anderson Cancer Center, Houston, TX; Deborah Kuban, MD, The University of Texas MD Anderson Cancer Center, Houston, TX

COVID-19

A comprehensive cancer center, located in the southeast, is actively engaged in establishing a network of strategic partnerships across the country with the intent of promoting access to specialized oncology expertise and offering patients novel clinical trial op-

portunities closer to home. Prior to COVID-19, due diligence/quality assessments of potential partners were completed on-site requiring multiple interdisciplinary teams to travel to the institution. With the onset of the pandemic, business travel was suspended, predicating the need to rapidly transition to a new assessment strategy. There was an immediate need to design and implement a comprehensive alternative that would concurrently facilitate the assessment processes while meeting the rigorous demands of quality assurance needed to move forward with a potential partner relationship. Multidisciplinary collaborative teams to include nursing, pharmacy, medical oncology, surgical oncology, radiation oncology, radiology, pathology, cancer support services, research and quality representatives met over several months to redesign assessment processes and transition to a virtual methodology. Teams utilized videos of key elements and virtual discipline specific assessment meetings to serve as a surrogate for the on-site strategy. Supportive tools were developed to provide the potential partner with additional guidance needed to navigate the process. Two virtual health-system assessments were then completed with overall success and client satisfaction. Efforts resulted in improved efficiency and process effectiveness, significant savings of travel and personnel time, and broader engagement by both parties. The need to manage all elements of the assessment process virtually fundamentally altered the way the institution viewed this essential element in the potential partner evaluation process. Video production was felt to be time consuming for the partner including details such as hazardous drug compounding, management of patient infusion areas, and clinic workflows. Challenges were also encountered in developing initial relationships due to the lack of in-person contact. Therefore, once COVID travel limitations are lifted, it is anticipated that future partner assessments will likely be a blended strategy of virtual and in-person visits which will both efficiently assess quality while building initial interpersonal relationships. Development of a new strategy for data gathering and management of the quality assessment process has allowed the organization to broaden its perspective, enhance efficiency, and thoughtfully seek new ways of learning.

P140

BUILDING AND IMPLEMENTING AN ONCOLOGY CONTINUING EDUCATION SERIES FOR NURSING

Kylie Kuck, MSN, AGCNS-BC, Smilow Cancer Hospital at Yale New Haven, New Haven, CT; Evanica

Rosselli, BSN, MSN, OCN®, Yale New Haven Hospital,
New Haven, CT

Professional Development

The Commission on Cancer (COC) requires that oncology nurses hold an oncology certification or complete 36 Continuing Education (CE) credits specific to cancer care over 3 years. Additionally, nurses who are currently certified are required to maintain CE's for certification renewal. The Oncology Nursing Professional Development Specialists (NPDS) implemented an oncology continuing education series to offer nurses CEs monthly. Nurses hired to any oncology unit throughout the health care system are enrolled in a series of oncology classes as part of their orientation. However, there was not an opportunity within the organization for experienced nurses to participate in oncology specific educational opportunities. By implementing a monthly continuing education series, nurses of all experience levels and in different roles are able to participate and earn CEs while promoting professional development. Each NPDS signed up for one month to facilitate the series, chose their topic based on their expertise or personal interest, and created their own content or activity which was presented virtually. Day sessions were held twice monthly on different dates and times to target the most staff. The off-shift NPDS offered night sessions to target staff from four system hospitals. The continuing education series was submitted and approved for 1 CE per session. An electronic survey was created to capture participation and allow the NPDS team to collect data. Overall, 100% of participants answered "yes" when asked "As a result of this activity, I was able to increase knowledge of oncology nursing care." Staff were also asked to share at least one action they will take to change their professional practice as well as general comments and suggestions for future topics. After 2 months, 21 CEs have been awarded. The continuing education series has been well received by nurses within the system. Non-nurse participants have started to join sessions to further their oncology knowledge. Optimal day and times for sessions continue to be evaluated to increase participation. The sessions utilize a virtual platform and incorporated interactive activities such as annotation, polls, and discussion. Nurses use the sessions to network with other care centers in the system and share experiences and best practices. The NPDSs highlighted their areas of expertise and are able to interact with other nurses and staff outside their covered units and locations.

P141 IMPLEMENTATION OF A VIRTUAL ONCOLOGY RN TRANSITION TO PRACTICE PROGRAM

Julianne Luttrell, MS, RN, CNL, NPD-BC, Providence,
Renton, WA

Professional Development

Social distancing requirements from COVID-19 had a significant impact on the ability to conduct in-person training and drove an increased need to offer nursing staff education through online formats. Our large multi-state healthcare system had an existing Oncology RN transition to practice program that included online modules, classroom didactic, and in-person simulation. Our team of RN program managers adapted the program to a virtual Oncology RN Residency (new graduate) and Fellowship (new to specialty) option. We incorporated 3 content delivery modalities into the program depending on each educational objective: (1) asynchronous virtual - learners complete work online independently, (2) synchronous virtual—learners are "in class" online at the same time with a class facilitator, and (3) synchronous live—small groups of learners are in a classroom or sim lab in-person. The synchronous live option was reserved for those objectives that require a demonstration of a skill. In addition, we created a virtual simulation option. We incorporated best practices for virtual learning and utilized an online platform designed for education. We also created facilitator guides and training resources for our educators to quickly get up to speed on facilitating virtual education which may be unfamiliar to many Nursing Professional Development Practitioners (NPDs). Our initial pilot in summer of 2020 included a cohort of 18 oncology RN residents and fellows. Feedback from both facilitators and participants was positive. Since that time the virtual program has been extended to other facilities within our system and 260 learners have been enrolled. A recent participant commented "Even though most classes were virtual, I feel that all of the instructors were fully prepared and kept everyone engaged in class. It was never boring. I believe virtual classes is a good platform for online meetings." Use of a virtual learning platform to facilitate an Oncology transition to practice program is of great value when limitations are placed on in-person learning. In addition, cohorting learners from more than one facility together can be accomplished through the virtual format and optimizes the use of limited nurse educator resources.

P142 **REFLECTIVE PRACTICE FOR DEALING WITH** **EMPATHIC DISTRESS IN NEW RESIDENT** **ONCOLOGY NURSES**

Dana Malick, MN, RN, CMSRN, Seattle Cancer Care Alliance, Seattle, WA; Amanda Hansen, MDiv, BCC, CT, Seattle Cancer Care Alliance, Seattle, WA; Briana Sanger, MSN, RN, OCN®, Seattle Cancer Care Alliance, Seattle, WA; Kathleen Shannon Dorcy, PhD, RN, FAAN, Seattle Cancer Care Alliance, Seattle, WA

Oncology Nursing Practice

When encountering death and suffering in oncology clinical practice, new resident nurses experience job-related distress such as compassion fatigue, empathic distress, and burnout. All of which contribute to lack of job satisfaction and failure to succeed in transition to professional practice. Literature reviewed demonstrated reflective practices have a positive effect on nurses' well-being and decrease the effects of work-related distress. Our large NCCN designated academic oncology center did not offer education to address this empathic distress syndrome. The purpose of this project was to create an interdisciplinary CE accredited class to demonstrate skills of reflective practice for new resident oncology nurses to strengthen their capacity to deal with empathic distress. An experienced oncology nurse in her graduate studies researched issues relative to new resident oncology nurse retention. Empathic distress was identified as a key factor. She collaborated with the spiritual care team to develop a 60-minute curriculum on reflective practice. The course was team taught by a nurse and a chaplain, in a virtual-live and recorded for on demand viewing format. Nurses (n=33) and resident nurses (n=1) from inpatient and ambulatory units comprised the audience. Feedback highlighted the importance of reflective practices in all clinical nurse practice. The provision of tools for reflective practices such as mindfulness, self-compassion, and grief rituals were identified as valuable. The collaboration between chaplaincy and nursing was seen as most useful in role modelling professional teamwork in addressing empathic distress. This presentation on reflective practice is now integrated into the basic orientation to all new resident oncology nurses at our large academic center. All staff accessibility to learning self-care techniques, such as reflective practices, have been found to alleviate the symptoms of compassion fatigue, empathic distress fatigue, and burnout and so improve oncology care outcomes. Collaborative efforts between oncology experts are essential components for education and support on

death, suffering, and empathic distress for nurse residents' orientation as well as all staff.

P143 **TREATMENT OF TRIGEMINAL NEURALGIA** **WITH STEREOTACTIC RADIOSURGERY**

Kathleen Maloney-Lutz, MSN, RN, OCN®, CNRN, NYU Winthrop Hospital, New York, NY; Maureen Oliveri, MSN, RN, NYU Winthrop, Mineola, NY; Jennifer Gillespie, BSN, RN, NYU Langone, Mineola, NY; Lorelyn Tirado, RN, NYU Langone Long Island Hospital, Mineola, NY

Professional Development

Trigeminal Neuralgia (TN) is a rare, non-malignant central nervous system condition affecting one or more branches of the fifth cranial nerve, the trigeminal nerve. The occurrence of TN is extremely rare. TN is primarily unilateral; however, there are rare cases of bilateral TN. Pain is the predominant presenting symptom, consisting of sudden, stabbing, burning, aching sensations which can become debilitating. TN is a progressive condition initially presenting with periodic attacks lasting for brief periods followed by asymptomatic periods. As TN progresses the gap between occurrences may become shorter, and the pain intensifies. Unfortunately, pain medications only provide minimal relief, if any. Stereotactic radiosurgery is an effective treatment modality for TN; however, a cisternogram is necessary for planning treatment. The CT-cisternogram examines the cisternal portion of the trigeminal nerve, which is the treatment target. Radiation oncology is seeing an increase in TN cases. Stereotactic radiosurgery offers pain relief with minimal side effects for these patients. It was determined that nurse and patient education needed to be reviewed in order to provide excellent nursing care to this increasing patient population. One radiation oncology nurse, with a background in neurology, conducted informal educational sessions for the newer nurses unfamiliar with TN. Once this education was complete, a standardized way of educating the patient was discussed. Educational sessions with the patient include the process of obtaining a CT-cisternogram to be used for treatment planning; the immobilization device the patient would wear during treatment, and the radiation treatment itself. Pain assessments occurred during each patient appointment utilizing the 0-10 Numerical Pain Rating Scale. This assessment included pain level, location, type, interventions performed and result, assessment of known triggers, and a neurological exam. Data reviewed from 2016-2021, demonstrated an increasing number of these patients receiving stereotactic radio-

surgery for TN, one presenting with bilateral TN. Prior to initiation of treatment, pain scores averaged 8/10. One-month post-treatment pain scores averaged 1/10, and patients described shorter episodes with longer intervals between pain occurrences. Radiation oncology nurses are integral in the care of patients with trigeminal neuralgia. Patients rely on nursing expertise to guide them from consult through to post-treatment care. The nurses continually reinforce their knowledge of TN to improve patient understanding of the entire radiation process.

P144 USE OF NURSING INTRODUCTORY PHONE CALL FOR NEW PATIENTS APPOINTMENTS AT THE RUSH UNIVERSITY CANCER CENTER RESULT IN LOWER CANCELLATION RATES

Sharon Manson, RN, MS, ACNP, OCN®, Rush University Medical Center, Chicago, IL; Mary Ellen Hand, BSN, RN, OCN®, Rush University Medical Center, Chicago, IL; Candace Moore, RN, BSN, Rush University Medical Center, Chicago, IL; Nicole Marcheschi, RN, BSN, Rush University Medical Center, Chicago, IL; Michelle Stamp, RN, MSN, OCN®, Rush University Medical Center, Chicago, IL; Maggie Gladman, RN, BSN, Rush University Medical Center, Chicago, IL

Coordination of Care

In July of 2020, following significant financial losses secondary to the Covid pandemic, physicians were asked to see any new patient within one workday. Obtaining pertinent medical records is critical to a new oncology patient appointment and this was unachievable in that timeframe. As a compromise, a decision was made to have oncology nurse navigators attempt to contact these patients within 1 workday. This became commonly known as the twenty-four (24) hour call. The goal of the 24-hour call was to establish personal contact, assess patient needs, alleviate anxiety, ensure the patient was scheduled with the correct provider, and to explain covid precautions in the facility. Nursing assessed if the patient was medically stable to wait until scheduled appointment date and if they agreed to the date. Physicians were consulted to rearrange the date of appointment, if indicated. Information technology (IT) built a work-queue identifying patients that scheduled a new patient appointment. Nursing leadership assisted navigators in utilization of the work-queue and establishing filters for their team. Additionally, a smart text was built for the electronic medical record which created a script for assessment and more rapid documentation. To evaluate the nursing time invested for this initiative, the nurses were asked to select a

pre-determined field at the end of the encounter, documenting the time required to complete the activity. This EMR documentation was built with reportable fields. Standard work was created. Nurses were asked to attempt calls within one day, to leave a direct phone number for return calls if unable to reach the patient and to make at least two attempts to reach the patient. Small adjustments were made to the process over time for patients in which the call did not seem indicated. After 11 months of the introduction of 24-hour calls, 6975 new patients had scheduled appointments. 72% of patients received attempted calls. 35% of those did not answer the call. When reviewing cancelled appointments, 89.9% of patients that had phone contact were rescheduled and seen by a provider compared to 50.5% of patients that did not get a call, or the patient did not accept the call. The average length of the phone call and documentation was reported to be 11 minutes.

P145 HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY: IMPLEMENTATION & EDUCATION FOR THE NON-ONCOLOGY HEALTHCARE WORKER

Christina Matousek, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT; Evanica Rosselli, BSN, MSN, OCN®, Yale New Haven Hospital, New Haven, CT; Lisa Barbarotta, MSN, APN-BC, AOCNS®, Yale New Haven Hospital, New Haven, CT; Amanda Luyckx, MSN, RN, CCRN, Yale New Haven Hospital, New Haven, CT; Dana Clifton, Med, LSS GB, LSS BB, Yale New Haven Hospital, New Haven, CT; Carolina Pires-Dionisio, BSN, RN, Yale New Haven Hospital, New Haven, CT

Oncology Nursing Practice

Hyperthermic intraperitoneal chemotherapy (HIPEC) is an intraoperative procedure where a patient with peritoneal surface malignancies receives chemotherapy during intensive cytoreductive surgery. The treatment exposes the peritoneum to chemotherapy and targets microscopic disease that cannot be surgically removed. Utilization of HIPEC was new to our institution, requiring implementation of new workflows and chemotherapy education to operating room and surgical intensive care unit (SICU) staff. The purpose of this project was to implement a HIPEC program while maintaining consistency and compliance with existing chemotherapy safety standards. Our team utilized a multidisciplinary approach when developing workflows and education. Partnership was established with operating room leadership, nursing professional development specialists, pharmacy, perfusion, anesthesia,

environmental services, outpatient oncology nursing, SICU leadership, and materials management to develop workflows. Educational materials and in-services were provided to involved staff. There were multiple, hands-on practice sessions with pertinent team members starting with identification of patients through transfer to SICU. This allowed team members to become familiar with equipment, expectations, and precautions required to care for the HIPEC patient. Adjustments were made during debriefs of mock cases. Efficient ways to communicate were developed to prevent breakdowns in the established process. During initial HIPEC cases, oncology education team members observed the procedure, answered questions, and ensured compliance with the established workflow. Our team concluded that teaching methods were successful by utilizing teach-back method and direct observation. There have been six HIPEC cases since the start of our program with zero safety events reported. Collaboration between departments improved knowledge and safety of non-oncology healthcare workers while caring for HIPEC patients. The HIPEC initiative has revealed other neoplastic drugs given intraoperatively that require workflow updates to maintain safe practice. Our teams are currently aligning safe handling policies across the operative setting. Our communication methods continue to be improved upon based on feedback from the multidisciplinary team. Implementation and education of the HIPEC procedure required an innovative, interdisciplinary approach which included in-person and virtual education. We sought to align our existing chemotherapy policy and standards with the HIPEC workflow. In addition, we implemented a second intraoperative pause prior to drug administration, which allows each team member to raise concerns, ask questions, and don personal protective equipment. Our innovative methodology ensured the safety of both patients and staff.

P146 **MAKING AN ONDEMAND OPTION FOR A LIVE CHEMOTHERAPY COURSE**

Rebecca McClelland, MSN-Ed, RN, OCN®, UPMC Hillman Cancer Center, Pittsburgh, PA
[Professional Development](#)

The world is rapidly changing, and the world of education is moving right along with the rest of the world. On demand learning, remote education, and technology driven educations are becoming a norm, which means nursing education has to keep up with

the educational trends to best teach nurses to care for patients in these changing times. This kind of innovation led University of Pittsburgh Medical Center (UPMC) Hillman Cancer Center (HCC) Department of Professional, and Patient Education strive to offer an OnDemand version of a live chemotherapy course required for staff orientation. UPMC HCC is comprised of outpatient cancer centers across Pennsylvania, Ohio, New York, and Maryland. UPMC HCC along with UPMC hospitals across the region offer a quarterly live course on chemotherapy with a test and UPMC certification for our healthcare professionals when the course is completed. Problems arise when a nurse is hired in between the quarterly courses making the staff member unable to administer chemotherapy until they have completed the course. The course director for the quarterly Chemotherapy and Biotherapy courses reached out to the UPMC Center for Continuing Education in the Health Sciences (CCHES) team to see if it was possible to make a completely on demand course within the system. The CCHES team agreed an on demand course would be an asset. Along with the CCHES team, the course director for the Chemotherapy and Biotherapy course began the process to build this new education module. Recordings were made from all lectures within the chemotherapy class to maintain consistency in learning and added to the new course. Pre-course and post-course instructions were made and recorded for the on demand course along with certificate and evaluation. The new OnDemand Chemotherapy course was ready to be tested. Several UPMC HCC nurse managers, educators and nurses were recruited to evaluate the course for content and ease. All feedback was positive, and the program is set to begin in September 2021.

P147 **NALOXONE TRAINING: AN OPPORTUNITY FOR ONCOLOGY NURSES TO SAVE LIVES**

Gretchen McNally, PhD, ANP-BC, AOCNP®, The Ohio State University James Cancer Hospital, Columbus, OH; Eric McLaughlin, MS, Center for Biostatistics, The Ohio State University, Columbus, OH; Robert Baiocchi, MD, PhD, Internal Medicine Division of Hematology, The Ohio State University, Columbus, OH; Robin Rosselet, DNP, RN, CNP, AOCN®, The Ohio State University College of Nursing, Columbus, OH
[Oncology Nursing Practice](#)

Overdose deaths have increased during the Covid-19 pandemic, likely attributed to fentanyl, a synthetic opioid. Naloxone is a harm reduction strategy, and

similar to a fire extinguisher, to be used in emergencies. If administered in time, naloxone can reverse an opioid overdose. A hospital-wide survey of multidisciplinary oncology healthcare providers evaluating experiences and knowledge related to opioid use disorders (OUDs) was distributed via email over a 4 week time period in early 2020. This abstract focuses on naloxone administration and nurses, including Advanced Practice Providers (APPs). The total possible sample was ~1560 participants (~360 APPs and ~1200 nurses). The final sample included 180 APPs and 518 nurses (n = 698). The response rates were 50% for APPs and 43% for nurses. The mean age for nurses was 38.4 (SD 11.4) and 40.2 (SD 10) for APPs. A greater percentage of participants were female (n = 641, 91.8%) and White (n = 631, 90.4%). Overall, 49.7% of nurses (n = 257) and 62.3% of APPs (n = 112) had worked in oncology for > 5 years. Participants were asked to respond to the following statement: "I feel comfortable administering naloxone in the community". A greater percentage of APPs (39.4%, n = 69) compared to nurses (29.1%, n = 145) answered no. Overall, the majority of nurses (n = 201, 40.4%) and APPs (n = 71, 40.6%) answered "Yes- I would feel comfortable with training". Nurses (n = 309, 64.2%) and APPs (n = 104, 60.1%) were interested in attending a naloxone training class. Many oncology nurses and APPs would feel comfortable administering naloxone in the community with training, and the majority are interested in attending a naloxone training course. This represents an opportunity for oncology nurses and APPs to positively impact the opioid epidemic, for not only patients affected by cancer, but there may be a positive trickle-down effect on families and communities. Incorporating naloxone training as a continuing education opportunity for oncology nurses and APPs, and may increase knowledge, decrease addiction stigma, and ultimately save lives.

P148 PIVOT! TRANSITIONING FROM IN-PERSON ANNUAL TRAINING TO INTERACTIVE, ASYNCHRONOUS EDUCATION DURING THE COVID-19 PANDEMIC

Jessica Miles, MS, RN, CNS, AOCNS®, UC Davis Health, Sacramento, CA

[Professional Development](#)

Asked to go above and beyond during the COVID-19 pandemic, nurses were left with little time for continuing education and development of skills. Historically, the unit hosts an annual in-person 'Skills Day'; however, in-person large group meetings were limited by the health system to minimize the spread of COVID-19.

The aim was to facilitate annual nursing education for 80 nurses on an oncology/BMT unit, while complying with pandemic restrictions. With this goal, unit leadership devised QR code-enhanced interactive education posters. Topics were determined based on unit quality goals, mandated education, and feedback from Clinical Nurse IIIs (CNIIs). In total, five poster topics were chosen, including allogeneic transplant, autologous transplant, CAR-T cell therapy, infection prevention, and mobility assessment. Poster content was developed by the CNIIs and Clinical Nurse Specialist, in collaboration with subject matter experts. Each poster included a scannable QR-code linking to a 5-10 question quiz, using digital survey software. If any questions were answered incorrectly, the survey alerted the RN and directed them back to the poster for review to re-attempt the question. Posters were displayed on the unit over a two week period in May 2021. Nurses were allowed up to 2-hours of paid time to complete the activities. In total, 100% of nursing staff (n=80) completed the 2021 skills day successfully. Feedback on the QR-code enhanced posters was overwhelmingly positive. For example, 99% (n=77) of staff reported the online quizzes were easy to access and complete, and 95% reported they learned new knowledge/skills. All staff (100%) reported the information was relevant to their practice and quiz questions were appropriate to the information presented. In evaluation comments, staff endorsed the flexibility of the asynchronous posters and the ability to self-pace content review. Utilizing QR-code enhanced posters embedded with quizzes allowed for interactive annual education of a large group of staff at the height of the pandemic. Integrating these self-paced learning strategies into traditional demonstrative skills stations and lectures appeals to a range of learning styles, optimizing engagement and comprehension. Digital survey software and QR-codes enhanced the traditional poster knowledge translation format, transforming a passive education tool into an interactive activity, providing real-time feedback, and ensuring that staff left the activity with accurate comprehension of the content.

P149 DEVELOPMENT OF AN ONCOLOGY SPECIFIC NURSE RESIDENCY PROGRAM

Jennifer Missland, MSN, RN, OCN®, CCRN, Roswell Park Cancer Institute, Buffalo, NY; Heather Huizinga, MSN, RN, OCN®, Roswell Park Cancer Institute, Buffalo, NY

[Professional Development](#)

Having an oncology specific nurse residency program is crucial to supporting new nurses transition-

ing to practice. In 2015 staff nurses noticed a need for additional education and encouragement and development of emotional resiliency of new graduate oncology nurses. Nursing Professional Development created a 6-month program to meet this need. The program was redesigned in 2018 to incorporate the Vizient transition to practice model. After initiation the program leadership recognized a need for more oncology specific topics and adapted the program to address these shortcomings. In 2021 the program was accredited with distinction as a practice transition program by the ANCC. The purpose of this project was to develop and provide expanded knowledge of the oncology nursing practice to support oncology nurses as they transition to practice. All new hired nurses with less than 1 year of experience are enrolled in the program. They are required to meet monthly in four-hour increments for 12 months. Topics include oncologic emergencies, ethics, end-of-life care, symptom management, disease specific topics, self-care and resiliency, delegation, and prioritization, and are required to submit an evidence-based practice project at graduation. The residency program has demonstrated improvements in nursing satisfaction, nursing retention, and eased the transition to practice for new nurses. Based on resident monthly evaluations the program leadership recognized a need for redesign to incorporate more oncology topics and develop part of the program to include resiliency as the compassion fatigue was becoming increasingly evident. Feedback from previous and current resident cohorts, including oncology specific education into their transition to practice program has increased emotional resiliency and elevated their comfort in caring for this specialized scope of nursing. This program is specialized to meet the needs of new graduate oncology nurses and stands out from other transition to practice programs. The support and education continue to grow and develop monthly in line with evidence-based practice and nursing oncology research.

P150 ENRICHING THE PROFESSIONAL DEVELOPMENT OF ONCOLOGY CLINICAL NURSES SERVING AS CO-INVESTIGATORS IN A VIRTUAL REALITY RESEARCH STUDY

Kacey Morgan, BSN, RN-BC, Helen F Graham Cancer Center, Newark, DE; Camille Mahoney, BSN, RN, OCN®, Helen F Graham Cancer Center, Newark, DE; Kristina Sten, BSN, RN, OCN®, Helen F Graham Cancer Center, Newark, DE; Susan Birkhoff, PhD, RN, Univer-

sity of Pittsburgh, Pittsburgh, PA, and ChristianaCare, Newark, DE

Professional Development

Patient-centered technology designed to meet the health related needs of individuals with cancer is surging, as technology becomes more embedded in their care. Because of this surge, there is a tremendous opportunity for oncology nurses to partner with nurse scientists to discover which technologies may have a positive impact on oncology care and nursing practice. This collaboration strengthens the professional development of oncology nurses while simultaneously striving to improve oncology care. The purpose was to enrich professional development activities for outpatient oncology nurses when partnered together with a nurse scientist to co-investigate a nurse-led intervention using a virtual reality experience for individuals preparing to undergo radiation treatment for the first time. Limited options exist for outpatient oncology nurses to invest in their professional growth and scholarship. When presented with an opportunity to create a customized virtual reality experience and to build a study protocol with a nurse scientist, the oncology nurses provided their clinical expertise and knowledge to ensure a successful end product and study launch. Because this was a new endeavor for the oncology nurses, they sought to garner department-wide support before participating in this opportunity. They met weekly with the nurse scientist building the study protocol together and leading the effort to edit the virtual reality video for content, context, and clarity. This partnership resulted in a successful launch of an Institutional Review Board approved virtual reality study evaluating the impact of patients' emotional wellbeing, as well as provided a profound professional investment in oncology nurses' scholarship and development. Having nurses involved as co-investigators brought a much needed awareness about their critical role in creating and testing technology designed to impact patient experiences. Successfully developing, planning, and executing a technology focused study afforded outpatient oncology nurses an opportunity to use different skillsets that supports patient care and experiences with a new and innovative approach. As co-investigators, they could also leverage their clinical expertise about patients and oncology care that is often underutilized in clinical research. Investing in oncology nurses' professional development through scholarship leads to a deepening understanding of nursing science which ultimately impacts nursing practice and patient outcomes. Offering virtual reality experiences is a cutting edge modality to enhance patient education.

P151 CREATION OF A STEP-DOWN UNIT THROUGH THE UTILIZATION OF NEWLY TRAINED CRITICAL CARE NURSES DURING THE COVID-19 PANDEMIC

**Kelly O'Sullivan, BSN, RN, PCCN, Memorial Sloan
Kettering Cancer Center, New York, NY; Jamie
Granieri, MSN, RN, CCRN, Memorial Sloan Kettering
Cancer Center, New York, NY**

Coordination of Care

At this 514 bed New York City Magnet recognized, NCI-designated Comprehensive Cancer Center the COVID-19 pandemic had a significant impact on the oncology population, propelling the creation of a formalized step-down unit (SDU). At the start of the pandemic, it was identified that more intensive care unit (ICU) beds were needed to accommodate the surge of critically ill COVID-19 patients. The thoracic surgery unit was identified as the target unit for overflow of ICU beds. The thoracic surgery nurses were sent to a critical care bootcamp class for didactic education, focusing on the evidenced-based practice guidelines for critical care nursing. While caring for the critically ill COVID-19 patients, the surgical oncology nurses worked alongside ICU registered nurses (RNs) to expand on their newly gained knowledge and refine their critical care skills. Real time education was provided, focusing on drip titration, arterial lines, and advanced airway management. As the number of COVID-19 patients declined, there was an recognized need to maintain these critical care beds within the institution. A decision was made to permanently transition the thoracic surgery unit to a step-down unit (SDU). Two new critical care services were created to function as an extension of the ICU. SDU team C focused on patients requiring vasopressor support and/or sedatives, while SDU team D focused on patients with tracheostomies requiring mechanical ventilation. The newly created critical care services allowed our oncology patients to receive higher levels of care, without being admitted in the ICU. From July 2020 to July 2021, SDU-C had 319 admissions, with 23% of the patients admitted from ICU. Within this same time frame, SDU-D had 34 patients admitted, with 88% of them admitted from ICU. This data revealed the need for additional critical care beds. Creation of this step-down service has allowed the institution to decant the ICU and assist with patient flow needs. To assist with the transition of these two critical care services, a standard of care was created by an expert-level nurse in collaboration with nursing leadership, to guide the nurses and advanced practice providers with admis-

sion criteria and frequency of nursing care. The newly created SDU allowed for nurses to retain their critical care knowledge, while simultaneously allowing for closer monitoring for our oncology patient population.

P152 AN IMPLEMENTATION OF A PHASED APPROACH ONCOLOGY TRAINING PROGRAM FOR EXPERIENCED REGISTERED NURSES

**Joy Octaviano, MS, RN, CNS, AOCNS®, OCN®, Stanford
Health Care, Stanford, CA; Yuliya Behey, MSN, RN,
OCN®, BMTCN®, Stanford Health Care, Stanford, CA;
Tashawa Williams, BSN, RN, OCN®, Stanford Health
Care, Stanford, CA**

Professional Development

High quality and safe patient care are the utmost priorities for patients with cancer. One of the challenges of a large academic center has been the dramatic increase of cancer patients on active treatments and supportive care admitted on non-oncology ward. A need to expand the inpatient oncology services by converting two general medicine wards into oncology units are imperative to continuously care for this growing patient population. To address the need of expanding the oncology service line on the inpatient acute care setting, an educational training plan has been developed to facilitate the seamless transition of experienced nurses into the oncology specialty. Oncology training using various platforms and tools have been created to support preceptors, charge nurses and leadership teams. The collaboration of Oncology Clinical Nurse Specialists, Unit Educators, and Nurse Professional Development Specialists provided a comprehensive program based on the American Nurses Association Scope of Standards, Oncology Nursing Society Standards of Practice, and Caring Science as the theoretical foundation of practice. The training was implemented using a phased approach. Phase one training consisted of a four web-based courses, three prerequisite modules followed by a preceptor-facilitated clinical observation, and an 8-hour instructor led virtual class. Phase two training required the completion of ONS/ONCC online Chemotherapy Immunotherapy course, a 4-hour in person skill training and a clinical practicum on chemotherapy administration. Pre and posttest were given to nursing staff to highlight crucial information about chemotherapy safety precautions before, during and after administration. Identifying key information for review ensures that nurses have an adequate knowledge and skill competencies to safely administer chemotherapy and care

for oncology patients. During the period of March 2020 to September 2021, a total of sixty nurses participated in the Oncology Training Program. Overall, we have lost three nurses through interdepartmental transfer and voluntary end of employment, resulting in 95% retention rate. The phased approach implementation of the Oncology Training Program paved the way for experienced Registered Nurses to transition to oncology specialty. Focusing on the individualized learning needs of the nurses and an incremental structured roll out of educational plan, allow time for learning, build staff enthusiasm, identify process gaps, enhance communication, and reduce resistance to change. Other organizations may adopt a similar approach to train experienced non-oncology nurses.

P153

WHAT IS THE CURRENT UPDATE ON ADVANCED METASTATIC BASAL CELL CARCINOMA (BCC) PATIENTS RECEIVING TARGETED THERAPY IN THE NEW ERA OF MOLECULAR PROFILING: NURSING CONSIDERATIONS?

Karen Oishi, APRN, AGPCNP, MDACC, Houston, TX

[Patient Education and Safety](#)

BCCs are the most common type of skin cancer, and they typically tend to grow slowly without metastasizing. The first line of treatment options includes local therapies such as surgery or radiation modalities that are generally effective in controlling the disease. However, there are a very few systemic therapy options available especially in the setting of advanced, recurrent or metastatic disease. I seek to explore recently approved biologic therapy options utilizing molecular profiling and their nursing considerations. Patients with advanced, recurrent, or metastatic BCC have an unmet need for effective systemic treatment options particularly with limited systemic options. However, recent advances in cancer medicine exploring potential systemic therapy in targeting pathways based on tumor molecular characteristics are fascinating. Oncology nurses play a huge role in educating and advocating for the patients receiving targeted therapies to improve quality of life and overall survival. It is imperative to continue to educate nurses on new novel agents that can enhance our understanding of the complex disease and better assist the patients receiving biologic treatment in the world of individualized and personalized medicine. The learner will be able to identify the names of the targeted agents currently FDA approved for advanced BCCs and state a manageable side effect. I performed current literature

search using online engine such as PubMed and MEDLINE on the topic of BCC systemic treatment, targeted agents and the key words of oncology nurses. After the data analysis, it was clear that there was a limited educational information published for outpatient oncology nurses to educate themselves on the topic. The outpatient oncology nurses will seek additional literature in educating advanced BCC patients on systemic treatment including targeted agents and any potential adverse events management. Oncology nurses need to be cognizant of currently studied targeted agents used to treat BCC patients. As an increased number of patients are receiving novel targeted agent treatment, oncology nurses need to engage in collaborative groups to educate and improve management of adverse events.

P154

ONCOLOGY NURSE RETENTION: STANDARDIZING ONBOARDING PROCESS

Sandy Page, MSN, RN, OCN®, UT Southwestern

Medical Center, Dallas, TX

[Oncology Nursing Practice](#)

Over the past year as a leader in oncology infusion, my department had a consistent increasing turnover rate with oncology nurses. Feedback from exit interviews revealed a dissatisfaction with orientation and onboarding. The perception of inconsistency in onboarding, preceptors and lack of support left many newly hired nurses feeling less confident and safe in their nursing practice resulting in high turnover rates. Peer reviewed literature has shown that nurses who do not feel they have been safely trained to administer cytotoxic drugs will most likely leave the field of oncology. Oncology nurses deal with complex treatment and handle high stress situations, which contributes to nurse burn out. As a leader, I saw a need for immediate intervention. A small work group was formed with senior infusion nurses, leadership and an oncology educator. We met weekly to review the current onboarding process. A condensed orientation packet with competencies was created. These competencies were based on QOPI standards and ONS recommendations. Senior nurses from the work group attended a formal preceptor class. New hires were paired with preceptor trained senior nurse. I met with each new hire weekly to review their progress and obtain feedback from onboarding experience. Weekly goals were set with orientees and preceptor and reviewed at the end of each week. Research shows that new hires are more likely to be retained for 3 years if the onboarding process is structured. We were challenged to create

a robust standardized onboarding process to help increase the retention rate of oncology nurses in infusion. Retention has improved and with the feedback from new hires it continues to evolve. Open communication, evidence based practice, support from leadership and empowerment have proven that we are headed in the right direction and are prepping our infusion nurses to provide safe care while remaining confident and engaged. A standardized onboarding process has improved staff engagement, confidence, nursing practice, and overall retention.

P155 UNLICENSED ASSISTIVE PERSONNEL (UAP) ORIENTATION AND TRAINING STANDARDIZATION IN A LARGE OUTPATIENT ONCOLOGY NETWORK

Brittini Prosdocimo, MSN, RN, BMTCN®, UPMC Hillman Cancer Center, Pittsburgh, PA

Coordination of Care

University of Pittsburgh Medical Center (UPMC) Hillman Cancer Center (HCC) is a large academic cancer center consisting of medical and radiation oncology locations throughout Maryland, New York, Ohio, and across Pennsylvania. Standardization of processes and procedures throughout all 70 UPMC HCC locations is preferred to ensure patient and staff safety, positive patient experience, and accountability of duties. Variations in patient acuity, staffing mix, and other factors make process standardization challenging in all avenues of care. An inconsistency in training for assisting with bone marrow biopsy procedure was discovered from patient feedback alerting the UPMC HCC safety director. Through surveying laboratory technicians and unlicensed assistive personnel (UAP), a gap in training, standardization of process, and competency was noted in the bone marrow biopsy assisting process. Nursing, UAP, laboratory, education, and safety department heads convened to address the bone marrow biopsy assisting training gap and discovered an opportunity to improve standardization of orientation and annual competency of UAPs across the UPMC HCC network. The education department took the lead on this initiative and coordinated workgroup meetings to establish UAP current processes to include orientation and annual competency paperwork. Step one was to understand the current state and step two included identifying gaps and addressing needs based on best practice, policy, and operational ability. To date, the group has successfully determined current practice and identifies gaps in training. Based on gaps, the bone marrow biopsy

assisting training process and orientation checklist have been amended to include consistency of orientation topics relevant to best practice and UAP scope of practice. Next steps for the workgroup are to standardize the content of the annual competency training and finally implement all new training materials across UPMC HCC UAP teams. Once training is implemented across the networks, follow up assessment will be completed monthly and then bi-annually for the first year. The workgroup will review orientation, annual competency, and training materials on an annual basis moving forward to ensure best practice.

P156 BENIGN HEMATOLOGY: PROCESS DOCUMENTS FOR THE NEXT GENERATION

Georgina Rodgers, BSN, RN, OCN®, NE-BC, Cleveland Clinic Health System, Cleveland, OH; Patricia Brown, RN, BSN, Cleveland Clinic, Cleveland, OH; Nicole Coleman, RN, BSN, Cleveland Clinic, Cleveland, OH; Nancy Dalpiaz, RN, BSN, Cleveland Clinic, Cleveland, OH; Carol McDonald, RN, BSN, Cleveland Clinic, Cleveland, OH; MaryKay Moore, BSN, RN, OCN®, Cleveland Clinic, Cleveland, OH

Coordination of Care

Benign or “non-cancerous” hematologic blood disorders can be chronic, lifelong illnesses that do not affect overall life span, while others can be severe and life threatening. Treatment varies depending on the type of disease and ranges from periodic observation, use of steroids, transfusion support, coagulation factor support, immune-modulating therapies to complex chemotherapy. Our Registered Nurse Care Coordinators (RNCCs) provide specialized care to these patients as part of a multi-disciplinary disease team and are tasked coordinating patient care and treatment. Within our health system, our benign hematologists treat common and rare blood disorders as well as very rare, inherited metabolic disorders in conjunction with geneticists and genetic counselors. Some of the rare disorders we treat include Gaucher’s disease, Pompe disease, Hunter syndrome and Fabry disease. The RNCC works closely with the provider, pharmacy, financial teams, insurance carriers and drug companies to obtain authorization for the initiation of treatment with specific enzyme infusions at an appropriate site of care. The diseases are very rare, navigating treatment initiation can be complex and the volume of patients on treatment is quite low. In high complexity, low volume processes, there is a common concern in how to maintain competency in the processes required provide care to these rare dis-

ease patients. Leadership appreciated the complexity of this care and initiated a project to aid in the transition of knowledge through detailed, disease based job aids for RNCCs. The benign hematology RNCCs, leadership and a clinical project manager began collaborated with the benign hematology nursing team to create disease focused job aids that provide concise descriptions of diseases, associated symptoms, typical labs and common treatments. Particular details regarding authorization, patient case management enrollment, co-pay assistance, and product support were included in the job aids to ensure that the required steps were clearly documented for the team. The compiled information has been developed into a resource manual that has been uploaded to our cancer program's intranet. The location allows for easy access to information at all locations across the health system in Ohio and Florida. The development of these resources has ensured that newly on-boarding and covering RNCCs have easy access to detailed instructions for a more seamless transition of care among the team.

P157 WHERE HAVE ALL THE ONCOLOGY ADMISSIONS GONE? GETTING OUR PATIENTS BACK TO THE ONCOLOGY UNIT

**Karen Roesser, MSN, RN, AOCNS[®], Sarah Cannon
Cancer Institute at Johnston-Willis Hospital,
Richmond, VA**

Coordination of Care

Dedicated inpatient oncology units represent one destination that passionate oncology nurses often choose and patients request because of the staff's compassion and expertise. However, changes in the inpatient setting have reduced oncology admissions. This may be due to increased outpatient approved treatments or the institution of the Quality Oncology Practice Initiative (QOPI) guidelines with its emphasis to keep patients out of the hospital. More recently, as COVID continues to overburden hospitals, it has led to the obvious need to admit to any open bed to improve hospital throughput. The purpose of this project was to improve the number of oncology admissions to the inpatient oncology unit. This included the initial admission from the Emergency Department. Additionally, if that was not possible, then to transfer oncology patients from other inpatient units to the oncology unit when a bed became available. Initially, this issue was addressed with key stakeholders to obtain their buy-in. These included: oncologists, hospitalists, transfer center, throughput coordinator, chief

medical officer, emergency department physicians/director, chief nursing officer, and oncology director/staff. Several interventions were put into place. These included: identification of the "oncology" admission level of care designation, adding comments to diagnosis, reviewing four daily reports (oncology consults, distress scale, navigator report, and CHG bathing with central line) to identify potential patients for transfer, and reviewing patient records. Prior to instituting any changes, it was noted through medical coding that oncology patients represented 25% of the population on the oncology unit. After instituting these interventions to increase oncology admissions, this has increased to 35%. This issue is one that many hospitals are struggling with as COVID hospitalizations have surged. Our goal is to increase oncology admissions to 50% of the patients on the oncology unit. Plans are underway to provide telemetry monitoring to the entire hospital including the oncology unit. This will allow for admissions based on a higher level of care than we currently can provide. This represents one hospital's efforts to leverage available resources to bring oncology patients back to the oncology unit. This is a staff, physician, and patient satisfier.

P158 STANDARDIZING EDUCATION FOR IMPLANTED VENOUS PORT NURSE CHAMPIONS ACROSS A HEALTHCARE SYSTEM

**Evanica Rosselli, BSN, MSN, OCN[®], Yale New Haven
Hospital, New Haven, CT; Kylie Kuck, MSN, AGCNS-
BC, Smilow Cancer Hospital at Yale New Haven, New
Haven, CT; Patricia Szabo, MSN, RN, OCN[®], Smilow
Cancer Hospital, New Haven, CT**

Professional Development

Implanted venous ports are not utilized frequently outside of the oncology population in this healthcare system. Although super-users have been identified on non-oncology units, there are frequent phone calls to the oncology service line requesting assistance. Oncology nurses are often asked to access and de-access implanted venous ports for patients on non-oncology units. Super-user training was not standardized and no consistent follow-up existed to ensure nurses maintained competency. The purpose of this project was to outline initial and ongoing education and competency requirements to improve confidence of implanted venous port super-users. Our goal is for super-users to be equipped with the tools they need to be successful in managing implanted venous ports while the oncology service line will continue to support clarifying

questions and concerns. An online learning module has been developed which includes videos and questions to assess learning. Seven topic specific instructional videos include: gathering supplies, identifying power ports, palpating and selecting needle length, accessing, troubleshooting, de-accessing, and electronic medical record documentation. Initial validation includes completion of the online learning module, accessing utilizing a manikin, observing port access on a patient, and completing a competency checklist while accessing a port on a patient. Ongoing competency includes annual completion of the online learning module and competency checklist sign off. This standardized method of initial and ongoing competency will allow super-users to feel confident in basic implanted venous port skills. With the resources readily available and annual training built into the competency, they should be able to access and de-access uncomplicated ports without intervention from the oncology team. Success will be measured by tracking how many staff complete the training. The videos are currently posted on the oncology sharepoint website for easy access to the information at the time it is needed. Next steps include gathering data from the health system educators to determine super-user confidence after completion of initial training. This project developed a standardized comprehensive training program for non-oncology nurses to achieve and maintain implanted venous port competency throughout a health system. This empowers identified super-user nurses to practice confidently and safely.

P159 DEVELOPMENT OF AWARD WINNING PATIENT-DESIGNED INFORMATION FOLDERS FOR NEW CANCER PATIENTS

Marguerite Rowell, MSN, MBA, MSM/HM, ONC, SCRNI, Miami Cancer Institute, Miami, FL; Morgan Nestingen, MSN, APRN, AGCNS-BC, OCN®, ONN-CG, University of Colorado, Miami, FL

Patient Education and Safety

Partnering with patients to design education materials may enhance effectiveness and usability, and address health literacy challenges. Patients and caregivers touched by cancer are ideally positioned to partner with oncology nurses and other stakeholders to design materials which meet the needs of and improve quality of life in newly diagnosed patients. Miami Cancer Institute (MCI) partnered with patients, caregivers and key stakeholders to redesign our New Patient Folders. This participatory design approach ensured patient education materials were informative, engaging and effective for newly diagnosed cancer patients.

In 2018, focus groups planned revised contents and design of two New Patient Folders (Adult & Pediatric versions). English- and Spanish-speaking patients and family members worked alongside clinical teams, Marketing and leaders throughout the design process to determine key content, images and overall design. In 2019, first editions were launched in October. From 2020-21, digital versions were launched to support telehealth patients. Patient, caregiver and staff feedback was incorporated to further refine 2nd editions. Newly diagnosed adult and pediatric cancer patients (n = 33) were surveyed to evaluate perceptions of the folders. Results demonstrated 91% of English-speaking adults (n=22), 100% of Spanish-speaking adults (n=11), and 100% of pediatric patients felt the folder (1) provided helpful information about resources and services; (2) described what to expect during treatment; (3) supported organization and planning and (4) addressed questions, concerns and approaches to self-management. In 2020, the adult and pediatric folders received national recognition through 8 competitive award programs. The folders have since undergone revisions to address feedback including (1) reduced size, (2) inclusion of various genders and ethnicities and (3) representation of all cancer diagnoses. Participatory design should include patients, caregivers and oncology nurses when planning new patient teaching materials. Oncology nurses may use new patient folders to introduce services, set expectations and provide teaching to improve quality of life in newly diagnosed cancer patients. Cancer patients diagnosed during the pandemic experience increased depression, anxiety and uncertainty and often receive telehealth vs. onsite services. Web-based patient education materials have proven effective and engaging teaching tools. MCI's dynamic, digital folders increased access and convenience for our patients.

P160 AN INTEGRATED REVIEW AND DEVELOPMENT OF A TOOLKIT FOR REGISTERED NURSES ON OSTOMY CARE

Tara Russo, FNP, DNP, Memorial Sloan Kettering Cancer Center, New York, NY; Cira Fraser, PhD, Monmouth University, Monmouth, NJ
Professional Development

Each year, many oncologic patients undergo surgery to create an ostomy. Nurses play a vital role in patient teaching and guidance in how to self-manage their ostomy. Nurses are often the first health care provider to teach patients basic ostomy skills and provide any needed psychosocial support that they may require

due to their new ostomy. In addition to assisting a patient to become competent in the physical aspects of caring for their ostomy, addressing their unique psychosocial concerns and issues can ultimately increase their self-management skills and quality of life. Registered nurses are instrumental in evaluating and addressing the psychosocial needs of patients. Their ongoing support, education and referrals can have a positive impact on an ostomates overall adjustment to life with an ostomy and quality of life. The purpose of this project was to develop and evaluate a toolkit of educational materials and resources for registered nurses on ostomy care. A descriptive design was used for this ostomy education toolkit study. The toolkit was reviewed by participants during one session. Information presented covered the psychosocial needs of ostomy patients, quality of life, support programs and ostomy types. Illustrations and links to online videos and organizations aided in learning. Total time for the study was approximately 60 minutes which included reviewing and completing informed consent, review of the presentation and completion of the Evaluation of Ostomy Care Toolkit Survey. Participants (n=31) found the educational intervention utilizing an electronic toolkit to be overwhelmingly useful to practice. The evaluation survey used a 4-point Likert-type scale (1=Definitely No, 2=Not Entirely, 3=To Some Degree, 4=Definitely Yes) with mean scores ranging from 3.71 to 4.00 with a standard deviation of 0.00 to 0.46. Qualitative data suggested the toolkit was well received among participants. The educational intervention focusing on the care of the ostomy patient was found to be a useful tool by registered nurses. Toolkits have the potential to be an effective method for enhancing nurse's knowledge of ostomy care and should be investigated further with nurses in other nursing specialties. The use of educational toolkits can be a useful method of providing education. Utilizing an electronic format allows for participants to access at any location, on their own schedule and complete at their own pace.

P161 RACIAL DIVERSITY WITHIN ONCOLOGY HEALTHCARE LEADERSHIP INCREASES POSITIVE OUTCOMES

Aliënne Salleroli, MS, BSN, RN, OCN®, Yale New Haven Hospital- Smilow Cancer Center, New Haven, CT
[Professional Development](#)

There is currently a large disparity between oncology healthcare leadership that identify as people of color and those who that identify as white. It is well es-

tablished that having a racially and ethnically diverse healthcare staff improves patient care. One of the major objectives in oncology nursing is diversity, equity and inclusion in clinical practice but often excludes diversity, equity and inclusion in leadership itself. Diversifying leadership could have significant impacts for both patient care and organizational health. This conceptual study aims to determine if having racially and ethnically diverse leadership in oncology healthcare organizations leads to positive outcomes and increasing organizational health. In this context, racially and ethnically diverse refers to individuals who identify as people of color or nonwhite individuals. A literature review was completed to identify themes and common outcomes from different healthcare models in relation to leadership by itself and diverse leadership. In addition, racial and ethnic healthcare disparities were reviewed to determine the types of positive outcomes desired. A conceptual process was used to create guidelines that would support racial diversity in leadership leading to positive outcomes. The results showed that having ethnically and racially diverse leadership in healthcare did improve patient care, quality of life, improved patient outcomes with fewer adverse events, improved employee satisfaction, retention, increased financial reimbursement, and designation as preferred healthcare providers. It also determined that diversity alone will not increase positive outcomes. There must be strong leadership skills as well as a unified vision for the diversity to be successful in improving outcomes. Changing the paradigm of how we envision diversity interventions was equally important as how they were implemented. Increasing the diversity in oncology healthcare leadership is successful at improving the sustainability and profitability of healthcare organizations and enriching the health and wellness of communities in which they serve. Oncology nursing needs diversity to flourish in all areas of practice. Assessing the needs of oncology diversity, equity and inclusion interventions rarely looks at the diversity of leadership making those decisions. If the decisions are not made by diverse leadership, then critical needs may be overlooked. By looking through the lens of diverse leadership we open up a new area for opportunities for inclusive oncology nursing practice.

P162 MAKING THE CASE FOR REMOTE WORK FOR ONCOLOGY NURSING DURING TRANSITIONAL TIMES

Camille Servodidio, MPH, RN, NE-BC, Smilow Cancer Hospital, New Haven, CT; Gean Brown, MSN, RN,

OCN®, CNML, Smilow Cancer Hospital, New Haven, CT; Shagunna Muse, MBA, DBA, Smilow Cancer Hospital, New Haven, CT; Kylie Kuck, MSN, AGCNS-BC, Smilow Cancer Hospital at Yale New Haven, New Haven, CT; Donna Viner, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT; Xiaohan Zhou, BSN, RN, Yale University School of Public Health, New Haven, CT

Coordination of Care

The COVID 19 pandemic led many healthcare organizations to adopt a remote workforce model for employee safety. A multidisciplinary committee formed to ensure the work environment was productive and satisfying for staff. Both clinical and nonclinical positions were included in the project. The purpose of this workgroup was to assess the feasibility for remote work for cancer hospital positions. The workgroup aimed to develop virtual teams to support patient centered care, leadership, communication, and social cohesion as contributors to virtual success. This workgroup identified and clarified hospital clinical and administrative roles with necessary technologies suitable for successful implementation by remote staff. Administrative and clinical managers were surveyed to assist with role clarification, software needs, and potential implementation costs. Team members collaborated with hospital ITS department on project requirements leading to the development of a standard technology bundle and budget. Another team created a Tips & Tricks resource for common software applications used off-site. Staff demonstrated success in full and hybrid models of remote work. Productivity measures provided metrics with objective outcomes for each remote work role. A distributed employee satisfaction survey revealed a return rate of 63/1174 (5%). Positive comments included preference for hybrid work model, economic savings, decreased commuting time, increased work efficiency, and enhanced work/life balance. Challenges included technology, connectivity issues, and decreased social interactions. Remote healthcare was new to most employees and managers. There was a learning curve related to knowledge and technology gaps. The committee was able to combine efforts with the technology department to develop best practices for remote staff which allowed them to provide the best possible care to patients. The multidisciplinary workgroup was able to provide recommendations to hospital leadership regarding training and required resources. These recommendations were accepted and implemented and remote employees were able to have access to technology and equipment that was not pre-

viously available. Recommendations presented by the workgroup allowed remote employees to work at the highest functioning level without compromised patient care. As staff continue to transition to remote work or are newly hired into roles where remote work is appropriate, a standard bundle of necessary equipment and resources allows for a more smooth transition and onboarding process.

P163

SAFETY IN NUMBERS: NURSING LEADERSHIP ENHANCES PATIENT SAFETY DURING A ROLLOUT OF PHOTODYNAMIC THERAPY AT A COMPREHENSIVE CANCER CENTER

Baylee Sharma, MSN, AGPCNP-BC, PCCN, Memorial Sloan Kettering Cancer Center, New York, NY; Sophia Mediratta, MSN, AGPCNP, CCRN, Memorial Sloan Kettering Cancer Center, New York, NY; Catherine Bautista, MS, CNS, OCN®, Memorial Sloan Kettering Cancer Center, New York, NY

Coordination of Care

Navigating how to “do no harm” can be complicated when all cancer treatments carry some level of risk, and it’s a primary function of nursing leadership to guide their staff in the process. Photodynamic Therapy allows for treatment of lesions in the lung or esophagus at any stage of disease, with either curative or palliative intent, however there is significant risk of burns and ocular damage if the patient is exposed to light during the next 4-8 weeks. This presents a challenge to an institution where patients have outpatient and inpatient encounters across several well-lit campuses during that time. An additional complexity was that only a small volume of patients will qualify for this procedure each year (approximately 5-10). A Nursing Leadership Triad at a comprehensive cancer center developed a unique approach to manage this problem. In this model a Clinical Nurse Specialist, Nursing Professional Development Specialist and Nurse Leader came together to provide clinical expertise, education and operational support, respectively. This therapy had been utilized within the institution approximately 20 years prior, after a long hiatus is experiencing a new groundswell of clinical support. In preparation for re-emergence, operational safety concerns, education needs and practice updates were handled by the Leadership Triad in accordance to their unique roles to maximize the value of their expertise with one goal in mind—zero patient harm. Operational protections included coordination of and alerts

to the five required sites (outpatient, infusion, pre and post procedure, endoscopy suite, inpatient) as well as ancillary areas the patient could touch including emergency department and intensive care staff. Pharmacy support is critical to success due to expense of the required medications and is coordinated by the operational lead via specialized email distribution. Measurements of safe lighting were taken by the electrical engineer and included in policy and education. A key success was adding a clinical alert into the documentation system for “light precautions”. Clinical Nurse Specialist support was required to develop comprehensive patient education and a Standard of Care detailing light precautions and safe practice. Education was provided both live, virtually, and as an enduring module linked within the Standard of Care for staff refreshers. Six months into the program with an N of 2 patients, zero harm has been maintained.

P164 RECONSTRUCTING ONCOLOGY NURSING IN AN OUTPATIENT ENVIRONMENT

**JoAnn Silcox, RN, MSN, CCCTM[®], Thomas Jefferson
University Hospital, Philadelphia, PA**

Professional Development

Challenges in attracting oncology nurses to work in outpatient clinics and oncology infusion has been problematic with the changing demands of nursing today. History was for nursing wanting to be out of rotating schedules, holidays, and weekends. The changing trend is now for nursing not being drawn to these clinic roles or infusion units, and how to make these positions creative and desired has been a challenge. In addition to staffing this site was without defined nursing leadership, experiencing massive resignations, and prevalent lack of trust from nursing staff for structure and processes to be supported, combined with a void of attention to the creation of excellence in oncology nursing practice. Also, how to entice seasoned oncology nurses to work in outpatient, with less patient contact, less flexible schedules was incorporated into our recruitment strategies. We also kept in mind how to hire nurses into an environment that will support retention of these nurses in this time of the greatest exit from traditional nursing. This topic will explore the process in rebuilding an oncology program, forming nursing leadership, developing an ongoing educational opportunities, creating a new nursing workforce, establishing a collaborative practice for nursing and providers that was absent prior, in a robust Medical Oncology Clinical Practice, com-

bined with an Outpatient Oncology Infusion Unit, newly acquired from a large academic hospital, due to licensure changes. Outlined will be the challenges in building a leadership team, recruitment of new staff, many without oncology experience, introduction of a new EMR system, and managing a culture not open to leadership and change. Also reviewed will be mentoring new nursing leadership to partner with physician leads, current onsite operation leadership and creation of new systems of communication, education and support. Recruitment strategies and challenges will be reviewed as well as outlining the challenges orientation provided with no onsite preceptors, new nursing leadership, and new non oncology staff. Explored will be how recruitment, orientation and mentorship was created, along with establishing new leadership structure, developing trust among team and physician, and outline barriers, and solutions.

P165 WELCOME ABOARD: MENTORSHIP AND DEVELOPMENT OF ONCOLOGY NURSE MANAGERS

**JoAnn Silcox, RN, MSN, CCCTM[®], Thomas Jefferson
University Hospital, Philadelphia, PA**

Professional Development

Recruiting into the manager role is one of the most difficult positions to fill. Once the manager is hired great attention needs to be given to onboarding into this role. Quite often we are faced with managers who have never managed before, are excellent clinicians, but have never lead a team or department. Adding a specialty as Oncology can be quite challenging not only for the novice manager, but also the seasoned manager. How to create structured educational onboarding experiences with a changing environment presents barriers needing to be overcome. Too often events take precedence over the manager able to take the time out for learned experiences, and not place into the fire before having the skills to manage the crisis. Developing an onboarding and mentoring format involves an oncology interdisciplinary team to coordinate learning experiences that will be added value to this role. This team includes physicians, social work, human resources, administrators, operations, and ancillary departments, all who interact with this role. This presentation will review onboarding of an oncology nurse managers for both inpatient and outpatient units. Barriers will be reviewed, and solutions presented. Holding accountable other disciplines to support will be outlined and strategies to support this effort. Highlighting will be the importance of commu-

nication, written documentation, engagement of Vice President to this process and how the onboarding must include nursing staff members. Also discussed will be defining what mentorship means and how current nurse managers need to be educated on how to effectively mentor new managers, how to provide constructive feedback, outline written plans and how to arrange structured time to review progress. Escalation of concerns and how to navigate problem solving, arrange for additional experiences and support overall onboarding process are skills needing support for managers and resources and processes to assist will be reviewed.

P166 ESTABLISHING A DIVERSITY, EQUITY AND INCLUSION INITIATIVE IN A CANCER CLINICAL TRIAL OFFICE AT AN ACADEMIC CENTER

Shahnaz Singh-Kandah, MSN, AGPCNP-BC, 161 Fort Washington Avenue, New York, NY; Edward Bentlyewski, MSN, APN, NP-C, AOCNP®, CCRP, CUIMC Herbert Irving Comprehensive Cancer Center, New York, NY; Frances Brogan, MSN, RN, OCN®, CCRP, CUMC Herbert Irving Comprehensive Cancer Center, New York, NY; Moury Minhaz, BS, CUIMC Herbert Irving Comprehensive Cancer Center, New York, NY; Yacha Genfi, RN, MSN, NP-C, Columbia University Herbert Irving Comprehensive Cancer Center, New York, NY; Gail Crawford, BSN, RN, CUMC Herbert Irving Comprehensive Cancer Center, New York, NY

Professional Development

Clinical trial enrollment of minorities, particularly Latinx and Black patients, lags behind that of the general population. Our Cancer Center is an NCI Community Oncology Research Program for Minority and Underserved populations (MU-NCORP) with 48% enrollment to interventional clinical trials from underrepresented minority populations. While above the national average, interventions are needed to address these gaps. The COVID-19 crisis highlighted inequities in health care for communities of color. In response to this, our department created a task force comprised of nurses, nurse practitioners, and research staff with the goal of addressing barriers that prevent underrepresented minorities from enrolling in clinical trials as well as compounding factors that contribute to poor health outcomes. In regards to clinical trial representation, additional efforts are needed to ensure underrepresented minorities are included in studies. Following major events in 2020, our staff expressed the need to contribute in a meaningful way by examining the gaps within our department and the cancer

center as a whole. Our goals are to reduce implicit bias particularly when approaching patients about clinical trials, address socio-economic barriers impacting enrollment of diverse patients, and increase visibility of clinical trials. The task force developed a survey to assess the experience of patients and clinical trial discussions. Questions ask about logistical barriers, interpersonal provider relationships, and patient perceptions of discrimination. The data from these surveys will inform tailored patient education regarding clinical trials and guide clinicians in the best way to communicate clinical trial information. The team meets regularly to tackle adjacent issues associated with lack of inclusion. Strategies include enhanced racial and ethnic minority leadership recruitment, transparency in research findings, creating tools for the retention of clinical trial participants, and using social media to address misconceptions. Establishing a diversity, equity, and inclusion initiative empowered our staff to make concrete steps towards increased health equity. Our team has formed relationships with patient advocates and collaborated the community engagement office to continue working on changing the stigma of clinical trials through public education. Future projects include cultural competency training for staff, social media campaign for clinical trials awareness, and interpreting data from patient surveys to implement changes in clinical practice.

P167 ONCOLOGY NURSING SOCIETY HACKATHON— ADDRESSING AMBULATORY CARE CHALLENGES THROUGH INNOVATIVE ONCOLOGY DASHBOARD SOLUTION: READY SET GO!

Sunny Stirling, PhD, MBA, RN, OCN®, CMSRN, RN-BC, Sharp HealthCare, San Diego, CA; Mary Shields, RN, MS, OCN®, City of Hope, Duarte, CA; Lisa Cusaac, RN, MSN, OCN®, MedStar Georgetown University—Lombardi Comprehensive Cancer Center, Washington, DC; Nancy Hampton-Jones, DNP, APRN, AOCNS®, AGCNS-BC, Miami Valley Hospital, Dayton, OH; Alice Catches, BSN, RN, OCN®, Johns Hopkins Kimmel Cancer Center at Sibley Memorial Hospital, Washington, DC

Oncology Nursing Practice

Ambulatory infusion centers face operational challenges that can lead to increased errors, delayed care, lower patient and staff satisfaction, loss of revenue, and safety issues. ONS hackathon is a 4-week challenge to create innovative solutions to address these problems. The purpose of this project was to synthesize an innovative solution to address infusion center operational challenges. The team followed Hackathon design thinking

processes—problem analysis, desirability, feasibility, business model development, and final pitch preparation. Unsigned order, lab related issues, same day provider appointment, chemo consent, and prior authorizations were identified variables that impact operation across diverse practice settings and EHR platforms. The variables were prioritized based on desirability and feasibility. Then, 5 Why process was performed. The team agreed that the ideal state of infusion center would be that every patient is ready to be infused prior to their appointments. Literature supported that the patient wait time was less with finalized treatment orders compared to without finalized treatment orders. Although EHR contains all pertinent information, gathering them from each patient's chart is labor intensive, and a worklist manually maintained outside EHR is not accessible to everyone. All care team members: providers, nurse leaders and staff, would benefit from having a shared dashboard. This displays relevant information based on the priority to perform the work. The team's solution is a comprehensive dashboard which tailors to the different user groups. It contains all the important variables for infusion preparedness and displays the appropriate information based on individual priority. This real time dashboard can be used as a communication tool and a worklist among care team members. Incorporating Hackathon design thinking processes was successful. Hackathon judges evaluated the team's winning concept based on: patient and staff benefit and experience, feasibility and path to implementation, cost of care delivery, strategic thinking and impact, and ingenuity. The team generated prototype samples with a feasible business plan. The effectiveness will be further evaluated as development opportunities present in collaboration with ONS. Further research and product development are needed to evaluate the solution collaborating with nursing leadership, clinical Informatics specialists, and EHR vendor. Future plans to pilot the finished product at multi-site infusion centers to assess the impact of the solution on ambulatory operation efficiency, patients, providers and staff satisfaction is recommended.

P168 **RESPONDING TO MEDICAL EMERGENCIES** **IN AN AMBULATORY ONCOLOGY SETTING**

Patricia Szabo, MSN, RN, OCN[®], Smilow Cancer Hospital, New Haven, CT; Mark Makalinaw, Saint Francis Hospital and Medical Center, Hartford, CT
Oncology Nursing Practice

Responding to a medical emergency requires fast, coordinated skills and can be a stressful situation for staff. Basic life support (BLS) certification is only re-

quired every two years. For healthcare workers who work in the ambulatory oncology setting, cardiac arrest is an infrequent event causing staff to have a lack of confidence in their abilities to handle such urgent situations. The purpose of this project was to improve staff confidence when responding to a medical emergency in an ambulatory oncology care center. Nurses and care associates attended a two-hour education session, which consisted of three sections: classroom, skills training, and simulation. In the classroom, participants were given an overview of current American Heart Association (AHA) guidelines and team dynamics when responding to a cardiac arrest. Skills training included use of a manikin to assess quality of compressions and ventilation techniques. Lastly, participants practiced responding to a cardiac arrest using simulation. Group debrief was conducted following the simulation. Participants completed pre and post surveys consisting of Likert scale confidence questions. There was 41 completed surveys. Results showed that staff responses as being "confident" or "extremely confident" to respond to a medical emergency increased from 49% to 93%. Students have different learning needs requiring use of multiple teaching methods to help improve understanding of what is being taught. Participants were able to apply what was learned during classroom and skills training to a realistic simulation scenario. Practice of BLS skills in an environment that is safe and realistic can build staff confidence. One drawback to simulation is that acquired skills can diminish within a few months without frequent application. To support ongoing skill development, a surprise emergency response simulation has been planned in September 2021 on the oncology unit to assess retention of skills from the prior training. The simulation environment was designed to replicate an outpatient treatment area using of a life-sized adult manikin sitting in a recliner chair with intravenous fluids infusing. A primary focus of this education session was team dynamics, including teaching responder roles, coaching others, and practicing a questioning attitude during an emergency. Strategies were discussed and implemented to safely move the manikin from the chair to the floor in order to administer adequate chest compressions.

P169 **IMPLEMENTATION OF END-OF-LIFE CARE** **TRAINING AT A COMPREHENSIVE CANCER** **CENTER**

Carolina Uranga, MSN, AGCNS-BC, RN, OCN[®], GERO-BC, NPD-BC, City of Hope, Duarte, CA; Judith

Rosario, BSN, RN, City of Hope National Medical Center, Duarte, CA; Jennifer Phung, BSN, RN, City of Hope National Medical Center, Duarte, CA; Tran Le, BSN, RN, City of Hope National Medical Center, Duarte, CA; Dung Banh, MSN, RN, NEA-BC, City of Hope National Medical Center, Duarte, CA

End of Life

Care of the dying is a vital nursing role and is an essential element of quality cancer care. The End-of-Life Nursing Education Consortium (ELNEC) curriculum provides educational resources and standardized toolkit to improve palliative care with emphasis on pain, symptom management, communication skills, self-care, and bereavement support. Forty registered nurses from an oncology medical-surgical unit completed an online baseline questionnaire which showed 73% (N=29) had not received palliative care training. This evidence-based project was developed by frontline nurses to assess nursing knowledge, skills, and attitudes towards end-of-life (EOL) care. Addressing the gap in knowledge, skills, and perceptions of EOL care through education may impact early and integrated palliative care interventions. Using the resources from ELNEC, a pre-and post-intervention with long term follow-up was designed. A convenience sample of 37 nurses from an oncology medical surgical unit completed a 10-hour online ELNEC Core Curriculum and attended a 6-hour virtual workshop which included case studies, videos, and interactive activities. Three workshops were offered. Each participant completed an online questionnaire prior to completing the online EOL course and virtual workshop to assess and identify knowledge, attitudes, and perceptions. The same online questionnaire will be sent to participants at 3 and 6-months post-intervention to re-assess knowledge, attitudes, and perceptions. The baseline EOL questionnaire indicated that 80% of nurses (N=32) have provided palliative care, 13% (N=5) "feel confident" in providing EOL care and the average knowledge scores were 81.5%. For all workshops combined the average pre and post knowledge test results were 77.4% and 84.2% respectively. The month and 6-month results are pending. The online and virtual approach was chosen in consideration of the current pandemic. Nurses are in a unique position to improve EOL care through knowledge acquisition. ELNEC expertise in the design of the workshop, leadership support, and engagement by frontline staff ensured the initial success of the program's aim to provide EOL education. A limitation is reliance on a self-reported questionnaire which may be biased in measuring practice change. The project highlights the

importance of professional development in EOL care and should be considered required training for oncology nurses. Dissemination of the results can lead to the expansion of this training to implement a best practice for the organization.

P170

USING A MODIFIED PROFESSIONAL DEVELOPMENT TOOL TO INCREASE RETENTION AMONGST REGISTERED NURSES WITHIN A UNIVERSITY MEDICAL CENTER

Grant Williams, BSN, RN, University of Rochester Medical Center, Rochester, NY; Kaitlyn Baker, BS, RN-BC, University of Rochester, Rochester, NY; Laura Pieters, BS, RN-BC, University of Rochester, Rochester, NY; Amber Seeler, BS, RN-BC, University of Rochester, Rochester, NY; Evelyn Santos, BS, RN-BC, University of Rochester, Rochester, NY

Professional Development

Retention of registered nurses does not only increase clinical expertise of a medical system but saves a medical center \$50K per nurse that stays after orientation. Furthermore, staff engagement, satisfaction, patient safety, and positive patient outcomes directly relate to nursing retention. The goal of this project is to assist leaders to retain nurses by directing their team members' career growth, development, and advancement, using a modified Professional Development Assessment (mPDA) tool. Using the mPDA tool to guide the discussion, a program will begin for leaders to conduct semiannual 1:1 meetings with their direct reports to review career goals, development and advancement aspirations. A mPDA tool will be used during one-to-one meetings between leadership and staff nurses to help support a nurse's career and institutional goals. The mPDA tool is comprised of nine multiple-choice questions. Each question is based on a professional theme that pertain to the nursing profession. Once the nurse completes the assessment, their answers are then added up and scored using the scoring tool. This tool is modified to provide what professional development opportunities, promotional opportunities, and educational opportunities are available within the University of Rochester Medical Center and/or the greater Rochester, NY area. This tool should be used annually and will help leadership guide a nurse toward completion of his or her goals. Fifty nurses will be asked to fill out the mPDA with their career and institutional goals in mind. We anticipate that retention rates will increase after utilization and implementation of the PDA. We also anticipate that staff engagement will inadvertently increase. Re-

search has shown that nurses are more likely to stay within a medical system if they are fully supported by their leadership teams. Nurses who feel supported and are engaged are less likely to seek career opportunities from other institutions. With the use of this modified PDA tool, nurses will be able to plan for their future using professional development in a structured way. More time is needed to evaluate the impact of this tool within the nursing profession and how it relates to nurse retention.

P171 UTILIZING ALTERNATIVE TEACHING METHODS TO PROVIDE SOCIALLY DISTANCED EDUCA- TION DURING THE COVID-19 PANDEMIC

Cynthia Ydrogo, MSN, RN, OCN®, Karmanos Cancer Institute, Detroit, MI; Jesse Martinovich, BSN, RN, Karmanos Cancer Institute, Detroit, MI

Professional Development

Providing staff with new and continuing education is an expectation of the Karmanos Cancer Institute's (KCI) nursing education department. Navigating education during the COVID-19 pandemic required the nurse educators to seek alternative methods to provide education while abiding by social distancing requirements. Education that typically would have been provided via face-to-face classes and in-servicing needed an alternative method of delivery. To meet the education needs of staff and provide an engaging learning environment, the educators relied heavily on technology to bridge the social distancing gap. The two-fold purpose of the shift in education delivery method was to: (1) provide education in a safe environment that met social distancing guidelines, and (2) use an engaging teaching method that would meet the learners' needs. The use of hybrid education methods were implemented to provide staff with a robust and engaging learning environment. Educators utilized the institutions learning management system (LMS) to create blended learning activities that used a combination of video and poster presentations. Hard copy posters were printed and delivered to the units to reinforce the education. In addition, the videos were loaded to the hospitals intranet page to allow access to view as needed. Staff were assigned to learning activities within the LMS and were required to complete a post-test/evaluation which awarded contact hours at completion. Staff were required to complete a post-learning activity evaluation to measure the impact of the alternative teaching method. A Likert scale was used to rate the effectiveness of the blended teaching method; 1 being poor and 5 being ex-

cellent. 95% of the staff rated the education activity at level of 4 to 5. Staff stated that they found the teaching method beneficial and that they liked that they could work at their own pace and review the information as necessary. The COVID-19 pandemic required KCI educators to employ innovative methods to deliver knowledge to staff while respecting social distancing guidelines. Educators must be prepared to adapt new teaching methods to meet the needs of their learners. The use of technology can help to mitigate barriers of face-to-face education while providing an engaging and impactful teaching environment.

P172 PROMOTING GRIEF RESOLUTION FOR ONCOLOGY RESEARCH NURSES

Allison Young, BSN, RN, Vanderbilt-Ingram Cancer Center, Nashville, TN

Professional Development

This presentation discusses the development of bereavement overload, oncology research nurse bereavement, and approaches for nurse leaders to make workplaces more amenable to the processing of losses. Oncology is a specialty prone to employee attrition. This is felt especially acutely in research oncology, a subspecialty that requires additional education in ethics, protocol interpretation, and novel treatments. While many factors contribute to attrition, a major one is bereavement overload. Daily, oncology nurses provide care to patients who are suffering or approaching end of life, and the secondary trauma caused by close relationships with these patients can lead to compassion fatigue. For research nurses who generally have higher acuity, heavily pre-treated patients with whom they develop deep relationships, a loss can be devastating. When multiple traumatic patient events occur, these nurses may experience bereavement overload wherein emotional responses may be repressed, not allowing resolution of losses. Avoiding the emotional experience of mourning and one's bereavement needs contributes to stress and burnout, critically affecting the available pool of experienced oncology research nurses. Nurses cannot ignore their emotional responses to death and still provide adequate care for their patients and themselves. A lack of communication regarding losses contributes strongly to personal bereavement; nurses feel isolation and fear of criticism for expressing grief. To improve research oncology nurse retention and allow more effective caregiving, nurse leaders should provide grief resolution by creating positive work environments allowing expression of grief, providing

end-of-life and bereavement training beginning in orientation, and contributing to work-life balance to permit time to grieve losses. A planned intervention to allow nurses to apply Saunders and Valente's oncology-specific Bereavement Task Model, which helps nurses increase strength and resilience following a loss, will be facilitated through our facility's bereavement workgroup. With implementation of this model, oncology research nurses will more successfully undertake recommended bereavement activities, namely finding meaning in loss, restoration of integrity of one's professional skills and ability to cope, management of affect, and redefinition of relationships affected by loss.

P173 CLINICAL NURSES SUPPORTING ONCOLOGY NURSES' EDUCATIONAL NEEDS THROUGH RESOURCES, GUIDANCE, AND PROMOTION OF SELF DIRECTED LEARNING

Nataly Young, BSN, RN, OCN®, New York Presbyterian, New York, NY; Nicole Turkoglu, MSN, RN, OCN®, BMTCN®, New York Presbyterian, New York, NY

Professional Development

During the height of the COVID pandemic, there was a decrease in oncology patients and an increase in COVID patients admitted to the oncology unit. During the first half of the year there were many new nurses hired, leaving many without opportunities to take care of oncology patients. This created a knowledge gap in oncology care. The purpose of this project was to support and provide guidance and opportunities for oncology nurses to learn more about oncology nursing and taking care of oncology patients. Interventions: Plan: To survey nurses to find a gap in knowledge and assess to see if there is an interest in learning about oncology nursing educational opportunities. A six item multiple choice and open ended questionnaire was used. Do: An inservice was conducted and an oncology resource handout was given to staff. An online oncology resource handout was distributed to staff via email. Check: Monthly surveys were taken to assess progress with nurses using oncology resources. Act: Continued information on oncology nursing resources should be provided to staff regularly to continue to develop nurses' knowledge of the oncology patient population. Evaluation: In August 2020 oncology nurses (n=20) were educated on oncology nursing resources. In Sept, 6% read an oncology article and 39% took an oncology CEU. There was an increase in taking Oncology CEUs in October (50%) and November (50%). There was also an in-

crease in reading oncology nursing articles in October (60%), but it decreased in November (25%). These results show that educating the nurses on oncology nursing resources initially helped in increasing nurses taking oncology CEUs and reading oncology articles. Our recommendation is to continue to encourage staff to utilize oncology nursing resources and share opportunities for learning with staff. Our hope is to continue to be a resource for staff in directing them to learn more about oncology nursing through CEUs and journal articles as well as through direct learning opportunities during the work shift. Oncology nursing is a complex specialty requiring expertise in managing oncology emergencies, administration of various cancer therapies, symptom management, palliative care, and psychosocial needs of patients & families. Nurses require oncology specific education that is not always provided at work. Encouragement for staff to educate themselves is helpful in developing oncology nurses.

P174 BRANCHING OUT: LESSONS IN RESILIENCE THROUGH ONCOLOGY REGIONALIZATION

Xueni Zhong, BSN, RN, UCSF Health, Berkeley, CA; Aaron Mansfield, BSN, RN, UCSF Health, San Francisco, CA; Anita Piano, MSN, RN, UCSF Health, San Francisco, CA

Coordination of Care

The expansion of cancer services of a major university medical center in northern California began in fall 2019, resulting in the addition of three multispecialty oncology clinics and two infusion centers throughout the region. Through efforts to regionalize services by driving to provide consistent, high quality cancer care, the nursing team has collaboratively developed and implemented unique workflows to meet a continuously evolving environment. The purpose of this project was to provide the perspective of nursing leaders undertaking change management challenges within the scope of the regionalization of oncology services. This discussion will highlight lessons learned from the regional nursing leadership team, including: navigating partnerships with neighboring institutions, adding new members of an acquired nursing team, establishment and coordination of services in unique environments, optimal utilization of limited resources, and nursing leadership in the "start-up" environment. Opportunities and successes will be discussed through qualitative and quantitative means, including: Nursing Engagement & Retention, Patient Satisfaction, and Visit Volume Evolution. Efforts to regionalize cancer care provides numerous leadership

opportunities often atypical in mature parts of a health care organization. Expanding services to serve regional areas through opening and enhancing ambulatory centers offers great challenges but also high opportunity for professional and personal satisfaction. We will share lessons learned and wisdom gained that will benefit all nursing leaders throughout the oncology space, as well as provide positive impacts to patient care. Regionalization requires development of creative solutions in unique care delivery settings that often vary from traditional experiences. The formation of diverse, resourceful, collaborative teams is essential to succeed in this arena; bridging care to be closer to our patients is complex, necessitating creative and rapid adaptation to the specific needs of each environment.

P175 MEMBER ENGAGEMENT: HOW DOES A LOCAL CHAPTER CONTINUALLY RISE UP TO MEET THE EDUCATIONAL AND NETWORKING CHALLENGES DURING A GLOBAL PANDEMIC

Theresa Zielinski, RN, MS, OCN[®], Frontier Science Foundation, Amherst, NY; Marianne Jerla, RN, BSN, Roswell Park Cancer Center, Buffalo, NY; Edonn Ball, PhD, RN, CNE, SUNY Erie, Buffalo, NY

COVID-19

Caring for patients during the pandemic did not come to a halt, nor did educating nurses regarding novel cancer treatments. The transition to pharmaceutical sponsored virtual programs became a mainstay during the pandemic. As the virtual programs evolved, the challenges became apparent. It was observed quickly that virtual program attendance was low, so this became an area that needed to be explored. There was fear of losing member engagement, as networking is integral to nursing. Live programs were generally well attended, so how could we get members involved in virtual programs? The purpose of this project was to determine why our members did not participate in virtual programs and implement strategies to gain better member engagement. Questionnaires were sent via email to selected members of the local chapter with 7 key reasons listed for non-participation in virtual programs. Participants were asked to rank these in order of importance and responses were tabulated. The analysis of the survey results showed three key reasons for non-participation. No dinner /no participation, lack of motivation, and lack of networking. The results prompted discussion on strategies to resolve non-participation and how to promote educating our members. Strategies to improve member partic-

ipation included: offering food delivery during virtual programs, offering gift cards and raffles for those who attended virtually, and added more convenient dedicated dates and times to view programs while socializing via zoom. Increased member support started to evolve. All of these served as evidence that proven measures can increase engagement and keep our local chapter members collectively interested in being a part of the ONS Community. Furthermore, the pharmaceutical representatives also have a relationship with our members and communicated their appreciation for our commitment and feedback. This served to identify reasons for non-participation in virtual programs, but more importantly propelled the leadership team to focus on strategies to increase member engagement. These actions are crucial to the success of the local chapters, especially in light of an ongoing pandemic.

QUALITY IMPROVEMENT

P176 STANDARDIZATION OF ONCOLOGY NURSING SHIFT HANDOFF UTILIZING A CLOUD-BASED APPLICATION

Emily Albanese, BSN, RN, The Johns Hopkins Hospital, Baltimore, MD; Timothy Cameron, BSN, RN, OCN[®], The Johns Hopkins Hospital, Baltimore, MD; Jedediah Gervacio, BSN, RN, VA-BC, The Johns Hopkins Hospital, Baltimore, MD; Barbara Van de Castle, DNP, OCN[®], ACNS, RN-BC, University of Maryland School of Nursing, Baltimore, MD

Oncology Nursing Practice

Staffing changes within this Comprehensive Cancer Center during the pandemic clarified the need for standardized change of shift nursing handoff processes. Five inpatient units had different processes for shift handoff. Current literature indicates that standardization of handoff can positively affect nurse satisfaction and decrease adverse patient events. Improving communication through optimal handoff is a Joint Commission national patient safety goal, with safety experts recommending evidence-based criteria for handoff communications. This quality improvement project aimed to implement a web or mobile accessible technology to ensure social distancing and standardization of shift handoff among all inpatient units. A mobile application was implemented, allowing easy shift handoff according to a structured templates via verbal recordings or web-accessed written summaries. Staff

who participated downloaded the HIPAA-approved application to their personal phone or logged into a secure network computer. Report accuracy was measured by audits comparing reports against Joint Commission recommended criteria for four weeks after the process change. Staff satisfaction with the new process was measured through a survey two months after implementation. Audit data showed the most prevalent criteria included in the handoff report included illness assessment, patient summary, action items and contingency plans. Over 46% of users found the web-based application “extremely easy”, with 26% finding it at least “somewhat easy”. Both handoff methods demonstrated errors in timing of chemotherapy or lab tests. The new mobile verbal report was preferred by 62% of users, citing that written report encourages frequent copying and pasting which can lead to error. Users who preferred a typed report noted it was easy to print and write on during the shift. Some staff declined to download the application on their personal phone due to privacy concerns or unwillingness to use their own data for work needs, giving them only the typed option. The use of hospital approved phones to access this application would eliminate this concern, but is not a current option. Standardizing handoff report across all inpatient oncology units to web-based and mobile applications was successful, aligned with Joint Commission criteria, and received positively by staff nurses. More work is needed to enhance adherence to best practices, but the standardized approach provides an objective method to identify and address inconsistencies in practice.

P177 **DESIGNING DELEGATION IN A CLINICAL TRIALS UNIT**

Eileen An, MN, RN, OCN[®], Seattle Cancer Care Alliance, Seattle, WA; Kimberly Ito, BSN, RN, OCN[®], Seattle Cancer Care Alliance, Seattle, WA
[Oncology Nursing Practice](#)

Successful implementation of clinical trials requires efficient collaborative efforts between registered nurses (RNs) and support staff (e.g., certified nursing assistants [CNAs], medical assistants [MAs], and unit receptionists). Clinical trials have mandated protocol-specific tasks (serial vital signs and electrocardiograms) at set times that can be delegated to support staff. Adherence to task completion is essential to provide data to validate research. Research has shown that an absence of clear delegation and communication has contributed to conflict between members of the interdisciplinary nursing team. At an NCI-designated ambulatory clinical trials unit, the results of a

unit-wide survey revealed that the current system of task delegation was inefficient and led to the perception of mistrust and poor teamwork between nursing and support staff. The purpose of this project was to create a system for research task delegation for clinical trials protocol-specific interventions and promote interdisciplinary collaboration on an ambulatory oncology clinical trials unit. A team led by two clinical trials nurse educators engaged front-line unit staff (RNs, CNAs, MA, and unit receptionists) in designing a new workflow for task delegation. Standardized verbal communication hand-offs, visual and auditory tools, and written guidelines were identified as key components to the process. An assessment of each role's needs was integrated into the new workflow for task delegation. A centralized whiteboard prompted nurses to provide essential information related to the research task and led to clearer hand-offs between RN and support staff. Categories included the research task, timing, frequency, and protocol-specific requirements. Timers provided auditory cues to the staff for when tasks needed to be performed. Colored magnets provided a visual cue for task status as a communication feedback loop back to the task delegator. Meeting the needs of research-specific protocol requirements within a high-acuity ambulatory oncology clinical trials unit requires unit standards designed to support delegation. There has been high compliance of the new task delegation workflow from frontline staff. An unanticipated outcome of the tool was the visibility of capacity and workload of other members of the team. A survey six-months post implementation will reassess staff satisfaction of the unit's task delegation workflow and the atmosphere of teamwork.

P178 **REAL TIME AUDITS IMPROVE CENTRAL LINE CARE BUNDLE COMPLIANCE FOR CARE OF HOSPITALIZED ONCOLOGY PATIENTS**

Lauren Bearup, BSN, RN, OCN[®], Karmanos Cancer Institute, Detroit, MI; Lauren Nannoshi, BSN, RN, Karmanos Cancer Institute, Detroit, MI; Stacey Hague, MSN, RN, OCN[®], Karmanos Cancer Institute, Detroit, MI; Clara Beaver, MSN, RN, AOCNS[®], ACNS-BC, Karmanos Cancer Institute, Detroit, MI
[Oncology Nursing Practice](#)

An increase in central line-associated blood stream infections (CLABSIs) in hospitalized oncology patients generated the rollout of a new central line care bundle at Karmanos Cancer Institute. Central line care education was provided to nursing staff and various infection prevention measures were implemented

simultaneously. Hospital leadership expressed concern that implementation of several interventions at once may interfere with consistent execution of each. Real time compliance audits were proposed to ensure adherence to all components of the central line care bundle. The purpose of real-time audits of nursing compliance to a new central line care bundle was to improve compliance by providing instant feedback. An audit tool was developed to include critical aspects of central line care. Criteria included type of line, integrity of dressing, presence of drainage, date on dressing, alcohol caps on IV tubing, chlorhexidine gluconate (CHG) soap at shower/bedside, and documentation of IV tubing change and CHG bathing. Using the tool, two intravenous drug therapy (IVDT) nurses performed weekly in-person central line audits. They reinforced central line care teaching and the importance of CHG bathing with the patients, corrected any deviations from policy, and provided verbal reminders to bedside nurses in real time. Results were compiled weekly and distributed to leadership. Upon evaluation of the audit data, inconsistencies with documentation and the presence of CHG soap at the shower/bedside were the most common issues found. As the audits progressed, total compliance to the new central line care bundle improved. Unit managers took an active role in following up with staff to prevent further noncompliance. Current CLABSI rates compared to the previous year are stable. Oncology patients are often immunocompromised and especially vulnerable to CLABSIs. Real time audits with reinforcement of policy helped the nurses comply with their central line care. When compared to retrospective methods, real time audits allow for better risk management and error detection, ideally before infection occurs. The opportunity to provide immediate feedback to the bedside nurse allows for deviations to be corrected sooner and demonstrates to leadership a higher degree of reliability of nursing compliance to a care bundle.

P179 **STANDARDIZED DOCUMENTATION: A REFLECTION ON THE VALUE OF THE ONCOLOGY NURSE NAVIGATOR**

Jessica Beck, BSN, RN, OCN®, Duke Raleigh Cancer Center, Raleigh, NC

Oncology Nursing Practice

Nurse navigators work throughout the health system, yet vary in function. Our team consists of seven oncology nurse navigators in an outpatient setting adjacent to a satellite community hospital. The oncology nurse navigator's role is to identify and remove barriers

to care and serve as a point of contact for patients throughout their cancer journey. Clear communication with the patient and healthcare team is vital for navigators to provide high quality, team-based care. Currently, standardized documentation for oncology nurse navigators is not yet established. Therefore, it was essential to develop an electronic medical record (EMR) intake form to document the initial contact as a communication tool to close the loop with the patient's healthcare team. The purpose of this project was to describe the impact of the Oncology Nurse Navigator Intake Form: initial contact with the patient; assessment; identification of high risk patients; patient/caregiver education provided; resources and referrals provided. The nurse navigators identified a need for standardized documentation for the team. For six months, the nurse navigators developed and trialed a SmartPhrase™ documentation option after initial contact with new patient referrals. A nurse navigator working with a patient with any oncology disease could utilize this form. During our monthly navigator meetings, our team would review the Intake Form. Overall, the navigator group has found the SmartPhrase™ to be efficient for documentation, and can pull data for navigator metrics. Evaluation of the SmartPhrase™ documentation will be further enhanced by receiving feedback from clinic providers and nurses. Development and use of the Navigator Intake Form has been successful and easily adaptable in documenting patient care needs throughout their cancer trajectory. The initial contact a nurse navigator makes with the patient and their caregivers is vital to establishing easy access into the healthcare system. Additionally, it is valuable for the nurse navigator to communicate with the team the patient's barriers at pivotal points throughout their treatment plan. This innovative project contributes towards building a framework for standardized nurse navigator documentation within an EMR. It showcases the integral connection of nurse navigation within the healthcare team, as well as a navigator's contribution towards enhancing a cancer patient's care.

P180 **THE IMPACT OF A CHECKLIST ON QUALITY PATIENT CARE AND THE REDUCTION OF CLINIC VISIT TIMES IN PEDIATRIC PATIENTS WITH NEUROFIBROMATOSIS TYPE I**

Racheal Bingham, DNP, CPNP-PC, CPON®, MD Anderson Children's Cancer Center, Houston, TX

Quality Improvement

The project was implemented at a large ambulatory pediatric Neurofibromatosis (NF) Clinic in the aca-

demic center in the Texas Medical Center, Houston, Texas. We have a large new patient referral population due to the associated cancer risks and the recent use of MEK inhibitors in patients with NF1. The purpose of this scholarly project was to standardized practices in the NF clinic by establishing clinical guidelines, increasing the productivity of the new patients' appointment times with an evidence-based checklist (CL). It is crucial to optimize the patients' experience by evaluating the complete organ systems of those affected with NF1 and potentially decreasing clinic wait times. A new patient checklist can be beneficial to achieve these goals. The Plan-Do-Study-Act (PDSA) method of quality improvement was used for this pilot project. The author conducted a literature review to explore the benefits of a checklist in NF1. A CL was designed using evidence for the needs of the NF1 patient. This evidence-based CL was created with common clinical symptoms of patients with NF1 currently limited in the literature. A baseline 3-month time study confirmed the number of minutes spent for all new pediatric patient appointments for NF1. The new patient CL was implemented at each initial visit. The Advanced Practice Provider (APP) collected time data and completed the new patient CL. A baseline time study was collected January through May 2020, revealing five new NF1 patient visits with an average of 96 minutes to complete. From May 2020 through August 2020, a time study was completed with six new CLs, concluding an average of 101.3 minutes to complete the new patient visits. There was not an improvement in clinic times. There were multiple variables identified. They were related to the COVID-19 pandemic, staffing changes, and data highlighting clinical variability as a time critical issue when examining new patients with NF1. CLs allowed providers to document individualized patient information to readily identify each patient's specific disease burden, diagnostic workup needed for further evaluation, and ongoing needed management. It will also serve as a personalized, educational tool for families and patients with NF1.

P181 **THE RN FIRST CALL: DOES INCREASED PREPARATION PRIOR TO FIRST CONSULT HELP?**

Laura Birmingham-Williams, BSN, RN, MBA, Seattle Cancer Care Alliance, Seattle, WA; Amy S. Boswell, MSN, RN, OCN®, Seattle Cancer Care Alliance, Seattle, WA; Justin DeMars, BA, Seattle Cancer Care Alliance,

Seattle, WA; Farnoush Abar, MD, MPH, Seattle Cancer Care Alliance Peninsula, Poulsbo, WA

Coordination of Care

Newly diagnosed cancer patients frequently present with little understanding of their diagnosis and anticipated next steps, possibly leading to confusion and anxiety. The first visit essentials include review of outside records for comprehensive medical, surgical, psychosocial, and family cancer history. Additionally, patients must have appropriate diagnostic work up and complete all new patient paperwork. These missing components often can delay diagnosis and initiation of treatment. Providers often spend extended time attempting to gather this missing information during the initial consult, delaying all of clinic operations. The purpose of this project was to improve diagnosis and assessment at initial visit utilizing nurse telehealth pre-visit integrating Epic and MyChart interface assuring efficient and timely initiation of care according to clinical pathways. A team consisting of medicine, nursing, and IT collected baseline data on time of receipt of referral to new patient consult to initiation of treatment. A system was designed to pilot the use of a clinical nurse coordinator (CNC) overseeing the process of readiness for the initial consult. The MyChart electronic platform delivered forms for patient completion that then automatically populated the patient record in Epic. The CNC reviewed all outside information through Epic before a telehealth visit with the patient, confirming the information and facilitating any additional diagnostic workup needed for implementation of a clinical treatment pathway. Average time from referral to new patient consult was 9 calendar days. Average time for treatment initiation was 19 calendar days. After implementation of the new process with the nursing telehealth visit and timely collection of pertinent data, we found that patients were more informed at the initial consult resulting in a more efficient visit. Time from initial consult to initiation of treatment is continuing to be evaluated. Evaluation at six months will provide comprehensive analysis of program implementation and possible places to continue to improve provision of care in the initial stages for community oncology patients. Increasing efficiency provides not only individual patients with more timely care, but also increases clinic/physician capacity for seeing additional new patients.

P182 **INTEGRATING PHYSICAL THERAPY/EXERCISE INTO A COMMUNITY ONCOLOGY PRACTICE**

Carol Blecher, MS, RN, APN-C, AOCN®, CBCN®, Alliance Cancer Specialists, Bensalem, PA; Donna

Furlong, RN-BC, BSN, RN, Alliance Cancer Specialists, Bensalem, PA; Jean McGonigal, RN, OCN®, Alliance Cancer Specialists, Bensalem, PA; Patricia Foley, RN, Alliance Cancer Specialists, Bensalem, PA

Survivorship

There have been numerous articles documenting the benefits of exercise for individuals undergoing cancer treatments, initially to alleviate therapy related fatigue and more recently to maintain muscle tone and improve quality of life. The interest in exercise has become widespread for example, with the ONS Get Up, Get Moving Program and ASCO's Exercise During Cancer Treatment—Cancer.Net There has also been research in this area documented in CJON since 2008 and more recently in JCO and the Sports Medicine Journal. In July of this year, Alliance Cancer Specialists developed a relationship with ReVital to provide oncology patients in their community based practices, with supervised exercise/physical therapy during all stages of survivorship. At our site intervention can be initiated by the providers, nurse navigator, or the nursing staff based on their assessment of patient needs. Patients complete a modified PRO CTCAE developed by Revital which is a self assessment of a variety of symptoms/side effects. These referrals are routed through the nurse navigator who collects the data and sends the information along with orders, patient demographics, summary sheet and physician progress notes to ReVital. Patients may receive services at home and at various locations within the area. The intervention is evaluated through repeat PRO CTCAE data collection at three month intervals and discussions with the patients regarding their satisfaction and perceived helpfulness of the intervention. The role of exercise has been discussed for many years and has been adopted largely in hospital based programs, but many patients continue to be treated in the community. There is a need, not only to educate patients about the importance of exercise during the treatment stage of survivorship, but also a formal method for the provision of these services. We at Alliance Cancer Specialists, a multipractice Oncology Provider along with ReVital Cancer Rehabilitation have created a system in the community whereby our patients are provided with this evidence based intervention to improve physical and psychosocial function. This program development in the community setting is a novel approach to providing an evidence based intervention to patients, with the added convenience of remaining within their local area for a supervised program of exercised tailored to their specific needs.

P183

INNOVATIONS IN THE ELECTIVE CHEMOTHERAPY ADMISSION PROCESS

Nicole Bocchetta, MSN, RN, OCN®, Smilow Cancer Hospital/Yale New Haven Health, New Haven, CT; Brianna Lutz, MSN, RN, OCN®, Yale New Haven Hospital, New Haven, CT; Eileen Dehm, BSN, RN, Yale New Haven Hospital, New Haven, CT

Coordination of Care

Three inpatient oncology units at a large academic medical center coordinate elective anti-cancer treatment admissions for patients from 20 outpatient clinics and care centers across the health system. Lack of standardization can lead to patient care delays, increasing the amount of time from admission to treatment initiation. Minimizing process barriers and optimizing patient flow helps ensure safe and streamlined patient care. The purpose of the Elective Chemotherapy Admission Standard Operating Procedure (SOP) is to reduce the time from admission to treatment initiation. Consistent execution of this SOP will decrease the potential for error and improve elective inpatient chemotherapy workflow. The interventions included revision of an SOP to clearly delineate responsibilities and procedural steps, implementation of a mandatory biweekly meeting to address admission readiness, creation of an electronic flowsheet, and use of a shared calendar that helps to manage the number of patients scheduled per day. The chemotherapy meeting and shared calendar were not new interventions, but opportunities for improvement were identified. We expanded and optimized the meeting to include virtual attendance from all outpatient clinics and care centers and ensured consistent utilization across all sites. The innovative addition of a shared flowsheet was created in the electronic medical record allowing clear and concise documentation of the required pre-admission elements. This electronic outpatient to inpatient handoff ensured all elements were completed prior to admission and if not, the outpatient nurse then reviewed the plan with the primary team prior to admission. This handoff was the catalyst for obtaining insurance authorization and securing the inpatient bed on the appropriate unit. The revised SOP was implemented on December 14, 2020. Within a year, the average time from admission to treatment start time for patients on hematology oncology was 14.4 hours and decreased to 12.5 hours (13.2% decrease). On medical oncology the average time was 13.9 hours and decreased to 10.7 hours (23.0% decrease). On women's gynecology oncology the average time was 12.9 hours and decreased to 8.9 hours (31.0% decrease).

The goal is to further decrease the time on all units to 2 hours. Barriers to this include compliance with completing pre-admission elements, unforeseen need for medical management, and census/staffing pressures on the inpatient units. A multi-pronged approach was necessary to improve patient flow from outpatient to inpatient.

P184 DESIGNING AN ONCOLOGY IMMEDIATE CARE CENTER USING AN INTEGRATED FACILITY DESIGN APPROACH

John Bourgeois, MMHC, BSN, RN, OCN®, CCRP, NEA-BC, The Winship Cancer Institute of Emory University, Atlanta, GA; Karly Goozee, MSN, RN, OCN®, Emory Healthcare, Atlanta, GA; Hallie Marino, BSN, RN, BMTCN®, Emory Healthcare, Atlanta, GA; Danielle Roberts, MS, MMSc, Emory Healthcare, Atlanta, GA; Caleb Raine, MSPAS, PA-C, Emory Healthcare, Atlanta, GA; Daniela Casbourne, FNP-C, AOCNP®, Emory Healthcare, Atlanta, GA

Coordination of Care

Oncology patients frequently need urgent interventions to address acute issues. The need for a space to provide appropriate care for oncology patients was identified, and a multi-disciplinary team participated in an integrated facility design (IFD) event to create an oncology immediate care center (ICC). A team including oncology nurses and providers, emergency room (ER) nurses and providers, patient/family advocates, and patient care coordinators was tasked with designing the space. An ad-hoc team was included regarding specific processes for their departments. Guiding principles for the ICC included oncology patients to be treated in a dedicated space and avoid ER visits when appropriate. Using lean principles, a one-stop philosophy was developed with goals of bringing labs, assessments, treatments, and interventions to the patient. This enhances the patient's experience by providing the right care at the right time and place, instead of adding acute visits into a busy clinic or infusion center. Development of the ICC involved creating a conceptual design and an ideal flow process, which was one of the drivers of design. Current flow was mapped and revised to support the ideal patient experience. Leveraging experience and expertise, small teams created layouts to incorporate the seven flows (patients, family, staff, medication, supplies, equipment, information). After each iteration, the group gathered to review and challenge concepts and score the design. After several iterations, a final design that best met all criteria and supported patient cen-

tered care was selected. The final design containing 13 exam rooms was translated into a full-scale cardboard mock-up to be experienced in the future space. Around 35 people a day from various departments ran scenarios in the "cardboard city." Teams running scenarios were able to adjust the design to create an optimal layout. Oncology team members were able to identify medications, supplies, equipment, and anticipated procedures, which ensured room sizes and layouts supported the operations and design. The next steps include creating policies, workflows, and staff hiring with plans to open the ICC in April 2022. Once the ICC is operational, the effectiveness will be reviewed to make it more efficient in managing patients' conditions in an outpatient setting while increasing patient satisfaction utilizing patient, oncology nurse, and provider feedback. These reviews will be done at regular intervals with stakeholders.

P185 INTEGRATING PATIENT ACUITY SCORING IN AMBULATORY INFUSION CENTERS TO BALANCE NURSE PATIENT ASSIGNMENTS AND EVALUATE NURSING WORKLOAD

Carolyn Browne, BSN, RN, OCN®, University of Pennsylvania Health System, Philadelphia, PA; Melanie Zisa, BSN, RN, University of Pennsylvania Health System, Philadelphia, PA; Lisa Fidyk, MSN, MS, RN, Penn Medicine, Cherry Hill, NJ; Lisa Figueroa, BSN, RN, OCN®, Hospital of the University of Pennsylvania, Philadelphia, PA; Pamela Cappucci, MS, RN, OCN®, ASQ CSSGB, Hospital of the University of Pennsylvania, Philadelphia, PA; Pamela Tobias, MS, RHIA, CHDA, LeanTaas, St Clara, CA

Coordination of Care

In an effort to classify patient load, nursing activity, and time spent providing care two scoring methodologies are being trialed that attempts to approximate complexity and severity of nursing workload. Patient classification systems are widely used in the inpatient setting, yet a novel approach in ambulatory infusion centers. Center growth, operational constraints, and both patient and staff satisfaction scores has led the organization to explore the need for patient classification systems in the outpatient setting. The two different scoring methodologies are being compared head to head in similar centers within our organization over a three-month period with the goal to determine if acuity scoring is a better predictor of infusion nurse staffing needs than either patient visits or total scheduled patient hours alone. Post-trial data will be reviewed to determine efficacy and potential for sys-

tem wide adoption. Nursing completed a pre-survey prior to the trial and a post-survey at the completion to evaluate satisfaction. Patient acuity scores are documented in our medical electronic charting system and nurse staffing is reviewed daily. Data analysis is ongoing to help inform recommendations for change. Both a pre-assignment score calculated by the triage RN and a post assignment score, obtained by the treating nurse will be documented in the nursing flowsheet. This will help to determine if there is consistency in the pre and post scoring. If methodology of this scoring system proves valid and reliable, the aim would be to see a positive shift in nursing and patient satisfaction in addition to a decrease in wait times and overtime reductions.

P186 **BUG BUSTERS: A COLLABORATIVE, NURSE-DRIVEN APPROACH TO CLABSI ELIMINATION**

Amanda Burge, RN, City of Hope National Medical Center, Duarte, CA; Erica Dickey, MSN, RN, AGCNS-BC, OCN®, City of Hope, Duarte, CA; Kimberly Mercado, MSN, RN, BMTCN®, City of Hope, Duarte, CA; Lesley Han, RN, City of Hope National Medical Center, Duarte, CA

Oncology Nursing Practice

CLABSI prevention strategies are well established in the oncology patient population. But what do you do when you have all the best tools in place and the CLABSI incidence keeps climbing? Despite implementation of an evidence-based central-line bundle and numerous quality improvement initiatives, the incidence of CLABSI on one stem cell transplant (HSCT) unit exceeded the national benchmark in seven out of seven quarters between quarter 1 2019 to quarter 3 2020. In response, a task force comprised of frontline nurses, infection preventionists and nursing leadership was formed to definitively address this issue. The purpose of this project was to demonstrate how collaborative decision-making, peer-to-peer support and education may positively impact CLABSI incidence within the HSCT patient population. An evidence-based review of the literature was performed using the Fuld Institute method. A synthesis table was created to compare interventions discovered in the literature with current policy and practice. It was found that the literature supported the current central-line bundle. However, identified opportunities included creating a standardized shift checklist, staff education, and auditing infrastructure. The Bug Busters task force was created to guide and

facilitate the implementation of the interventions. The Bug Busters is comprised of day and night shift nurses. Their responsibility is to perform central line bundle audits, and to create and deliver education and interventions based on the findings from those audits. These interventions included a “Prevent infection in 6 steps” posters, educational shower hangers in each room, tubing change reminder cards, and updates to the documentation flowsheet. They collaborated with the education department to create content and perform central line competencies for all staff nurses on the unit. The Bug Busters were formed in December 2020. Central line competencies were completed on June 27th, 2021. As of the end of June 2021 the HSCT unit had 9 CLABSIs. The unit has experienced zero CLABSIs for 84 days since the completion of central line competencies. Maintaining a well-written policy and procedure and stocking the latest innovative supplies is simply not enough to eliminate CLABSI. Creating an infrastructure built on peer support and up-to-date information may strengthen the potency of evidence-based interventions. Combining shared decision-making, evidence-based best practices, and increased staff engagement transformed one unit from a poor performer to an exemplar.

P187 **PROCESS CHANGE PROJECT: IMPLANTED PORTS AND LABORATORY SPECIMEN COLLECTIONS**

Hailey Campbell, RN, Tennessee Oncology, Hermitage, TN; April Weis, RN, BSN, OCN®, Tennessee Oncology, Nashville, TN

Oncology Nursing Practice

Tennessee Oncology is a multi-site practice with more than 30 locations across Tennessee and northern Georgia. Tennessee Oncology has a high percentage of patients with implanted central venous access devices (ports). These devices were routinely accessed for reasons beyond chemo-immunotherapy infusions, including but not limited to blood draws, supportive care medications administration, and scans. Time studies completed in 2020 showed that port access for blood collection increased the time to obtain lab results by 7 minutes per draw. In some cases, delays up to 45 minutes occurred if troubleshooting was required during the access. An increase in incidence of compromised specimen integrity due to the presence of flush solution or other medications in the lumen or from poor specimen collection technique was also seen. This was quantified through number of hemolyzed specimens, increased/inaccurate clotting times, and diluted sam-

ples. Impaired specimen integrity impacted the providers' ability to make accurate treatment decisions and caused treatment delays because of repeat collection and processing. A review of literature supported the process change by validating an increased risk of central line associated bloodstream infections (CLABSI) with repeated/frequent port access. Risk for catheter associated clots was also a consideration for making a change. To increase efficiency of patient throughput and reduce port access frequency, the decision was made to pilot transitioning lab specimen collection from the port to venipuncture or fingerstick. The goals of the pilot were to expedite lab results and reduce risk for CLABSI and clot formation by reserving port use for infusion therapy. Each clinic was tasked with shifting the port access from the laboratory staff to nursing staff in the infusion suite. Patients were only accessed after the determination was made to proceed with treatment. Data was gathered throughout the transition on compliance with the change, patient time through the clinics and integrity of lab specimens. The outcome of the pilot was positive. Some clinics were able to reduce total port draws by as much as 20% in the first four months and preliminary data showed improved efficiency of workflows in the clinics. The pilot was extended into an enterprise-wide process change. It is projected that ongoing data collection will show impact on quality and efficiency of care and a reduction in port complications across the practice.

P188 IMPLEMENTATION OF A STANDARDIZED APPROACH TO BREATHLESSNESS MANAGEMENT IN PATIENTS WITH CANCER: A QUALITY IMPROVEMENT PROJECT

Yanka Campbell, DNP, AGPCNP-BC, CNE, Johns Hopkins University School of Nursing, Baltimore, MD; Brenda Shelton, DNP, APRN-CNS, CCRN, AOCN®, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD; Miki Goodwin, PhD, RN, PHN, CNE, NEA-BC, FAAN, Johns Hopkins University School of Nursing, Baltimore, MD

Oncology Nursing Practice

Cancer patients experience burdensome breathlessness that is inconsistently assessed and lacks complete palliation. Breathlessness is the third most common symptom among patients with cancer, affecting 15-53% during their disease trajectory. It can cause distressing consequences such as fear, anxiety, or sleeplessness and is associated with reduced quality of life. Optimal management of this symptom requires methodical assessment and implementation of

guided evidence-based interventions. The purpose of this quality improvement project was to implement a breathlessness algorithm to increase assessment in high-risk cancer patients and enhance nursing staff confidence in providing interventions. A nurse-driven breathlessness algorithm was developed and nurses received education on how to implement it on one unit within this academic medical center. The algorithm provided instructions for assessing breathlessness using the National Cancer Institute (NCI) dyspnea assessment scale and evidence-based recommendations for management. The project utilized a descriptive pre-posttest design to evaluate the clinical impact of the algorithm through changes in nurse knowledge, confidence, and attitudes related to breathlessness. Forty six percent of nurses (n=17) completed the educational intervention and pre-intervention survey. Five nurses (13%) from the pre-intervention group completed the post-intervention survey and were matched for outcome analysis. There was no change in knowledge or attitudes, but the nurses' confidence in breathlessness assessment and management increased a median difference of 2.0 on a 15 point scale. Nurses completing the post-intervention survey reported the algorithm was beneficial and assisted in care of patients. Baseline data indicated the existing dyspnea assessment scale was not used in practice. High-risk patients were identified by comorbid or cancer-related respiratory problems. Twenty-five high-risk patients were admitted during implementation, and only 20% (n=5) received a breathlessness assessment as intended. Of these, 80% (n=4) were symptomatic and could benefit from intervention. Improving nursing staff confidence through education and providing a standardized approach to breathlessness assessment provided an opportunity to optimize care. Findings suggest that the piloted algorithm was a helpful resource in the care of patients. Nurses became more confident in their ability to capture clinically meaningful information about breathlessness using the NCI dyspnea scale and were prepared to discuss interventions with patients and providers. Use of such assessments may be beneficial in other oncology units where patients frequently experience breathlessness.

P189 UTILIZING CENTRAL LINE PRACTICE VALIDATION TO REDUCE CLABSI (CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION) INCIDENTS ON AN ONCOLOGY UNIT

Dianna Assalone, MSN, RN, OCN®, BMTCN®, NE-BC, New York Presbyterian: Weill-Cornell Medical Center,

New York, NY; Dan Cernivani, BSN, RN, OCN®, BMTCN®, New York Presbyterian: Weill-Cornell, New York, NY
[Oncology Nursing Practice](#)

Central line associated bloodstream infection (CLABSI) are one of the most prevalent hospital-acquired preventable infections experienced by patients, prolonging admissions and costing hospitals thousands of dollars per case. Oncology patients are at a considerably higher risk of developing central line infections due to their neutropenic status and disease process. In December 2020, a blended oncology and stem cell transplant unit, 10 North, experienced a cluster of 3 central line infections in a one month period after not having a CLABSI for 16 months. The purpose of this project was to reduce the total number of central line infections on 10 North by 15% and improve overall nurse competency on central line maintenance. Nursing leadership devised a central line validation checklist based on the organization's policies to assess and provide mentorship to nurses on the following domains: PICC, Broviac, Mediport dressing changes, blood culture and lab specimen collection, and chlorhexidine gluconate (CHG) treatment process. To provide consistency, the clinical manager and program coordinator validated all nurses. Validation highlighted 2 pivotal areas of opportunity for 10 North nurses: blood culture and lab specimen collection process and CHG treatment process and pertinent patient education. Nursing leadership provided one-on-one mentoring for each nurse and provided them with the resources needed to care for central lines using evidence based practice. Nursing leadership collaborated with unit champions to develop education and huddle messages presented weekly. After the validation period, unit champions audit their peers monthly on central line best practice, with at least 10 audits per month. All 10 North nurses were validated within 1 month, completed by the end of January 2021. After the validation period, there have been no new central line infections on 10 North, resulting in a 100% reduction in CLABSI for this unit. Continued mentorship, education, and auditing of best practice will ensure we continue to minimize our incidence of central line infections on 10 North, with the overarching objective to maintain a zero harm environment. This initiative has been replicated the dedicated transplant unit with 68% reduction in CLABSI events.

P190

HOW AN OUTPATIENT ONCOLOGY URGENT CARE UNIT INCREASED PATIENT SATISFACTION

Stephanie Clark, BS, RN, OCN®, Baylor Scott and

White Health, Dallas, TX; Shawnette Graham, MSN, RN, OCN®, Baylor University Medical Center, Dallas, TX; Ruth Parcerro, MAN, RN, OCN®, Baylor Scott and White Health, Dallas, TX

[Oncology Nursing Practice](#)

In September of 2019, patient surveys were available using Epic departments allowing the outpatient infusion and urgent care areas to be separated for patient satisfaction score assessments. To drill down on areas of opportunity, technology was utilized to separate the departments and evaluate the independent patient experience feedback. Press Ganey is well known for developing and distributing patient satisfaction surveys for health care companies. In FY20 (July 2019-June 2020), the urgent care area noticed a decline in patient satisfaction scores for “likelihood to recommend” from a combined department score of 94.9 in FY19 to a score of 93.9 in FY20. Skilled oncology nurses provide after-hours care to patients experiencing issues related to disease and/or treatment related symptoms. “Likelihood to recommend” is a key metric in evaluating overall patient satisfaction with the outpatient services of the department. In FY21, a project was developed by the Shared Governance Practice Council to improve patient satisfaction scores. In November 2020, the Shared Governance Council addressed the low score of 62.5. An action plan included development of a resource binder that consisted of monthly patient surveys, education materials, and interventions developed by the unit practice council. Interventions included: (a) three education modules from the Learning Management System were assigned to staff to enhance communication skills, (b) a table of key words was posted on each nurse's mobile computer and at the nurse's station for visual reminders of communication phrases, (c) AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank) Service Behaviors were reviewed by staff with the goal to improve communication, promote patient comfort, and decrease patient anxiety, and (d) implemented thank you cards signed by staff and given at the time of discharge to personally thank the patient for allowing us to provide service to them. Survey response rate improved beginning in March and continued through the end of FY21. Scores in FY22 are improving with the sustained implementation of interventions. The outpatient oncology urgent care unit continues to evaluate opportunities for improving “likelihood to recommend” scores by developing and implementing additional interventions. The team will begin evaluating the impact of other domains within the satisfaction survey that could ultimately impact a patient's perception of the facility and the “likelihood to recommend” score.

P191
**TRANSITION OF A CHEMOTHERAPY
DESENSITIZATION PROGRAM FROM THE
INPATIENT TO AMBULATORY SETTING**

Julie Cronin, RN, DNP, OCN®, NE-BC, Massachusetts General Hospital, Boston, MA; Ellen Fitzgerald, MSN, RN, Massachusetts General Hospital, Boston, MA; Ben Slawski, NP, Massachusetts General Hospital, Boston, MA

Coordination of Care

Chemotherapy desensitization allows patients with a drug hypersensitivity reaction to safely receive their preferred line of therapy. Historically this treatment was given exclusively in the inpatient setting. Patients were either admitted to an inpatient bed or treated in infusion chairs on inpatient oncology. Upon review, it was estimated that approximately 40-50% of these treatments would be safe and appropriate for administration in the ambulatory setting. The purpose of this program was to safely transition the administration of chemotherapy desensitization treatments from inpatient oncology to the ambulatory oncology setting. Weekly meetings were initiated with multidisciplinary teams to identify the process for transition, including workflows, potential barriers and communication. Education, training and shadowing opportunities were provided for ambulatory nurses and the basics of cardiac monitoring were revisited as this practice was new to the ambulatory setting. Following implementation, weekly calls were initiated and email communications are ongoing. After completion of 17 months, over 300 chemotherapy desensitization treatments have been administered in the outpatient setting, which accounts for approximately 45-50% of all desensitizations administered. The patient experience has been improved as patients are able to complete their treatment without a required overnight inpatient stay. The program has resulted in hundreds of inpatient bed days saved, positively affecting inpatient capacity constraints. There has also been decreased treatment delays due to lack of inpatient space and an increased utilization of inpatient infusion chairs for other treatments. Fifteen nurses in ambulatory were trained on administration of desensitization and the program continues to expand. Education and training were collaborative between inpatient and ambulatory nursing. Use of cardiac monitoring required additional education and training for ambulatory staff. Ambulatory nurses enjoy administering this type of treatment and being able to offer this service to patients. This program high-

lights that chemotherapy desensitizations can be safely administered in the ambulatory setting.

P192
**PSYCHOSOCIAL DISTRESS SCREENING:
USE OF THE SOCIAL DETERMINANTS OF
HEALTH SCREENING TOOL IN ADULT RURAL
WISCONSIN CANCER PATIENTS**

Ashley Crowe, RN, MSN, UW Oshkosh, Oshkosh, WI, and ThedaCare Hematology & Oncology, Appleton, WI
Psychosocial Dimensions of Care

A diagnosis of cancer is overwhelming and stressful. Distress has been identified as the sixth vital sign in cancer care and has been associated with poorer health outcomes and greater mortality and morbidity. Furthermore, adult cancer patients in rural settings are considered a vulnerable population and are at increased risk for a multitude of psychosocial distresses. Current standards of practice to identify and refer patients with psychosocial distress do not exist, as well as a lack of routine screening and documentation to identify and refer patients in distress. This quality improvement project assessed if use of a standardized, validated psychosocial distress screening tool can effectively identify distress in adult cancer patients at seven rural Wisconsin cancer clinics. A comparison of six psychosocial distress screening tools identified social determinants of health (SDOH) as the most validated, evidence-based tool appropriate for this study. The SDOH screening consists of eight domains ranging from questions regarding alcohol use, depression, financial strain, food insecurity, intimate partner violence, physical activity, social connections, stress, tobacco use, transportation needs, postpartum depression, and housing stability. A comprehensive training of over 100 staff members and integration of electronic health record SDOH screening and algorithms for referral occurred prior to January start date. All adult cancer patients completed a SDOH screening prior to their weekly oncology appointment and predetermined trigger scores identifying distress generated social work referrals. Data analysis compared social work referrals from 2020 prior to SDOH implementation to referrals triggered within the trial period of January – September 2021. The mean number of referrals made per month in 2020 was 6 (SD= 10.01) as compared to an average of 126 (SD= 82.07) social work referrals post SDOH screening implementation, which demonstrates a statistically significant improvement ($r=1454.89$, $p=.000$). Implementation of the SDOH screening tool has helped identify psychosocial distress in rural Wisconsin cancer patients as

compared to previous lack of formal screening. An increased number of referrals were made to address financial, physical, psychological, social, and behavioral issues. Future studies identifying use of the SDOH tool in rural cancer centers could potentially show a reduction in a portion of the unnecessary burden both for patients and for the health care system leading to improved cancer treatment outcomes, survivorship, and improved quality of life.

P193 **PROMOTING A CULTURE OF SAFETY: HIGH RELIABILITY AT AN AMBULATORY ONCOLOGY INFUSION CENTER**

Klara Culmone, MSN, RN, OCN[®], NYU Langone Health, Perlmutter Cancer Center, New York, NY; Juliet Blass, MPH, NYU Langone Health, New York, NY; Laura Loninger, MA, RN, OCN[®], NYU Langone Health, Laura and Isaac Perlmutter Cancer Center, New York, NY; Rosmary Ramos, MSN, RN, OCN[®], NYU Langone Health, Laura and Isaac Perlmutter Cancer Center, New York, NY; Agripina Roxas, BSN, RN, OCN[®], NYU Langone Health, Laura and Isaac Perlmutter Cancer Center, New York, NY; Joshua Sabari, MD, NYU Langone Health, Laura and Isaac Perlmutter Cancer Center, New York, NY

Patient Education and Safety

Our NCI designated, comprehensive cancer center began its journey to becoming a high reliability organization (HRO) in 2018. The main concepts of HRO include: sensitivity to operations, no “simple” explanations, focus on preventing failure, defer to expertise, and resilience. These concepts can be applied to ambulatory cancer centers where the oncology nurse participates in various safety initiatives to prevent harm reaching the patient. The purpose of this project was to promote a culture of safety and eliminate preventable patient harm. A survey was sent, prior to HRO training, to the infusion unit staff to better understand local culture, teamwork and burnout. The survey investigated areas such as; safety climate, decision making, burnout, emotional recovery, teamwork, leadership, and readiness for improvement. HRO training was then initiated with all staff. Learning boards were instituted on the infusion units and the office practice units. This provided dedicated space to assist promotion of HRO principles, behaviors, and tools for daily unit management. This board is often used as a guide for the weekly HRO huddles, and is then updated based upon the needs identified during this huddle. Innovation, engagement, transparency are all encouraged to allow for effective and

clear communication. SMART (Specific, Measurable, Attainable, Relevant, Time-based) aims were also initiated. These aims included: patient arrivals within 15 minutes of scheduled appointment, patient arriving with signed orders, increased anticoagulation education compliance, zero extravasations, and zero falls. Courtesy of the staff assessed with patient satisfaction surveys was also included. Areas exceeding targets included patient arriving with signed orders, zero extravasations, and zero falls. Anticoagulation education is steadily improving; we are also working with medication reconciliation for accuracy. Patients arriving within 15 minutes of their scheduled appointment remains a challenge as this is driven by the office practice. The courtesy of staff had the highest level to attain, however we are close to target. Additionally, there was a marked improvement in communication amongst staff at all levels. Engagement of the staff along with staff appreciation was improved as they witnessed how their opinions were respected and often acted upon. Every opportunity that was revealed in the weekly huddle promoted shared accountability. An unexpected finding was that many involved in the huddles were able to acknowledge one another for specific achievements, reinforcing unity among the staff.

P194 **ARE WE COMPLIANT? HOW TO STRENGTHEN COMPLIANCE WITH FALL SAFETY PROTOCOLS**

Cathy Deleeuw, BN, RN, Karmanos Cancer Institute, Detroit, MI; Clara Beaver, MSN, RN, AOCNS[®], ACNS-BC, Karmanos Cancer Institute, Detroit, MI; Linda Willoughby, BSN, RN, Karmanos Cancer Institute, Detroit, MI

Patient Education and Safety

Hospitalized oncology patients have an increased potential for falls related to many conditions including decreased nutrition, chemotherapy side effects and post-operative complications. During auditing of fall prevention safety protocol, it was noted that there was a lack of compliance with all aspects of the protocol. This prompted the falls committee to ask each manager to come up with a solution to increase adherence to the hospital-approved fall prevention protocols. The purpose of this process improvement initiative was to evaluate the impact of placing the “Fall Safety Checklist” (FSC) and “Patient Safety Education Sheet” (PES) in the patient room. The goal was to see an increase in the compliance use of these tools during bedside shift report by the Registered Nurse.

This process improvement initiative used a Fall Safety Checklist during shift handoffs to complete a point-by-point review of the fall prevention interventions mandated by the hospital's fall prevention protocol. It also uses a "Patient Safety Education Sheet" which the patient signs to acknowledge the purpose of the fall safety initiatives. Both the FSC and PES are placed in the same spot in each patient room. The FSC is to be reviewed and updated at the beginning of the shift during patient handoff times. The PES sheet is to be reviewed with the patient upon arrival to the unit and reinforced when/if the patient is deemed a fall risk. Compliance data was collected for 4 months after intervention. The unit was audited weekly by the Clinical Nurse Specialist prior to placing the fall tools at the bedside. The compliance percentage prior to the intervention was 52%. After the initiation of the intervention, compliance increased to 88%. Compliance with fall protocols can help decrease fall rates of oncology patients. By placing the checklist forms in the patient room, the staff are held accountable for the completion of these forms. By making the forms more visible it allows the staff to use during bedside shift report. The goal of the fall safety checklist is to verify that all fall prevention interventions are in place at the change of shift and that the patient is aware of these interventions.

P195 IMPLEMENTING G8 SCREENING FOR EARLY IDENTIFICATION OF OLDER PATIENTS IN NEED OF COMPREHENSIVE GERIATRIC ASSESSMENT

Anne Delengowski, RN, MSN, AOCN®, CCCTM, Thomas Jefferson University Hospital, Gloucester, NJ; Andrew Chapman, DO, FACP, Thomas Jefferson University, Phila, PA; Michelle Lasota, BSN, RN, CHPN, Thomas Jefferson University Hospital, Phila, PA; Kristine Swartz, MD, Thomas Jefferson University, Phila, PA; Claudia Thomas-Nembhard, MSN, RN, Thomas Jefferson University Hospital, Phila, PA

Coordination of Care

Cancer is a disease of aging and the care of this population needs to be tailored to reflect the unique needs of these patients. The challenges with this population include multiple comorbidities, polypharmacy, lack of social support, sensory and functional impairment. Of note is that "functional" age is probably a better predictor of outcomes than chronological age in this population. This necessitates the need to have the patient properly assessed. To that end, a geriatric assessment (GA) is needed. This assessment should be

multidimensional evaluating many domains using validated tools. When the GA is done, it has been shown to improve survival, physical function and quality of life. A large academic medical center has embedded in their cancer center a Senior Adult Oncology Center (SAOC), which provides comprehensive geriatric assessments. This multidisciplinary team includes medical oncologist, geriatrician, nutritionist, pharmacist, social worker and RN coordinator. Referrals to this center previously was at the discretion of the treating provider or self referral. The team identified the need to improve the process of assuring the appropriate patients were referred to SAOC in a timely fashion. To that end, the team identified the need to have a more structure process for referrals. The group discussed the use of the G8 (1) screening tool. The tool consist of eight questions and takes approximately 5-10 minutes to perform. The G8 is completed on all new patients >65 years old. A script was developed to inform the patient about the purpose of the screening. A score \leq 14 is considered abnormal. Those with the abnormal screen will then be referred for a geriatric assessment. For ease of access, the tool was embedded into the EMR. Prior to the process, education was done for nurses on overview of geriatric oncology. Education was also done with appropriate staff that assist with performing the G8. After an initial pilot, the process has expanded to the entire oncology practice and in the process of being enterprise wide. To date over 458 G8 scores have been recorded. This session will describe the development and process for this project and outcomes from the inception.

P196 TRANSITIONS OF CARE: TEAMING UP TO MAKE A DIFFERENCE

Anne Delengowski, RN, MSN, AOCN®, CCCTM, Thomas Jefferson University Hospital, Gloucester, NJ

Coordination of Care

Ineffective care transitions can lead to adverse outcomes, including medication errors, lack of appropriate followup and avoidable ED visits. This issue is especially evident in regards to the oncology population. The need to improve the process of transitioning the cancer patient from acute care to ambulatory care is of utmost importance. The oncology acute care population at a large academic medical center was split between a medical oncology unit and a telemetry unit. This created a barrier to not only appropriate transitioning of patients from acute care to ambulatory care, but additionally to proper communication of ongoing patient needs. The clinical nursing leadership for both areas

met to develop a structured morning rounding process focusing on transition of care that would accomplish the following goals: (a) to assure vital communication is received by staff caring for the patients, (b) to improve transitions of care, (c) to improve metrics such as discharged to home, decreasing LOS and decrease 30 day readmissions, (d) to increase patient satisfaction, (e) to increase staff satisfaction, and (f) to improve patient/caregiver education. The leadership group met weekly to define the process of the rounding, who would attend the rounds and develop a script that would allow for concise necessary information to be shared with the interdisciplinary members. Additionally, the group defined the role of each member of the group. The rounding group consists of a progression leader, nurse representative for each area, case management, occupational therapist, pharmacist, appropriate medical providers and an outpatient representative that, in addition to other roles, provides real time appointments for patients for ambulatory visits. Presently these rounds occur Monday through Friday. All acute care cancer patients are discussed with the focus being transitions of care. Approximately 35 patients are reviewed daily for needs and the rounds last approximately 30 minutes. This session will discuss the process of the development of the rounds, sustainability of the project, successes, challenges to the process and outcomes. This innovative project continues to evolve with weekly group meetings to improve the process.

P197 IMPLEMENTATION OF STRUCTURED INTERDISCIPLINARY ROUNDS ACROSS A COMPLEX HEMATOLOGY & STEM CELL TRANSPLANT SERVICE LINE TO IMPROVE OUTCOMES

Erica Dickey, MSN, RN, AGCNS-BC, OCN®, City of Hope, Duarte, CA; Jennifer Peterson, MSN, RN, OCN®, BMTCN®, City of Hope, Duarte, CA; Monica Munaretto, MSN, RN, OCN®, City of Hope, Duarte, CA; Kezia Andrews, MSN, RN, City of Hope, Duarte, CA; Eufie Pulmano, MSN, RN, OCN®, BMTCN®, City of Hope, Duarte, CA; Janelle Saluja, MSN, NP, City of Hope, Duarte, CA

Coordination of Care

Interdisciplinary rounds (IDR) are associated with better patient outcomes and improved communication, however, no standard approach to IDR exists. The determination of team composition and goals is left to the organization, and is influenced by organizational culture, patient population, and medical team structure. The Advanced Practice Provider/RN (APP/

RN) Rounds Pilot Program aimed to improve communication between nurses and the providers, identify education and workflow gaps, decrease length of stay, and increase staff satisfaction with IDR. Lewin's Change Model was used to design the implementation. Both "sit-down rounds" and "walking rounds" were piloted to determine best fit for the organization. Specific roles were defined, and staff were provided with education on expectations for participation and preparedness. The Rounds Manager was responsible for facilitating staff participation in IDR and was assigned to a clinical manager or unit educator. The APP presented the patient to the RN, and the RN would review key points from a structured checklist. Hematology teams were introduced to the program one at a time. Team participation was based on the geographical cohorting model. Six months post-implementation, the first medical team experienced a 37% decrease in length of stay. Staff satisfaction was measured using a Likert scale with 5 meaning "agree" and 1 meaning "disagree." In response to the statement, "Participation in rounds added value to my day," staff expressed slightly higher scores with walking rounds (4.5) compared to sit-down rounds (4.4). In response to the statement, "I feel empowered to ask questions and contribute to the discussion during rounds," staff expressed higher scores with walking rounds (4.2) compared to the baseline survey (3.5). IDR facilitation required a higher-than-expected degree of coordination with the Rounds Manager, Unit Ambassadors and Charge Nurses. Vocera devices were purchased for the APPs to facilitate communication with staff. Discussions from IDR yielded education and process improvement initiatives. IDR provides an opportunity for the clinical manager and unit educators to increase visibility in the units and provide education in real time. Literature illustrated that rounds are not a one size fits all process and that variables unique to each organization need to be considered. We were able to incorporate those variables that worked for our institution and have seen wonderful results.

P198 RESTORING PATENCY TO A CENTRAL VENOUS CATHETER UTILIZING NURSE DRIVEN PROTOCOL

Tara Donnelly, MSN, RN, NE-BC, Overlook Medical Center, Summit, NJ; Kerstin Scheper, DNP, RN-BC, OCN®, CHPN, Atlantic Health System, Summit, NJ
[Oncology Nursing Practice](#)

Central venous access is crucial to the safe administration of cancer treatments. Complications of central

venous catheters (CVC) can include partial or complete catheter occlusions. These complications can lead to treatment delays and affect a patient's quality of life. Proper assessment and early intervention of occlusions can allow a patient's care team to successfully manage these complications. A nurse driven care algorithm for patients with a CVC with a partial or complete catheter occlusion can allow patients to receive more timely and efficient care. Early intervention to troubleshoot and resolve CVC occlusions will prevent treatment delays and allow patients to spend less time in the infusion centers waiting for the nurse to contact the physician to obtain an alteplase order. An interdisciplinary team developed a care algorithm consisting of a practitioner's order for the "Nurse to Implement Adult Inpatient Oncology and Outpatient Infusion Center Use of Alteplase for Thrombotic Occlusion Protocol" which was embedded in the health system's electronic treatment plans. When this order is signed, the nurses trained and competent in this protocol would implement the protocol and administer alteplase in the presence of a thrombotic occlusion. Nurses received education on thrombotic occlusions and the protocol after it was vetted by several hospital committees, including Nurse Practice Council. At multiple infusion centers within a healthcare system, medical records were reviewed on patients who received alteplase. Pre-protocol data showed an average treatment delay of thirty minutes. The protocol has been implemented and the organization is in the process of completing post protocol data review to evaluate for a reduction in treatment delays. Nurse driven protocols have positive impacts on quality patient care and empower nurses to make decisions and implement them as part of their scope of practice. This care algorithm will have a positive impact on nurses and patients. Nurses will spend more time focused on patient care through efficient workflows. Patients will benefit from improved workflows with a reduction of time spent waiting for the nursing team to obtain medication orders. To provide patients with high quality care, workflow inefficiencies need to be identified. The addition of clinical decision support systems embedded into treatment plans in the electronic medical record, will reduce workflow efficiencies.

P199
BONE MARROW TRANSPLANT (BMT) TV:
A TELEVISION-BASED EMPLOYEE
ENGAGEMENT INTERVENTION

Danica Dorlette, MPH, BSN, RN, OCN[®], New York
Presbyterian at Weill Cornell Medical Center, New

York, NY; Paige Ahearn, BSN, RN, BMTCN[®], New York
Presbyterian at Weill Cornell Medical Center, New
York City, NY

COVID-19

The COVID-19 pandemic has left an indelible mark on healthcare workers worldwide, causing burnout and moral distress. Symptoms and prevalence of burnout can be alleviated by implementing individual-focused strategies and minor modifications in work environments (Howell, 2021). These modifications may help to also increase employee engagement - the level of connection between employees and their workplace. In healthcare, engaged employees lead to higher patient satisfaction rates, increased patient safety, and improved quality of care. An interdisciplinary team at a large-urban academic medical center sought to increase employee engagement on a 16-bed inpatient bone marrow transplant unit. Ill effects of burn-out has contributed to unit decreases in quality outcomes, HCAHPS scores, and employee retention. Helping staff to be engaged in their work and committed to the organization has been cited to raise productivity, quality of care, and lower employee turnover. This project aims to increase engagement by 15% in 5 areas: employee satisfaction, recognition, job importance, growth and development. A television-based intervention was used as a strategy to improve engagement amongst an interdisciplinary team. A monthly-themed slideshow played continuously in the nurses report room and contains images and text that celebrate the individual, unit-values/activities, and achievements. Some of this includes opportunities for learning, celebration of employee professional and unit accomplishments, and peer-to-peer and leadership recognitions. Monthly-themed information that promote self-care at and outside of the workplace were portrayed as well. An electronic survey via Survey Monkey was disseminated using convenience sampling to the BMT interdisciplinary team members over the span of 3 months. Questions on the survey were pulled from the Gallup Q12 Survey, a validated tool for measuring engagement. The questionnaire included questions on satisfaction, recognition, support, development, and growth as a healthcare professional. The final survey results illustrate that our BMT team has seen a 25% increase in overall satisfaction in comparison to pre-intervention. In addition, increases between 30-40% have been noted in the remaining 4 aimed areas. The BMT unit has also seen quality metrics improve—CLABSI, CAUTI, Falls, and HAPI—during the intervention period. We plan on continuing this initiative and are eager to see its continued positive impact on the team.

P200 PROCESS IMPROVEMENT FOR COMPLETION OF ADVANCE CARE PLANNING IN RADIATION ONCOLOGY AMBULATORY CLINIC

Anna Du Pen, RN, MN, CHPN, Seattle Cancer Care Alliance - Peninsula, Poulsbo, WA; Berit Madsen, MD, Seattle Cancer Care Alliance - Peninsula, Poulsbo, WA; Kristina Gates, Seattle Cancer Care Alliance - Peninsula, Poulsbo, WA

End of Life

The incidence of new cancers in the United States is 1,898,160 (ACS) and ~50% of those patients will receive radiation therapy often in ambulatory settings. Advance Care Planning (ACP) is a process for patients and families to make decisions about personal future health care provisions. ACP has been associated with lower rates of CPR, ICU admission, earlier hospice enrollment, and decreased cost of care at the end of life. Research demonstrates low rates of completion in ambulatory oncology settings. NCCN Guidelines, ASCO and IOM 2015 recommend ACP for oncology patients. Nurses at a community radiation center identified an opportunity to increase patient ACP completion during radiation therapy. The purpose of this project was to improve patients' completion of Advance Care Planning in a community practice ambulatory radiation therapy clinic. Nurses collaborated with a team of physicians and administrators to assess ACP completion rates in radiation therapy patients and designed a standardized improvement to facilitate completion. Baseline data collected at new patient consultation for radiation therapy. Then a process was designed that imbedded ACP assistance into the workflow of the treatment course, reduced barriers to Advance Care planning by 1) developing a "Frequently Asked Questions about Advance Directives" for distribution to all new patients that report not having Advance Directives, 2) creating a visit with a Radiation Oncology RN to education patients on the fundamentals of DPOA-HC and Health Care Directives specific to Washington State, 3) having a notary on-site to finalize the documents, and 4) evaluating the outcome through repeat data collection. Following implementation of the standardized improvements ACPs completion rates increased from a baseline of 46% to 80% of radiation oncology patients in the clinic during their treatment course. Cancer patients have a risk of progression and decline during treatment which can lead to confusion and distress in the absence of designated surrogate decision makers and written preferences for medical care. Nurses are integral to the implementation of ACP for cancer pa-

tients as the course of therapy commences to provide strong patient-centric care delivery for patients and families, as well as assure best practice under current national guidelines. Building capacity to support ACP for radiation oncology patients in the ambulatory setting supports the achievement of best outcomes for end-of-life-care.

P201 SEQUENTIAL HAZARDOUS DRUG WIPE TESTING IN AN AMBULATORY COMPREHENSIVE CANCER CENTER

Seth Eisenberg, ADN, RN, OCN®, BMTCN®, Seattle Cancer Care Alliance, Seattle, WA; Xheni Waggoner, PharmD, BCPS, Seattle Cancer Care Alliance, Seattle, WA

Oncology Nursing Practice

Exposure to hazardous drugs (HDs) poses many significant risks to healthcare workers. Side effects range from gastrointestinal and respiratory complaints to infertility and miscarriages. Research has shown that HD contamination can spread from pharmacy areas and administration areas to other clinical and non-clinical locations within the healthcare facility. As a part of a comprehensive HD plan, the United States Pharmacopeia chapter 800 (USP <800>) recommends regular surface wipe testing to assess vulnerabilities in compounding and administration and highlight areas for improvement. Sequential wipe testing was performed in an ambulatory comprehensive cancer center to test for HD residue in 4 pharmacy compounding areas and 2 administration areas. Tested drugs included paclitaxel, 5-FU, cyclophosphamide, methotrexate, and doxorubicin. Testing occurred between December 2020 and June 2021 and was performed at baseline, 3 months and at 6 months using the sampling technique specified by ChemoGLO. The authors sampled the interior of a biological safety cabinet (BSC), air grate of BSC, floor in front of the BSC, floor of the personal protective equipment (PPE) doffing area in the compounding room, and the mixing bin for staging items needed for sterile HD compounding. In the administration area, the legs of one marked IV pole was tested along with the handle of a designated telephone at a nursing station. The identical locations and procedures were used by the authors for all 3 testing periods. The majority of the IV HD compounding, and all administrations were performed using the ChemoLock CSTD. Test number one revealed two areas above the level of detection (LOD); the mixing bin (5FU) and the IV pole (paclitaxel). Tests 2 and 3 were below the LOD for all drugs

in all areas. USP requires a 4-step cleaning/decontamination process for sterile compounding of HDs. The process was not utilized consistently for the mixing bins and could explain initial HD residue. Decontamination frequency was increased after the first results. While the IV pole was wiped down with an antimicrobial cloth between each patient, the legs were not included in the cleaning procedure, nor is it known how long the paclitaxel contamination had been there. This project demonstrated effectiveness of the CSTD and the need for improvement in cleaning the IV poles. Process changes and cleaning products are currently being discussed.

P202 FOCUSED REVIEW OF QUALITY MEASURES THROUGH A PANDEMIC

Kathleen Fedoronko, MSN, RN, OCN[®], Karmanos Cancer Center, Detroit, MI; Clara Beaver, MSN, RN, AOCNS[®], ACNS-BC, Karmanos Cancer Institute, Detroit, MI

COVID-19

Nurses at our NCI-designated comprehensive cancer center pride themselves on providing safe, quality, and compassionate care to our patients and their families. During the pandemic, our abilities to do so were truly tested. Family engagement is essential in the patient's cancer journey and it is routine for them to be at bedside during hospitalizations. We believe limiting visitors, and the loss of their encouragement and support of their loved one, influenced outcomes. Most notably the rates of falls, pressure injuries and infection rates increased during this time. Staff nurses, along with leaders and content experts, routinely participate in committees dedicated to reviewing our nursing sensitive indicators and offer suggestions/ideas of how to improve these measures. However, with the rates increasing, leadership needed to conduct a deeper review of nursing practice. The purpose of the additional task forces was to look at current practice and enhance strategies to improve the quality of care. In addition to meetings that the bedside staff were having, nursing leadership, the quality department, the Clinical Nurse Specialist (CNS), Chief Nursing Officer and content experts (e.g. WOCN, Infection preventionist) all participated in task forces focused on improving quality. The task force, with support from Nurse Practice Council (NPC), implemented new strategies which included re-education of the fall protocol and development of an escalation process for patient refusal, targeted Braden training, case study presentations and standardizing hygiene products

used by patients and staff. The rate of falls, infections and pressure injuries have not returned to pre-pandemic rates but are starting to show less variability. While our number of falls, pressure injuries and central line associated blood stream infections (CLABSI) were trending higher than 2020, we have been able to generate momentum with these new initiatives. We expect they will help us return to our norm of providing safe, quality and compassionate care that we can be proud of. By bringing the leaders and content experts together as a task force, a focused review took place and structured action plans were developed more quickly. Discussion at the NPC helped ensure a shorter turnaround time to implementation.

P203 USING THE COVID-19 PANDEMIC TO LAUNCH AMBULATORY CANCER CARE DELIVERY WORKFLOW TRANSFORMATION

Monica Fradkin, BSN, MPH, OCN[®], CNML, Smilow Cancer Hospital at Yale New Haven Hospital, New Haven, CT; Constance Engelking, RN, MS, The CHE Consulting Group, Inc., Old Lyme, NY; Anne Chiang, MD, PhD, Yale School of Medicine / Smilow Cancer Hospital, New Haven, CT; Jeremy Kortmansky, MD, Yale School of Medicine / Smilow Cancer Hospital, New Haven, CT
Coordination of Care

The Covid-19 pandemic placed enormous burdens on hospitals to rapidly accommodate an influx of critically ill patients. Our academic cancer center answered the call by relocating ten oncology practice sites comprising the cancer center to house Covid-19 patients. Existing workflows were modified to meet demands of new care settings. Senior leaders capitalized on the resulting opportunity to launch an enterprise-wide transformation initiative addressing four categories: inpatient, ambulatory, clinical research, supportive care. A structure for accomplishing this wide-ranging ambulatory quality improvement (QI) work was created. An Ambulatory Transformation Steering Group provides oversight; focused QI work is conducted by six teams. Care Delivery Workflow is one of six teams charged with addressing dimensions of outpatient care delivery identified in a current state assessment. The purpose of this project was to engage providers, patients and staff in the development, testing and implementation of novel care delivery workflows to create a "new normal" that elevates the patient experience, optimizes technology applications, enhances operating efficiencies, and increases overall satisfaction. An electronic survey comprising 100 questions addressing care delivery workflows was designed/

distributed to 1000 staff and providers as a first step in identifying improvement opportunities. Feedback from ~200 physician and staff was aggregated/analyzed to reveal themes, priorities and best practices. Ten areas needing attention emerged using a rank ordering activity including: 1) Clinic Flow Enhancement (Visit Type Criteria [In person vs Telehealth], Patient Scheduling, Diagnostic Imaging Access, Patient Visit Readiness); 2) Infusion Flow Optimization (Advanced Drug Release, Lab testing Coordination); 3) Video-enabled Patient and Family Education. Multidisciplinary teams convened to design and pilot new or modified workflows for implementation. A structured QI toolkit guides team activities; progress reports are presented regularly to Steering Group. Key findings of current state assessment revealed wide variation in workflows depending on location, volumes, staffing and provider preferences. Metrics to conduct effectiveness evaluations of new processes are customized to the activity and incorporated into each project. A high degree of engagement is evidenced by robust response to surveys, willingness and consistent participation of > 70 QI team members in addressing issues interfering with best care delivery. This large-scale QI project has several interlocking subprojects and involves multiple specialties/disciplines practicing in geographically different locations. Virtual meetings facilitated by Zoom technology enabled full multidisciplinary participation in this cross-organizational work.

P204 **MEANINGFULNESS IN PRACTICE: THE ONCOLOGY NURSE'S PERSPECTIVE**

Fabienne Gaillard Ulysse, DNP, AOCNP®, ANP, NYU Langone Health, Brooklyn, NY; Chenee Cytall, RN, BSN, OCN®, NYU Langone Health, Brooklyn, NY
[Oncology Nursing Practice](#)

The panorama of cancer care is advancing in the realms of technology, research, treatment modalities and care delivery. The incidence of cancer has drastically increased over the past decade and the oncology nurse is strategically positioned to provide invaluable care to patients through their journey from diagnosis to survivorship. In addition, the role of Oncology Nursing has expanded tremendously while nursing practice continues to develop and respond to the changing needs of patients with cancer and their families. The ability to continuously respond to these changing needs may be influenced by the oncology nurse's ability to derive meaning from practice. The purpose of this Quality Improvement project is to describe the oncology nurse's perception of meaningful-

ness in practice and the impact on care delivery. The project was conducted at an urban academic medical center. Twenty oncology nurses on the outpatient oncology center participated in a one-time survey study. Questions in the survey were developed based on the Clarke and colleagues' Holism model, and included 5 questions on the nurses' perception of the oncology nurse role, how it relates to staff/patient satisfaction, and the impact on quality of care. Descriptive summary statistics were calculated for the survey responses. 85% of the nurses reported feeling like he/she is part of something great which makes their practice more meaningful. Other common meaningful activities included "advocacy for the patient and their families" reported by 80% and attention to the whole person and not just the patient's cancer diagnosis reported by 90%. Potential barriers to deriving meaning in practice included "walking on a fine line" when needing to negotiate with the care team, investing in patients' lives, and finding balance in life reported by 90% of nurses as well as extensive paperwork being the least meaningful part of the practice, but 100% reported understanding the importance of required documentations. Understanding the meaningfulness of oncology nursing practice may increase role awareness in relation to care delivery. Quality improvement efforts should consider the ability of deriving meaning in oncology nursing practice as a strategy to improve the quality of cancer care delivery. Ability to derive meaning in practice may also promote oncology nurses' well-being, improve retention rates, and higher patient satisfaction with care.

P205 **PERIPHERAL VESICANT ADMINISTRATION**

Lindsay Gaskell, MSN, RN, OCN®, University of Iowa Hospitals and Clinics, Iowa City, IA; Jennifer Off, BSN, RN, OCN®, University of Iowa Hospitals and Clinics, Iowa City, IA; Lindsey Sadewasser, BSN, RN, OCN®, University of Iowa Hospitals and Clinics, Iowa City, IA
[Oncology Nursing Practice](#)

The University of Iowa Hospitals and Clinics Holden Comprehensive Cancer Center Infusion Suite administers peripheral vesicants to oncology patients daily. Vesicant chemotherapy can cause significant tissue damage if extravasation occurs during administration. We identified a need for process standardization and overall improved knowledge on the topic of peripheral vesicant administration amongst our staff. We also aimed to decrease the number of extravasations reported per quarter. The purpose of the project was to provide comprehensive education

to staff RNs responsible for administering peripheral vesicants in the Infusion Suite. We presented information on the updated policy/procedure for peripheral vesicant administration including tubing set up for IV push and IV bag administration in multiple small group sessions with staff. The new preferred method for checking blood return along with blood return frequency throughout vesicant administration was also reviewed. We also included information regarding symptom identification and management of extravasations as well as flare reactions. During the presentation, we asked for 1:1 return demonstration of proper tubing set up for both IV push and IV bag vesicant administration. A 15-point pre and post knowledge assessment was administered to the staff which showed overall improved knowledge on the topic. We also created informational pocket cards and a reference poster (attached) for the staff to reference as needed. We have seen a decrease in the number of adverse medication events i.e. extravasations since the completion of this quality improvement project and staff have expressed feeling more confident administering peripheral vesicants.

P206 **BUILDING PATIENT ASSIGNMENTS** **USING DATA ANALYTICS AND SHARED** **GOVERNANCE**

Karly Goozee, MSN, RN, OCN®, Emory Healthcare, Atlanta, GA; **Erin Peone, MSN, RN, OCN®**, Emory Healthcare/Winship Cancer Institute, Atlanta, GA; **Colleen Lewis, MSN, ANP-BC, AOCNP®**, Winship Cancer Institute of Emory University, Atlanta, GA; **Lana Uhrig, PhD, MBA, RN**, Winship Cancer Institute of Emory University, Atlanta, GA; **Obehi Ukpebor, LeanTaaS**, Santa Clara, CA

Oncology Nursing Practice

Patient flow is a primary driver of patient satisfaction and operational effectiveness in an oncology ambulatory infusion center (AIC). Proper nurse/patient assignments are critical to optimize patient flow. Constraints such as variable patient arrivals and patient acuity can make advanced patient assignments challenging. This report details how a 69 chair oncology AIC utilized data analytics and shared governance tactics to overcome these constraints and achieve a standard of making advance nurse/patient assignments. In fall 2020, nursing staff and leaders adopted the LeanTaaS nurse allocation tool with goals of decreasing patient waits and improving patient and staff satisfaction. Previous process improvement projects led to enhancements

through data driven solutions, however nursing concerns remained around patient flow bottlenecks and extended wait times. The function of nurse/patient assignment relied on a charge nurse to survey chairs and make assignments after patient arrival. Because of real-time assignments, surveyed nurses reported frustration and lack of control to adequately prepare for their patients. This contributed to care delays and decreased nurse and patient satisfaction. Leadership employed a shared governance approach enlisting the shared governance council to understand concerns of nurses regarding nurse/patient assignments, which included: unpredictable patient arrivals, lack of time for chart review, unexpected treatment changes, and add-on patients. The council was tasked with developing standard work (SW) and decision matrix for nurse assignments for various patient scenarios. The SW and decision matrix was integrated into the nurse/patient allocation tool. The charge nurse runs the nurse/patient allocation tool the day prior and makes nurse/patient assignments in advance, so nurses can prepare for their assignment. After implementation of the allocation tool process, patient wait times decreased by 25.5% and patients waiting greater than 90 minutes decreased by 61.4%. Patient volumes increased 7% during the post implementation period. Mean patient experience scores improved over 2 percentage points. In a post implementation employee engagement survey, 95% of respondents indicated high levels of satisfaction with their work and overall engagement index increased by 9% from previous years. Nurses appreciate and expect the nurse allocation daily to allow for advance preparation. Nurses are able to check orders, prepare blood products, or see if there are patient appointment changes. Securing support and input of frontline staff were key factors in project success.

P207 **IMPROVE THE KNOWLEDGE LEVEL OF** **PATIENTS INITIATING CHEMOTHERAPY** **IN THE AMBULATORY CARE SETTING:** **RECOMMENDATIONS FOR PRACTICE**

Neethu Gopinadh, MSN, RN, OCN®, VA-BC, **Phelps Hospital Northwell Health, Sleepy Hollow, NY**
Patient Education and Safety

The Centers for Disease Control and Prevention reports that about 650,000 patients diagnosed with cancer receive chemotherapy at outpatient clinics in the United States. The first infusion of chemotherapy is often anxiety-provoking for patients. Apart

from the diagnosis, uncertainty about the treatment plan and unfamiliarity with the healthcare team are contributing factors of anxiety and distress. This negatively impacts the ability of patients to comprehend and retain the critical information provided to them on the day of treatment. The purpose of this project was to improve the process of education for patients initiating chemotherapy, thereby improving patients' knowledge of potential side effects and self-care at home. A literature review using the CINAHL, PubMed, and Google Scholar databases was conducted. Five effective strategies were identified: (a) education on self-management of side effects, (b) timing of education (c) incorporation of audiovisual aids, (d) standardization of the educational content and materials, and (e) teach-back techniques. The Quality Oncology Practice Initiative standard 2.2 states that patients should be provided with comprehensive verbal and written or electronic information as part of an education process before starting each treatment plan. The quality of the evidence is high, and the practice recommendations are strong. High-quality randomized controlled trials on large samples tailored to diverse patient populations, primary languages, and cultures are also recommended. Standardized pre-chemotherapy education utilizing an education checklist, audiovisual aids, and teach-back techniques is recommended before the day of treatment. The HCAHPS scores related to self-management of side effects and self-care at home after treatment are measures to evaluate outcomes. Standardized pre-chemotherapy education will empower patients with the knowledge to prevent and manage the potential side effects of chemotherapy, recognize dangerous side effects and present to the emergency room promptly, and prevent unnecessary triage calls/unnecessary visits to the emergency room. Furthermore, it will reduce feelings of anxiety and distress, improve patients' ability to make informed decisions and adhere to the treatment regimen, thereby improving patient outcomes and the quality of life of patients initiating chemotherapy. Standardized pre-chemotherapy education will improve the HCAHPS scores, increase the reputation of organizations, and the incentives from the Centers for Medicare & Medicaid Services (CMS).

P208 RESEARCH AND NURSE COLLABORATION: BUILDING A FOUNDATION

Shawnette Graham, MSN, RN, OCN[®], Baylor University Medical Center, Dallas, TX; Kathleen Shuey, MS, RN,

ACNS BC, AOCN[®], Baylor University Medical Center, Dallas, TX; Joyce Ghormley, CCRC, BSW Health, Dallas, TX

Quality Improvement

Expanding Oncology Research is a focus strategy for the oncology units. The inpatient facility does not have an established research unit, patients are placed in one of the four specialized oncology departments. Nursing works in collaboration with research staff to evaluate protocols, participate in Epic order set builds, and determine patient placement based on the needs of the patient. Due to the increase in patient volume and number of research trials, patient placement on specific units for treatment was becoming difficult. Nursing and research staff needed a way to quickly work together to meet patient needs. The purpose of this project was to work collaboratively in creating a standard workflow to ensure patients received quality care, clinical staff have resources available, and trial requirements were met. A monthly nurse research collaboration meeting was initiated that identified processes that needed to be established. Interventions included creating a Teams site for collaboration, SharePoint site for research materials and patient admission lists, and utilizing Forms for clinical feedback on barriers. Documents include standard research flow chart, protocol assessment, protocol assignment, patient scheduling, level of care determination, expectations, escalation guide, consistent in-service format, use of Epic Beacon template, and how to update binders on the unit. Streamlining the processes have assisted in working collaboratively with the research department and nursing leadership team. Clinical nurses have seen standardization in in-service documents and education. Barriers that have been reported by clinical staff have been related to Epic builds and pharmacy workflows. Other identified concerns are the lack of an established process with new hires in both nursing and research in utilizing the documents or finding resources available. Restrictions with distancing due to the covid pandemic has also brought to light a need for virtual education or refreshers. As new charge nurses are trained, gaining access to the admission list or knowledge of where to find the list remains a challenge. The team has made progress in establishing processes and resources for nursing and research staff to utilize. We have work to do in creating a process that will ensure all new employees receive education on where to locate resources, what is available, and adding a research pharmacist to the team.

P209 **MAINTAINING PATIENT CARE IN THE AGE** **OF CYBER ATTACKS**

Cara Henderson, MSN, RN, CMSRN, CNML, Yale New Haven Hospital, New Haven, CT; Kelli-Ann Mancini, MSN, RN, OCN®, Smilow Cancer Hospital, New Haven, CT

Coordination of Care

Our organization had a credible threat for a potential cyber-attack. While prepared for routine downtime that may last for a limited duration of time, our organization was not well prepared for extensive downtime that could potentially carry into an unknown number of days or weeks. The purpose of this project was to ensure that patient care and daily operations are uninterrupted in the event of a cyber-attack on the hospital's electronic infrastructure and to provide the frontline staff with the necessary tools to provide seamless patient care. An interdisciplinary group, focusing on emergency preparedness, was convened to design a downtime process map that outlines patient care delivery and interdepartmental communication. The following scenarios were constructed and rehearsed: Direct admission for elective chemotherapy, direct admission or transfer of a patient requiring inpatient care, and admission from the post-anesthesia care unit (PACU). Existing downtime forms were utilized to re-create all aspects of care from admission to discharge. Processes were developed for reconciliation of patient care orders, chemotherapy verification/administration as well as physician consults, diagnostic imaging and laboratory specimen collection with result retrieval. A practice run was performed to validate the workflow as it pertains to safe patient care delivery in the above scenarios. A downtime drill was performed to include all members of the interdisciplinary team on the inpatient units. The drills were completed for each scenario and adjustments in the process were amended as necessary. A successful walkthrough was accomplished prior to completion. Downtime processes can be utilized efficiently for routine and planned downtime as well as for emergency operations. Downtime process maps were streamlined across all inpatient care delivery and are readily accessible to staff in the event of an emergency. Review of resources and procedures with staff were completed for awareness purposes. Preparedness is imperative to the success of safe patient care. We took our current system of downtime procedures and invigorated it to expand past routine maintenance downtime.

P210 **GIRD YOUR LOINS: IMPROVING** **PREPARATION FOR PROSTATE RADIATION** **THERAPY SIMULATION**

Amy Hicks, DNP, RN, ACCNS-AG, NEA-BC, Levine Cancer Institute, Charlotte, NC; James McBride, BSN, RN-BC, Levine Cancer Institute, Charlotte, NC

Patient Education and Safety

Prostate cancer is one of the leading types of cancer in males in the United States. Radiation therapy is a common treatment modality for this kind of cancer. As part of the treatment process, patients undergo a CT simulation that is used to plan the radiation therapy. During the CT simulation, the positioning of the prostate is important to ensure the accuracy of the radiation and to reduce the risk of damage to other organs. The proper position can best be achieved by avoiding rectal distention and ensuring a moderately full bladder. To reduce shifting of the prostate and maintain a consistent position, patients are asked to complete a bowel prep and arrive at their CT simulation appointment with a moderately full bladder. Inadequate preparation can result in cancellations, loss of revenue, inefficiencies, and poor patient experience. Prior to this project, the cancellation rate was 21%. An interprofessional task force was formed with the goal of reducing cancellations. Data was collected utilizing Microsoft Forms with a QR code to input information on prep completion and barriers. The team tailored interventions based on this data. Nurses collaborated with health literacy experts to revamp the patient education, including pictures and plain language. They also developed an automated alert in the EMR to notify the nurse 4 days in advance that the patient needed education to ensure there was adequate time to complete it. Reinforcement of the education was achieved utilizing Google Voice to send text reminders and a copy of the patient education. After implementation, the average cancellation rate dropped to 5%, a 78% decrease ($p=0.04$) and lost revenue decreased 70%. The goal was exceeded, and the results have been sustained through engagement of the interprofessional team. The delivery of education via a planned, systematic process that included assessment of readiness and barriers, an action plan to address barriers, and an evaluation of the learning performed by a nurse was key to the success of this project. The innovative use of technology to collect data on barriers, developing interventions, and evaluating each test of change also helped to drive improvement. The revamped education document using health literacy principles has been shared as a best practice to other sites in the system.

P211 IMPLEMENTING SAFETY ROUNDS IN RADIATION ONCOLOGY: NURSING INVOLVEMENT

**Karol Huenerberg, RN, APNP, FNP-BC, AOCNP®, UW
Health, Madison, WI**

Treatment Modalities

Radiotherapy will be utilized as a treatment method in over 50% of cancer cases. The field of radiation therapy is complex and ever changing. Safe delivery of radiation requires a team of members including radiation oncologists, advanced practice providers, physicists, dosimetrists, radiation therapists, nurses and support staff. Establishing and maintaining a culture of safety is imperative to the safe delivery of this treatment modality. The American Society for Radiation Oncology (ASTRO), in its standards to achieve accreditation status for radiation oncology programs, references a culture of safety. Standard 7 states “The radiation oncology practice fosters a culture of safety in which all team members participate in assuring safety, the practice capitalizes on opportunities to improve safety and no reprisals are taken for staff that report safety concerns (APEX Program Standards, 2020). Incorporating regular safety rounds in a radiation oncology department is an opportunity to involve all team members, including nursing, engaging them in a process to improve the culture of safety and quality in the department. To promote a culture of safety, safety rounds were implemented in the radiation oncology department at our large academic comprehensive cancer center. The safety rounds included all department team members. Nurses in the radiation oncology department at the main campus and the satellite location participated in safety rounds. Safety rounds were conducted twice a month by two Quality Assurance committee members by interviewing different groups of the department staff over a 9-month period, capturing all team groups. A standardized rounding tool was utilized. Rounding questions included: what is working well and why; do you have the tools and equipment to do your job; are there areas to improve; what is needed to improve safety; are there items that haven’t been followed up and is there anyone you’d like to celebrate? Department staff identified many actionable items to improve the safety and quality of the delivery of radiation therapy. Nursing staff at both locations actively participated in the safety rounds. They identified processes that are working well, specific areas for improvement, and several ideas to improve safety. As a result of the safety rounds, new processes were implemented. Safety rounds continue to be conducted on a regular basis.

P212 CHEMOTHERAPY EDUCATION FOR PATIENTS . . . VIRTUALLY FILLING THE GAP

**Catherine Jansen, PhD, RN, AOCNS®, The Permanente
Medical Group, San Francisco, CA; Kimberly
Beringer, RN, MSN, The Permanente Medical Group,
San Francisco, CA**

Patient Education and Safety

Preparing to start cancer treatment can be a stressful time and patients frequently report feeling anxious and sometimes overwhelmed. Oncology nurses play a pivotal role in educating patients about what to expect during treatment. Historically our clinic offered a weekly 1.5 hour in-person group class on chemotherapy, potential side effects, symptom management, and available community resources. Although the goal was for all patients to attend prior to initiating chemotherapy, several barriers (e.g., class schedule, language) were identified over time. Our team’s objectives were to 1) develop an abbreviated online chemotherapy course in multiple languages; and 2) develop a workflow to provide communication to all key stakeholders and facilitate patient awareness. In 2019, a small workgroup (director, CNS, staff nurses, health educator) collaborated on developing the chemotherapy course content, slides, and a corresponding script. A data analysis was done to determine language preferences of our current patient population and based on these results the group decided to concentrate efforts on Chinese (Cantonese and Mandarin) and Spanish translations. The health educator assisted with providing culturally appropriate pictures for the slides and a professional translation service was utilized for accurate interpretation of the class and script content. Other stakeholders within the department were consulted during the development of communication and patient outreach workflows. An Epic® smartphrase with corresponding links to the online course was created for communicating with patients via secure messaging in the appropriate language. The availability of an online chemotherapy class increased our ability to provide general chemotherapy education for a greater number of patients prior to treatment. Nurses continued to provide individualized teaching at the bedside regarding specific drug regimens and potential associated side effects. With the onset of COVID-19 in 2020 when virtual education became necessary, we were able to easily pivot and standardize this process to be incorporated in other sites within our organization in Northern California. A patient survey indicated that 72% of patients found the online course to be very to extremely useful. Vir-

tual chemotherapy courses can be indispensable for providing education prior to treatment, as well as being a reference for patients and family members throughout the duration of chemotherapy

P213 **NURSE LIAISON: BRIDGING THE GAP IN THE CARE CONTINUUM FOR AMBULATORY INFUSION PATIENTS**

Sandy Jellen, RN, OCN®, UCSD Moores Cancer Center, La Jolla, CA; Gabriela Lacatus, RN, BSN, OCN®, PhD, UCSD Moores Cancer Center, La Jolla, CA; Diana T. Nguyen, PharmD, BCOP, UCSD Moores Cancer Center, La Jolla, CA; Assuntina G. Sacco, MD, UCSD Moores Cancer Center, La Jolla, CA

Coordination of Care

In an NCI-designated Comprehensive Cancer Center, the introduction of a registered nurse liaison (NL) has significantly impacted the order review process for oncology, non-oncology, and supportive treatment plans. Prior to the implementation of this role, unsigned treatment plans were addressed by the charge nurse on the appointment day. This resulted in multiple phone calls to the provider leading to patient delays which may negatively affect patient safety and experience. The purpose of the NL role is to ensure proactive review that orders are signed and dated for the appropriate treatment plan, consent is verified, and resulted labs are within treatment parameters. A multidisciplinary team consisting of nursing, physicians, and pharmacy convened to develop a workflow for treatment plan order review. New cancer center guidelines and email communications were sent to referring providers regarding the need to sign orders three days prior to scheduled Infusion. Prior to implementation, nursing staff completed a baseline two week audit to capture the number of daily unsigned orders. During the pilot, two NLs reviewed approximately 150 treatment plans per day for order completeness, 3-4 days prior to the scheduled appointment. For each patient with unsigned orders, the provider was notified via a documented telephone encounter and courtesy page. The pilot results demonstrated steady improvement in the percentage of signed orders and reduction of provider pages and same day appointment cancellations. Average unsigned orders decreased from pre-implementation (n= 1,234) at 15.2% to 7.2% during the pilot (n=1,633). Pre-implementation (n=181), 43% of providers signed their orders without a same day call compared to the pilot (n=119) at 57.1%. An additional impact was the reduction of same day cancellations from 15% to 11%

which is the gold standard for the size of our cancer center. The implementation of the NL improved the order review process, resulting in better utilization of nursing time, and promoting efficient patient flow and access by reducing avoidable delays and same day cancellations. The NL is a comprehensive role that can assist other infusion centers experiencing patient delays related to same day unsigned orders.

P214 **FACTORS IMPACTING FALL RISK AMONG PATIENTS WITH CANCER: A RETROSPECTIVE CHART REVIEW**

Laura Johnson, MSN, APN, AGCNS-BC, BMTCN®, Rush University Medical Center, Chicago, IL; Courtney Adler, MSN, RN, Rush University, Chicago, IL; Julia Pyatetsky, MSN, RN, Rush University, Chicago, IL

Patient Education and Safety

Patients with cancer have an increased risk of falls and a fall event may have significant impact on the trajectory of a patient's cancer care. In the ambulatory cancer center at a large academic medical center, an increase in patient-reported falls and fall events occurring within the clinic space were identified. Unfortunately, fall risk assessment in the ambulatory setting is less detailed than the risk assessment completed during hospital admissions. Furthermore, fall risk assessments have historically neglected to reflect the complexities associated with cancer diagnoses and treatment modalities. The purpose of this project was to perform retrospective chart audits of patients with cancer who either fell in the cancer center or who reported a fall during risk assessment to identify common factors and themes that may increase fall risk. A thorough literature review was performed to identify known factors that increase fall risk among patients with cancer, resulting in a list of 24 variables to guide chart audit workflow and build a data collection spreadsheet. Audits were performed on patient charts within a defined 12-month time period. 482 patient charts were audited, including 12 who fell during a clinic visit and 470 who reported a fall upon in-clinic assessment. Statistical analysis was performed utilizing SPSS software and included Independent Samples t-tests and Chi-Square tests. Chart audit data trends suggest the following variables place patients with cancer at greater risk for falls: cisgender female, solid tumor diagnoses, metastatic disease, abnormal white blood cell count, low hemoglobin, low albumin, taking greater than four medications, and chemotherapy within 12 months. Patients who had a fall in clinic were found to have significantly lower albumin levels

and were more likely to utilize an assistive device for ambulation. Additionally, these patients were more likely to be receiving chemotherapy treatment, specifically carboplatin or Taxane drugs. Interestingly, 58.7% patients who experienced or reported a fall were not identified on assessment as a fall risk. The data collected during chart audits revealed a significant number of variables associated with falls among patients with cancer. The trends identified will allow for the development of a more focused fall risk assessment for the oncology patient population. Additionally, interventions to mitigate falls within the clinic setting can be tailored to the unique needs of oncology patients.

P215 **LVN TRACK: A SCHEDULING RESOURCE TO MANAGE SAME DAY CANCELS IN INFUSION SERVICES**

Gabriela Lacatus, RN, BSN, OCN®, PhD, UCSD, La Jolla, CA; Sandy Jellen, RN, OCN®, UCSD, La Jolla, CA
Coordination of Care

At a National Cancer Institute designated Comprehensive Cancer Center's outpatient Infusion Center (IC), Registered nurse (RN) utilization and chair turnover in a 52-chair facility have been challenging secondary to canceled appointments from same day for the labs/possible replacements for blood products and hydration/electrolytes. A range of 1-5 hours canceled appointments created a loss in revenue from the underutilization of nurse and chair time. As a result, these unexpected appointment cancellations have prevented the additional patients' access and efficient utilization of resources. The purpose of this IC project was to successfully establish a separate scheduling track staffed with 1 Licensed vocational nurse (LVN) partnered with 1 RN to accommodate blood product transfusions, hydrations, and infusions in the range of 1-5 hours and create available appointment slots in the main infusion schedule. Based on historical data of same day cancels of "lab/possible" types of appointments, a scheduling template was created using LeanTaaS tools for optimum chair utilization and nursing time. The LVN track roles and responsibilities was created to define the new workflow and the job duties for the LVN and the RN. Interested LVNs were trained alongside an RN to administer blood products, hydration and electrolytes. Up to 14 appointments per day were moved to this new track creating up to 40 hours of appointment availability in the main infusion schedule. Prior to the intervention, our infusion center saw a shrinkage of ~ 16 patients per day (nearly 18%), as compared to baselines of ~10% at similarly

sized sites with similar patient populations. Post implementation of the new track, appointment cancellations dropped to 12-14% with chair time loss reduced to approximately 45 hours. Overall monthly savings of \$3,600 from employing an LVN versus an RN for infusions within their scope of practice along with increased LVN job satisfaction. The implementation of the new scheduling track led to effective utilization of chair time and nursing time in the main infusion leading to additional appointment availability, more efficient resource utilization and increased patient satisfaction. The new IC scheduling model may serve as a template for other ICs experiencing unexpected cancellations resulting in missed appointment opportunities from the coupling of labs and possible supportive care appointments.

P216 **THE IMPACT OF LETTERS OF CONDOLENCE ON HEALTH CARE PROVIDERS IN THE ONCOLOGIC SETTING**

Kelly Leap, MSN, RN, AGACNP-BC, Memorial Sloan Kettering Cancer Center, New York, NY

End of Life

During end of life care, the health care team not only cares for the patient, but also the patient's family members. Both the World Health Organization and the Clinical Practice Guidelines for Quality Palliative Care consider care of the bereaved family members an integral part of palliative care. However, bereavement practices, specifically the act of writing a letter of condolence, have declined drastically in the modern health care system. While the primary goal of writing a letter of condolence is to support bereaved family members, studies have also found that this act positively impacts the health care provider, helping staff through the grieving process, providing closure, and preventing burnout. The purpose of this project is to standardize the process of writing letters of condolence and provide the education and resources for staff to incorporate this practice into their workflow. We piloted this project on a medical oncology floor. We provided educational in-services to staff (RNs, PCTs, Unit Assistants) and provided all necessary resources (cardstock, envelopes). Staff receive a bi-weekly report via email of any patient that was admitted to the floor within the last two weeks and has a death notice in the chart at the time the report was generated. We are evaluating staff via surveys at numerous intervals including pre-education, post-education, and 1, 2, and 6 months post-implementation to evaluate actual use, willingness to use, staff satis-

faction, and disruption in workflow. Diverse bereavement practices have been noted not only among different hospitals, but also between units within the same hospital and even providers within the same department. Due to these inconsistencies, objective data is greatly lacking for both health care workers' and bereaved relatives' experiences with sending and receiving a letter of condolence, respectively. We hope that our project can contribute to the evidence, specifically within the oncologic population. We recognize that health care providers are much less likely to partake in bereavement practices due to a lack of training in medical and nursing schools and thus a lack of confidence in one's ability or role in the setting of death. In an effort to improve compliance, we have standardized the practice by providing guidelines on the content of the letters.

P217 IMPLEMENTATION OF AN ORGANIZATIONAL PLAN TO ADDRESS BURNOUT IN HOSPICE EMPLOYEES

Rebecca H. Lehto, PhD, RN, FAAN, Michigan State University, East Lansing, MI; Patricia McDaniel, Northstar Care Community, Ann Arbor, MI; Rachel Derry, Northstar Care Community, Ann Arbor, MI; Carrie Heeter, PhD, Michigan State University, East Lansing, MI; Patrick Miller, RN, MBA, MHSA, FACHE, Northstar Care Community, Ann Arbor, MI; Michael Paletta, MD, Northstar Care Community, Ann Arbor, MI

End of Life

Hospice professionals who care for patients with cancer who are at end-of-life face work-related challenges that place them at increased risk for burnout. Limited evidence-based approaches have been reported on organizational efforts to address burnout and reduce occupational stressors with participatory involvement from employee stakeholders. In a large statewide hospice organization, six focus groups were initially conducted with mixed groups of interdisciplinary healthcare employees to evaluate workplace stressors and to determine team member perceptions relative to burnout and its' management. An innovative multifaceted organizational strategy was then conceived and implemented after a careful evaluation of the focus group report to address occupational stressors and support employees across rural and urban regions involved in home or institutional hospice care delivery. Given identification of fundamental needs, interdisciplinary work groups were developed and tasked with addressing each of the four major areas of employee concern including work-related stressors, technology

issues, staff appreciation/recognition, and communication. Management of work-related stressors included establishment of consistent staffing rules, flexible scheduling, and self-care resources. To improve technology challenges areas that were addressed included duplicative processes, protocols related to electronic communications, and consistent education and support. To address staff appreciation, strategies such as positive communications, team engagement, and perquisites were identified. To enhance communication among team members, tactics such as all staff calls, daily reflections, and open office hours were developed. Implementation of the work groups and delivery of the workplace changes are in process and have both practice and research implications. Employees have expressed positive feedback related to having a voice in organizational change with management buy in. Some of the innovative strategies identified can be directly adopted by other hospice and healthcare organizations. The process itself, of stakeholder engagement with focus group findings to generate solutions may be utilized in other settings seeking occupational strategies to address workplace stressors and improve employee well-being.

P218 TEACHING WITH TELEHEALTH

Elizabeth Llewellyn, BSN, RN, OCN®, Dana Farber Cancer Institute, Milford, MA; Katherine Magni, MSN, RN, OCN®, Dana Farber Cancer Institute, Milford, MA; Anna Kosiba, BA, MPH, Dana Farber Cancer Institute, Boston, MA; Emma Dann, DNP, RN, OCN®, NEA-BC, Dana Farber Cancer Institute, Boston, MA; Janet Nixon, BA, Dana Farber Cancer Institute, Milford, MA; Terri Jabaley, PhD, RN, OCN®, Dana Farber Cancer Institute, Boston, MA

Coordination of Care

A cancer diagnosis often brings unprecedented stress and uncertainty to patients and families. COVID-19 further intensified those feelings. Initial face to face visits that had provided the foundation for a successful course of treatment for patients and families had to be reconsidered. Oncology nurses were concerned that infection control measures of social distancing and the limitation of visitors would be detrimental to patients' support networks and sense of wellbeing. In an NCI-designated Comprehensive Cancer Center in the Northeast, nurses explored telehealth options that would assist them in maintaining excellent, patient-centered care while focusing on infection control safety, particularly for immunocompromised patients. Studies support the benefit of telehealth

among patients and health care workers to help minimize the risk of COVID-19 transmission, overcome barriers to healthcare delivery, and facilitate safe and effective access to services, including those provided by nurses. Previously, rarely used telehealth services were rapidly deployed during COVID-19, resulting in a paradigm shift where virtual visits has become the new norm. The purpose of this quality improvement project was to evaluate the feasibility of conducting telehealth video nurse visits from the perspectives of nurses, patients and schedulers. Nurses designed telehealth visits for new patients beginning their journey with chemotherapy and immunotherapy treatments. Virtual teaches were scheduled for patients through the patient portal with instructions on how to access the visit. Nurses, patients and schedulers were surveyed for outcomes. Surveys indicated that 93.8% of patients and 73.79% of nurses preferred telehealth to telephone teaches: 91.44% of patients reported that using the technology was extremely easy. Patients' mean satisfaction score with the visit was 93.8 (0-100); while nurses' mean score was 73.46 (0-100). Schedulers reported that scheduling a telehealth visit required no additional time. Oncology patients prefer telehealth to telephone nurse teaching visits and find the technology easy to use. Patients express greater satisfaction with telehealth visits than nurses. Visits can be easy to schedule. COVID-19 resulted in approximately 20% increase of patient portal use as a means of patient communication with their care team. Oncology nurses concerned about easing patients' minds and making their journey as easy as possible can be assured that telehealth teach visits can be an effective way to provide remote, patient-centered care that is acceptable and feasible.

P219 **IMPROVING PATIENT CARE THROUGH** **HANDOFF COMMUNICATION**

Janet Lucas, MSN, RN, OCN[®], Cleveland Clinic, Cleveland, OH; Corrine Shepherd, BA, Cleveland Clinic, Cleveland, OH; Carolyn Best, BSN, RN, Cleveland Clinic, Cleveland, OH; Georgina Rodgers, BSN, RN, OCN[®], NE-BC, Cleveland Clinic Health System, Cleveland, OH; Kimberly Page, MS-HCA, BSN, RN, CNML, NE-BC, Cleveland Clinic, Cleveland, OH; Mark Kyei, MD, Cleveland Clinic, Cleveland, OH

Coordination of Care

Our healthcare system consists of a main campus and several regional oncology centers. Patients may maintain their primary oncologist but receive treatment at an alternate location. Many of these patients arrived

for treatment without nurse to nurse handoff communication and experienced treatment delays due to inappropriate scheduling, missed authorizations, and potential patient safety concerns (e.g. unknown reaction history, ambulation status). There was no formal process in place for handoff communication and RN Care Coordinators were not aware when patients initiated scheduling at an alternate location. The purpose of this project was to develop a formal process for RN Care Coordinator handoff communication using Situation-Background-Assessment-Recommendations (SBAR) format at these transitions of care including to/from Main Campus to/from Regional sites. A multidisciplinary team was formed and reviewed existing tools and functionalities in our electronic health record. We wanted to identify a list of patients whose ordering provider was at an alternate location of treatment administration. Initial results failed to identify these patients. A secondary review of available resources including the Epic Build Team and Cancer Analytics resulted in two available options. The Epic (EHR) report was chosen due to its ease of use and real time reporting capabilities. The report uses scheduling information from the EHR to populate appropriate patients. An encounter can be generated directly from the report. A template is applied, completed and routed to the appropriate receiving staff. The template note includes the ordering provider, date scheduled at alternate location, diagnosis, regimen, consent status, and pertinent patient clinical status information. The encounter becomes a permanent part of the chart and can be easily located and viewed by any member of the care team. Training and implementation of this process will take place in October 2021. We will monitor template usage post implementation to evaluate effectiveness of the handoff process. We hope to see use of the designated template to demonstrate increased handoff communication among the sites. We will periodically connect with the teams to obtain feedback and improve the process as needed. When used correctly, the report will identify patients receiving treatment outside of their home location and nurses will provide SBAR communication to the receiving location ensuring up to date, relevant information is communicated for the provision of high quality, patient centered care.

P220 **IMPROVING NURSE RESPONSIVENESS** **ON INPATIENT ONCOLOGY UNITS**

Brianna Lutz, MSN, RN, OCN[®], Yale New Haven Hospital, New Haven, CT; Laurie Crouch, MSN, RN, Yale New

Haven Hospital, New Haven, CT; Desiree Sanchis, RN,
Yale New Haven Hospital, New Haven, CT

Patient Education and Safety

A large academic medical center houses four high-acuity inpatient oncology units: hematology, medical, gynecology, and surgery. Targeted hourly rounding is a screening of the patient's pain, positioning, proximity to personal items, toileting needs, and preferences completed by the RN and patient care associate (PCA), and is critical to patient safety and patient experience. Press Ganey measures unit level performance of quality care using the indicator "Response of Hospital Staff." The hourly rounding column aims to provide real-time visualization in the electronic medical record system of the hourly rounding status on each patient in order to improve Press Ganey responsiveness scores, allow for streamlined documentation within the column, and improve patient safety and satisfaction. An hourly rounding column was built into the patient list. A green dot indicates that patients have been rounded on within the hour. A red dot indicates that it has been over one hour since they were rounded on. The dot turns green if any of these data points are documented on as part of the standard nursing workflow: vital signs, pain assessment, intake/output, fall risk interventions, activity, ambulation, hygiene, positioning, and MAR documentation. A red dot prompts the RN and PCA to provide targeted hourly rounding immediately. For patients rounded on within the hour without a specific data point to document, the dot will turn green by documenting "safety round/ check completed." Press Ganey data is collected monthly for each unit and benchmarks a threshold of 73.3%. Recent data indicates a range from 42.9% to 67.4% from April to August 2021. The goal after implementation is to monitor for improved performance in three months. A formal go-live will take place in October 2021. Staff currently participating in the soft roll-out appreciate the ability to visualize hourly rounding status and streamlined documentation. A tips sheet and short video demonstrating the utilization of the hourly rounding column were created. The goal is not to add documentation for RNs and PCAs, rather to integrate data points that are already part of their workflow into an easily visible indicator on the patient list. This prompts staff to round on patients who have not been seen in the last hour and allows for streamlined documentation of data points located in different areas of the chart.

P221 BRIDGING THE GAP BETWEEN AMBULATORY INFUSION CENTERS AND

HOME INFUSION TO ENHANCE CONTINUITY OF CARE

Dana Mahan, BSN, RN, Penn Medicine, Cherry Hill, NJ;
Lisa Fidyk, MSN, MS, RN, Penn Medicine, Cherry Hill,
NJ; Lisa Fitzpatrick, RN, BSN, MSN, Penn Medicine,
Cherry Hill, NJ

Coordination of Care

Care coordination is essential to provide safe, effective and seamless nursing care at a suburban health care system. In the ambulatory infusion outpatient setting, gaps in communication and organization of care activities for patients requiring home infusion services have been identified. There was no established method of communication between infusion and home care nursing staff to address clinical or social needs. With the support of health system leadership, the role of a liaison nurse was created to close the loop of communication and enhance care delivery. The overarching goal was to develop a method of communication between clinic, infusion and home infusion departments to enhance safety and care continuity. Examples include: communicating symptom management, history of equipment errors, line issues, and psychosocial concerns. A nurse from both the ambulatory infusion and home care setting were selected for the role. Guidelines were created and staff education provided regarding role and responsibilities. Event reporting data, Press Ganey results and staff surveys helped to identify need and are being monitored throughout implementation to confirm value and sustainability. The liaison nurses are responsible to be the point of contact for staff caring for patients who receive both infusion services in the ambulatory and home care setting. When a need arises, system messaging between liaisons is used to bridge the gap. Meetings are set up quarterly with the liaisons and leadership to address case scenarios and opportunities for improvement. To date, port care has improved due to our ability to communicate adhesives dressing allergies/sensitivities, need for subcutaneous injection self-administration education, symptom management related to chemo induced nausea and vomiting. Evolution of the role is also being explored as electronic medical health record enhancements are underway to support clinical communication and to identify shared educational and shadowing opportunities between departments. Enhancing relationships between home and ambulatory infusion centers will not only strengthen collaborative efforts, but also establish an additional layer of trust with patients and their support team.

P222 IMPROVING ADVANCE DIRECTIVE SUBMISSION FOR LUNG CANCER PATIENTS PRIOR TO SURGERY

Becky Mark, MPH, The Permanente Medical Group, San Francisco, CA; Olga Egovora, BS, The Permanente Medical Group, San Francisco, CA; Kimberly Beringer, RN, MSN, The Permanente Medical Group, San Francisco, CA; Catherine Jansen, PhD, RN, AOCNS®, The Permanente Medical Group, San Francisco, CA

Coordination of Care

Lung cancer continues to be the leading cause of cancer deaths and overall five-year survival rates range from 7-25%. While it is recognized that conversations regarding advance care planning are essential, there is a paucity of information regarding the prevalence of these discussions in this population prior to surgery. The advance care planning process involves selecting a person to make health care decisions and/or give specific instructions regarding health care in the event the patient is incapable due to sudden injury or illness. These important decisions are based on a patient's values, beliefs, and experiences. Kaiser Permanente refers to this as Life Care Planning. The objectives for this project were to 1) determine a historical baseline for advance directive discussion and completion; 2) develop a workflow to increase the percentage of life care planning discussions and advance directive forms scanned into patients' charts prior to lung surgeries by 10% compared to historical cohort. A review of historical cohort data on Advance Directive discussions and completion prior to surgery for a three-year period (2017-2019) was completed. A partnership between a health educator with the surgical navigator was established to develop a new workflow to increase the number of suspected lung cancer patients having life planning discussion and completion of an advanced directive prior to surgery. As the patient's surgery is scheduled, the navigator informs the patient that the health educator will contact them to complete their life care plan. The Health Educator provides an introduction and instructions regarding the advance directive. Once completed, the Health Educator reviews and enters the important contents into the patient's electronic medical record. The advance directive is then sent to be formally scanned into the patient's electronic record. Historical cohort data on Advance Directive discussion and completion prior to surgery for 27 patients confirmed a 33% discussion and completion rate. An evaluation comparing the historical cohort with post intervention data will be completed at the end of the year. Additionally, the feasibility of the intervention will be discussed.

P223 IMPLEMENTATION OF AN ORAL CHEMOTHERAPY SMART FORM IN AN OUTPATIENT SETTING

Maria Market, RN, BSN, PCCN, Fox Chase Cancer Center, Philadelphia, PA; Allison Ward, RN, MSN, OCN®, CCRN-K, RN-BC, Fox Chase Cancer Center, Philadelphia, PA

Oncology Nursing Practice

Oral chemotherapy (OC) is standard of care for specific cancers and becoming more commonly prescribed in the oncology setting. Adherence to OC is critical to achieve optimal outcomes. Monitoring appropriate dosing, providing patient education, and managing symptoms are essential for maximizing adherence. The goal was to create and implement a Smart Form tool (SF) within the Electronic Medical Record (EMR) addressing multiple variants regarding OC compliance. As part of the 2020 Quality Oncology Practice Initiative Certification Program, only 33% of patients on OC had a documented OC plan, 7% were assessed for adherence, and 0% had documentation reflecting efforts to address non-adherence. A SF was designed to provide a standard form for documenting the treatment plan, education, and monitoring for OC. The SF was integrated into nursing, pharmacy, and physician workflows to capitalize on shared communication tools. Weekly review of the SF and feedback forms generated real-time progress reports. The SF was utilized by oncologists, pharmacists, and nurses chosen to participate in the pilot over an 8-week period. During that time, 223 patients on OC were seen in clinic. Feedback from pilot participants influenced changes in the content fields of the SF and workflow. At completion of the pilot, 45% of patients on OC had the SF completed. An OC plan was documented in 41% of patients, compared to 33% at baseline. In addition, 87% had an administration schedule, compared to 81% prior to implementation. The number of patients contacted following the start of OC increased from 4% to 35%. Medication adherence was assessed in 35% of patients, compared to 7% initially. Documented discussions addressing medication adherence increased to 78% from 0%. Introduction of the SF in pilot clinics improved compliance documentation for OC. The SF use introduced a standard process for monitoring safety, educating patients, and assessing and addressing non-adherence, which is necessary for improving patient outcomes. The SF will be implemented throughout the ambulatory clinic setting as a standard workflow for all patients on OC.

P224 IMPLEMENTATION OF STANDARDIZED CENTRAL LINE CARE BUNDLES TO DECREASE CLABSI RATE

Jesse Martinovich, BSN, RN, Karmanos Cancer Institute, Detroit, MI; Carly Williams, BSN, RN, Karmanos Cancer Center, Detroit, MI; Clara Beaver, MSN, RN, AOCNS®, ACNS-BC, Pittsburgh, PA

Oncology Nursing Practice

Use of central line care bundles has been reported as one strategy to decrease central line associated blood stream infections (CLABSI). Due to an increase in CLABSIs at Karmanos Cancer Center (KCC), a task force was created to review all current evidence and the current policy/practice. KCC did not have a standardized central line care bundle, and the inpatient and ambulatory settings were using different procedures. Evidence found that incorporating CHG impregnated disks, alcohol caps, standardized CHG bathing, and CHG swabs into care bundles can benefit in the decreasing of CLABSI rates. The purpose of this quality improvement project was to incorporate the best-evidence related to central line care into a standardized bundle and decrease hospital-wide CLABSI rates. A hospital wide central line bundle was implemented to decrease CLABSI rates. This bundle included the implementation of a CHG impregnated disk for all accessed infusaports, alcohol caps on all needless connector access points, changing from alcohol swabs to CHG swabs in all inpatient areas, and re-education of CHG bathing practices in both the ambulatory and inpatient population. All nursing staff received education on the central line bundle. The goal of the education was that all staff would deliver the same care and message to their patients as well as to improve compliance in the use of the bundle. Additional focused education on CHG bathing included documents to discuss all possible scenarios for CHG bathing and patient expectations once they were admitted to the hospital. The standardization of the bundle and education were completed over a six-month period. As of August 2021, there has been a decrease in the overall number of CLABSI from 2020. Staff were receptive to the education and changes to the central line care. Ongoing line audits are being performed to assess continued compliance to the central line bundle. When quality measures such as increased CLABSIs are identified, organizations should look at all care and evidence to pinpoint opportunities to improve or reinforce current practice. Implementation of a standardized central line bundle based on the current evidence can decrease CLABSI rates.

P225 “TIME OUT!” STOP THE PUMP PROGRAMMING ERRORS

Kelly McCormick, MSN, RN, OCN®, NPD-BC, St.

Luke’s University Health Network, Easton, PA; Denise Dianna, BSN, RN, OCN®, St. Luke’s University Health Network, Easton, PA; Alicia Schaeffer, BSN, RN, St. Luke’s University Health Network, Coaldale, PA; Sara Orzel, BSN, RN, St. Luke’s University Health Network, Stroudsburg, PA

Patient Education and Safety

The Infusion Centers at a large multi-site teaching hospital system use only two features of the BBraun Smart Pump due to lack of Oncology drugs in the pump library. The “set/time/volume” feature which allows the RN to input the volume to be administered and the length of time; the pump then calculates the rate of administration. The “titration” mode allows a program to be set to administer medications on a pre-set schedule. Patient safety reports are continuously mined by leadership for trends/repeating errors. In Spring of 2020 with the launch of Epic Beacon, there were multiple errors related to the programming of the pumps. In the 10-month period prior to the go-live of Beacon there were 5 noted pump programming errors. In the 6 months post Beacon implementation there were 14 documented pump programming errors, a significant increase and concern for patient safety. The implementation of Beacon was a move from paper orders to electronic orders and barcode scanning. The focus may have shifted away from the programming activity at the pump and contributed to the errors since the RN’s focus was on performing Beacon-related skills. A Pump Programming Task Force was formed and concentrated on reducing external distractions and increasing RN focus. A scripted time out process was formulated, in addition to two RNs completing an independent double check on chemotherapy. Time out scripting was to be used every-time a medication was being programmed. The three keywords, time out, quiet, and safety, were required. For data collection, ten weekly audits for scripting were done and tabulated. A laminated 3x5 inch card was placed on each IV pole as a visible reminder to staff. Time out compliance of 100% was achieved and sustained across all campuses by the 6 week mark. This correlated with a significant decrease in pump programming errors. Medication event reports were monitored for errors related to pump programming. There were zero errors reported from the implementation for the first 4 months. At the 6-month mark, there were 2 reported. This demonstrated a 71% de-

crease in pump errors and an achievement of the stated AIM to reduce errors by 60%. Audit reports continued to demonstrate almost 100% compliance with the process. The 71% reduction of errors still proved true at one year.

P226 **“DO YOU HAVE AN ADVANCE DIRECTIVE?”: A COLLABORATION BETWEEN NURSES AND SOCIAL WORK TO INCREASE ADVANCE DIRECTIVE DOCUMENTATION**

Rachel Mea, MSN, RN, OCN®, The Hospital of the University of Pennsylvania, Philadelphia, PA; Ellen LeGrand, BSN, RN, The Hospital of the University of Pennsylvania, Philadelphia, PA; Brianna Simon, MSW, LCSW, The Hospital of the University of Pennsylvania, Philadelphia, PA; Erin Lighthouse, MBA, PMP, CSSBB, Hospital of the University of Pennsylvania, Philadelphia, PA; Erin Marturano, MBE, MSN, RN, Hospital of the University of Pennsylvania, Philadelphia, PA; Kristen Maloney, MSN, RN, AOCNS®, The Hospital of the University of Pennsylvania, Philadelphia, PA; Daniel Landsburg, MD, The Hospital of University of Pennsylvania, Philadelphia, PA

Coordination of Care

An advance directive (AD) is a legal document that allows patients to identify a durable power of attorney to direct care when they are unable to express wishes or are incapacitated. Nurses at an academic medical center have screened for ADs on admission to the hospital for over 30 years, yet many patients have not completed an AD or have one on file in the electronic medical record (EMR). Nurses and social workers are an underutilized resource in completing ADs. From July through November of 2020, 23.6% of discharged oncology patients had some form of an AD. The purpose of this project is to increase the documentation of an ADs, with an indirect goal of reducing the percentage of patients who spend less than 3 days on hospice. Nurse and Social Work champions were educated to assist patients in completing Our Care Wishes (OCW), an online platform that can be used to document ADs. OCW can be linked to the patient's EMR, allowing both inpatient and outpatient providers to see the document. From January 2021 through September 2021, 145 OCW consults were referred to the champions. Of those, 114 patients received the information or had a discussion with the champions. The 31 patients who were not counted in the number did not meet criteria for discussion (e.g., altered mental status, code status changed, or ICU transfer). 34 patients completed new ADs, lead-

ing to an average of 1.03 new AD per week. During the time of this project, hospice length of stay less than 3 days has decreased from 19.6% to 13.4%. Advance care planning notes among discharged patients increased from 20% to 45%. Nurse and social work champions facilitate advance care planning and documentation of ADs. Advanced care planning and ADs are associated with goal-concordant care and earlier utilization of hospice. While the decrease in hospice length of stay cannot be directly correlated to this intervention, over time we hope increased documentation will allow further investigation of this relationship and sustain the gains made. Promoting partnership between nurses and social workers to ensure completion of ADs can assist providers in delivering goal-concordant care potentially leading to decreased unplanned admissions, reduced hospital cost, and improve quality of life.

P227 **CREATING AN ON-LINE REPOSITORY TO ALIGN AND SUPPORT ONCOLOGY INFUSION NURSING PRACTICE ACROSS AN ORGANIZATION**

Michelle Mitchell, MN, RN, OCN®, Seattle Cancer Care Alliance, Seattle, WA; Phuong Huynh, MN, RN, OCN®, SCCA, Seattle, WA

Oncology Nursing Practice

Oncology clinical care has quickly evolving innovations in treatment and patient care. It is essential for clinical nurses to have access to the most recent education and tools. Policies and Procedures are important but do not address practice education needs. Given the complexities of providing care across multiple departments, and at five community site locations, the development and dissemination of education is a mandate to reduce siloed efforts and assure consistency in practice. Innovations in technology provide the platform to support accessibility, efficiency, and standardization of educational resources. The purpose of this project was to standardize oncology infusion practices across a large NCI-designated oncology center, with the development of an internet repository of education and tools integral to best practices in quality oncology care. A team (nurse leaders, clinical nurse specialists, clinical leadership, and educators) coalesced a workgroup to assess current and ideal state and create a resource repository. Categories of resources and criteria for documents were used as the framework for site organization. Categories include medication references, pump resources, titration rates and calculators, regimen worksheets,

unit newsletters, and a sidebar with commonly accessed links (e.g., Up to date). Planning for site launch included: tools for marketing and navigating the site, information to be disseminated at staff meetings, and access notification to all current staff. The committee met weekly to review and evaluate feedback, site content, and utilization metrics. Evaluation is ongoing for real time improvement of internet resource repository. Evaluation metrics include site usage, total page views, average time spent per user, and page traffic by time of day. The successful launch of a new electronic health record system, EPIC actually leveraged the possibility of an internet resource repository. Through the repository staff had universal access to nursing job aids, practice change updates, education tutorials, and sharing of resources throughout the organization. The creation of this site has promoted collaboration between local and community educators, standardization of educational resources, and greater accessibility to front-line staff assuring better oncology patient outcomes.

P228 **TRACKING PURPOSEFUL HOURLY ROUNDING WITH DIRECT PATIENT FEEDBACK**

Kathy Mooney, MSN, RN, ACNS-BC, BMTCN[®], OCN[®], The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD; Laurie Bryant, MSN, RN, APRN-CNS, Sidney Kimmel Comprehensive Cancer Center, Baltimore, MD; Melanie Cohen, BSN, RN, Johns Hopkins Hospital, Baltimore, MD; Lisa Hartle, MS, APRN-CNS, AOCN[®], Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD
Patient Education and Safety

Purposeful hourly rounding (PHR) is a well described nursing intervention that proactively addresses the needs of patients and improves patient safety outcomes and satisfaction scores. Tracking PHR can present a challenge. Methods of tracking include EHR documentation, flip charts, paper logs and staff locator data, however these audits only track the presence of staff in the patient room and not the quality of the interaction. RN's are overwhelmed with the amount of documentation and auditing required. The Clinical Nurse Specialist group at this NCI-designated comprehensive cancer center wanted to reinvigorate PHR and engage staff in this project. The goal was to improve and track the quality of PHR interactions through direct patient feedback. All units received refresher training on PHR. Direct patient feedback was obtained by the Clinical Customer Service Coordinators (CCSC) during their routine patient rounds. Patient were asked two questions. "Our goal is to check on you frequently,

can you tell me how often your care team has checked on you?" and "when we check on you, do we consistently ask about your specific comfort and personal needs (pain control, toileting needs, positioning and possessions in reach)?" The CCSC's collected ten audits per month on each unit. The results were logged into a hospital audit system. Between February and August 2021, question 1 responses indicate patients perceive they are being checked on at least every 1-2 hours 90-100% of the time. Question 2 responses indicate patients perceive they are specifically being asked about their comfort and personal needs 98-100% of the time. Patient comments were also tracked, which were important in providing feedback to the staff on PHR and promoting staff engagement. PHR has a positive impact on patient safety outcomes. Nurses are asked to engage in many different initiatives simultaneously, and it is important to identify ways that both measures success and motivates staff to continue to value the work. Direct patient feedback is a means to measure success that does not add to nursing workload. Specific examples from patient/family comments reflect how PHR is valued and recognized by patients and contributes to patient satisfaction. To ensure sustainability audits will continue monthly to evaluate for compliance. If negative trends are identified, direct observation of PHR will be implemented.

P229 **USING A PLAN-DO-STUDY-ACT MODEL TO DESIGN AND IMPLEMENT AN INAUGURAL UNDERGRADUATE ONCOLOGY NURSING ELECTIVE**

Madison Morgan, BSN, RN, OCN[®], UNC School of Nursing, Chapel Hill, NC; Stephanie Betancur Grondona, BSN, RN, UNC School of Nursing, Chapel Hill, NC; Lorinda Coombs, PhD, CNS, FNP-BC, AOCNP[®], UNC School of Nursing, Chapel Hill, NC; Kimberly Wehner, DNP, FNP-BC, UNC School of Nursing, Chapel Hill, NC; Deborah Mayer, PhD, RN, AOCN[®], FAAN, University of North Carolina, Chapel Hill, NC; Ashley Leak Bryant, PhD, RN-BC, OCN[®], FAAN, UNC, Chapel Hill, NC
Oncology Nursing Practice

As the increased incidence of cancer diagnoses and development of novel treatments converge, the nursing workforce must meet the growing demand for high quality cancer care. However, many undergraduate nursing programs lack oncology courses or clinical experiences to prepare students to care for individuals and families with cancer. The purpose of this project was to design a three-credit undergraduate oncology nursing elective course using the Plan-Do-Study Act

framework to prepare nursing students to transition into oncology practice. The course faculty met weekly to plan lessons and develop topical content of cancer trends and statistics, risk reduction, treatment modalities, palliative and supportive care, psychosocial and caregiver support, survivorship, inclusive care, and professional development. Content encompassed pediatrics through older adulthood. Leaders from ONS, HPNA, and APHON were invited to present, and HPNA. Eighty-two baccalaureate students registered for the virtual elective offered in Summer 2021, of which 80 were accelerated BSN and 2 traditional BSN. Thirty-seven (45%) intended to work in pediatric or adult oncology after graduation. Fifty-seven percent had prior clinical experience caring for patients with cancer. Students were provided time in class to complete questionnaires regarding their experiences and knowledge of various oncology topics, which included the Palliative Care Quiz for Nurses (PCQN) at 3 time points: T1, first day of class (N=82), T2, mid-semester (N=48), and T3, last day of class (n=40). The study was reviewed and deemed not human subjects research and therefore exempt by the Office of Human Research Ethics in May 2021. Data from T1 regarding student interests were used to modify course content. For example, course faculty chose to emphasize pediatric cancer care and invite an APHON representative based on high student interest in pediatrics. Of students who completed both, scores from T1 to T3 on the PCQN were most improved for items related to families being present at bedside until death and morphine as standard pain management. The course received positive feedback and high praise from students. Most felt the didactic nature of the course could have been supplemented with practical experiences in a clinical setting, but faculty were limited due to COVID-19. Future iterations will incorporate suggestions for improvement, and the course faculty plan to offer an interprofessional elective in subsequent semesters.

P230 SMALL STEPS TOWARD GIANT STRIDES IN DEVELOPING A NEW ONCOLOGY OUTPATIENT PHYSICAL THERAPY SCREENING PROGRAM

Kathleen Morrison, BSN, RN, OCN®, St. Francis Hospital and Heart Center, Roslyn, NY; Eileen Dwyer, BSN, RN, OCN®, St. Francis Hospital and Heart Center, East Hills, NY; Diane Conlon, MSPT, CES, St. Francis Hospital and Heart Center, Roslyn, NM

Screening, Early Detection, and Genetic Risk

The advancement in cancer treatment options and increased patient survival has significantly impacted

positive patient outcomes. Unfortunately, patients still have to endure harsh side effects and life altering physical and functional impairments from treatment. Physical therapy is an essential discipline that is often underutilized with this population, potentially leading to declining physical functioning which, may interfere with their cancer treatment. According to the literature, cancer survivors are twice as likely to have physical and functional limitations as persons without cancer. Early intervention with physical therapy for the oncology population can improve strength, endurance, decrease fatigue, improve pain management, increase independence, and enhance overall wellbeing. Therefore, at our cancer center, we acknowledged the importance of developing an easy accessible physical therapy screening program. This program serves to identify our cancer patients at risk for developing physical deficits from cancer treatment decreasing daily function and leading to poor quality of life. This early intervention with physical therapy promotes improved patient outcomes, increased patient satisfaction, and improved quality of life. Recognizing that our infusion nurses are the patient's first and primary educators, the introduction to this service was provided at the patient's first visit. The purpose of this collaborative project was to start an "Oncology Outpatient Physical Therapy Screening Program." This project was launched in January 2021 and is ongoing. The Infusion nurse gave newly diagnosed cancer patients a physical therapy screening form to complete on their first outpatient admission. A weekly tracking system was utilized in collaboration with the physical therapy department in referring patients for follow-up screening evaluations with a physical therapist. This collaborative project has enhanced our ability to obtain physical therapy needs assessment prior to the start of treatment and provide a timely screening by a physical therapist. Availability of a program supervised by trained health professionals leads to increased patient satisfaction, positive patient outcomes, and enhanced quality of life. Total screenings as of August 2021 is 156: 5 referred to outpatient physical therapy, 6 home exercises and 1 homecare.

P231 IMPROVING ORAL ONCOLYTIC EDUCATION AND CONSENT COMPLIANCE BY ADDING ONCOLOGY NURSING SUPPORT

Morgan Nestingen, MSN, APRN, AGCNS-BC, OCN®, ONN-CG, University of Colorado, Miami, FL; Marguerite Rowell, MSN, MBA, MSM/HM, ONC, SCRNP, Miami Cancer Institute, Miami, FL; Yamile Leon, MSN, RN, OCN®,

ONN-CG, ONN-CG (T), Miami Cancer Institute, Miami, FL; Tania Silva Santos, MSN, RN, OCN®, Miami Cancer Institute, Miami, FL; Cindy Byrd, DNP, ACNP-BC, Miami Cancer Institute, Miami, FL; Barbara Matias, MSN, RN, Miami Cancer Institute, Miami, FL

Patient Education and Safety

Oral oncolytic therapy supports convenient at-home treatment and increased use of telehealth services common during the SARS-CoV-2 pandemic. However, these medications are associated with serious side effects and require complex education, informed consent, guidance and treatment monitoring. Oncology nurses play an important role in patient education, initiating consent, identifying symptoms and monitoring patient outcomes. The purpose of this project was to improve Miami Cancer Institute's (MCI) oral oncolytic education and consent process by adding oncology nursing support to prescribing clinics. Key stakeholders including oncology nurses, pharmacists, physicians and leaders met to review existing oral oncolytic education and consent workflows and outcomes. An initial audit demonstrated compliance at approximately 60%. Nursing support was identified as the "missing ingredient" in clinic settings, as nurses were often committed to specific roles (e.g. procedure RN, nurse navigator) and unavailable for same-day teaching and consent initiation. A team of experienced oncology nurses were trained in oral oncolytic education, provided mobile tablets and tasked to support on-call oral oncolytic education and consent needs across several medical oncology clinics. Daily huddles, audits and weekly stakeholder meetings were used to evaluate program success. Key metrics included: (1) nurse education, (2) referral to pharmacy, (3) pregnancy testing or waiver, (4) physician documentation, (5) completion of the entire consent form and (6) signed consent available in the patient record. Consent compliance improved house-wide from 60% to 82% (n=56) overall and 96% (n=25) in clinics exclusively using the new process during the first two weeks with sustained improvement across the first month. Each non-compliant case was addressed and tracked individually to ensure eventual compliance. Oncology nurses are well positioned to partner with pharmacy and physician colleagues to improve system delivery of oral oncolytic agents. Cancer centers should consider availability of nursing resources, nursing proximity to clinics, workflows and follow-up to improve education and consent compliance. Reliance on oral oncolytics is expected to grow as new agents and regimens are tested. This agile, on-call use of oncology nursing support made efficient use of limited nursing

resources while addressing key clinical challenges in the administration of oral therapy.

P232 TRANSITION OF CARE IN THE OUTPATIENT SETTING

Catherine Oplinger, MSN, RN, OCN®, AMB-BC, Jefferson Health NJ, Sidney Kimmel Cancer Center, Sewell, NJ

Coordination of Care

In the face of a hospital or outpatient practice closure, large-scale transitioning of patients to a new provider is a necessity. A gap in available information for the patient population related to the transition of care for oncology patients affected by a closure was identified. As would be expected, significant stress, emotional turmoil, and unrest among patients, caregivers, and staff at the facility resulted. A project was undertaken during the 90-day window for closure which focused on providing guidance and information to this vulnerable population and addressing the emotional aspect of the loss of their trusted provider and care team. This effort centered on the nursing focus of managing the continuum of care in the setting of an outpatient transition for patients with complex diagnoses. The prevention of gaps in care during a transition was the primary goal. An informational brochure was developed and distributed to patients until the date of closure. Because many patients and caregivers expressed that they would continue to treat with their current providers for as long as possible, urgency in locating a new provider was stressed throughout the brochure. The brochure encouraged patients to reach out to their current team early to begin their transition so that they would have a provider in place well in advance of closure. Tips and suggestions for both patients who were actively treating and those who had transitioned to survivorship were provided. The need for additional support during the transition period was addressed as well as the importance of managing related stress and emotional turmoil. General oncology resources for both online and via phone were included. Hospital and practice closures continue to happen, with an increase being seen in the southern United States. Additionally, many large hospital systems are acquiring smaller practices which often results in changed practice locations. Transitions of care are well addressed in the inpatient setting, but additional attention and research are needed to prevent gaps in care for those in the outpatient setting. Educating patients and caregivers regarding the process, urgency, and importance of transitioning care

involved interactive dialogue and written materials in the delivery of direct instruction as well as options for support through their emotionally challenging transition. Oncology nurses are uniquely positioned to address this issue.

P233 DEVELOPMENT OF A PATIENT SAFETY SOLUTIONS COMMITTEE TO REVIEW EVENTS AND IMPLEMENT QUALITY IMPROVEMENT PROJECTS

Jessica Parra, MS, RN, Mount Sinai Health System, New York, NY; John Mato, BSN, RN, CHPN, New York Presbyterian-Columbia University Medical Center, New York, NY; Aarti Bhardwaj, MD, Mount Sinai Hospital, New York, NY; Cardinale Smith, MD, PhD, Mount Sinai Health System, New York, NY

Patient Education and Safety

The Joint Commission's 2021 National Patient Safety Goals include patient identification, staff communication, medication safety, and infection prevention. The reporting and review of safety events that affect patients and staff is critical to providing safe, high quality care. Staff are empowered to practice in a culture of safety and report any events that caused harm or had the potential to cause harm. The purpose of this project was to develop a multidisciplinary committee that reviews adverse events and develops systems and practice change solutions. The oncology service line of our hospital system lacked a formal method of reviewing safety incidents; therefore, the Patient Safety Solutions (PSS) Committee was developed. The committee consists of an interdisciplinary group of peers, including nurses, physicians, pharmacists, social workers, and administrative staff. Events are reported using an online software. The reports are received by our quality team and those that meet criteria for review are investigated, summarized, and presented at monthly PSS Committee meetings. During the meetings, cases are discussed and potential solutions are developed. The committee then votes on standard of care using a Continuous Quality Improvement (CQI) Classifications tool. If necessary, smaller workgroups are formed to carry out quality improvement (QI) projects and corrective action plans (CAPs) discussed during the meetings. Common outcomes and CAPs include staff education and the development of new workflows, policies, or guidelines. All case data, including patient demographics, case summaries, outcomes, and ongoing projects are tracked using a custom-developed REDCap survey. Due to an increase in the volume of reports received, the committee now

meets twice per month. The group has reviewed 103 safety events and has developed 29 new workflows, policies, and guidelines. The PSS Committee is committed to ensuring that the hospital system's patients continue to receive the safest, highest quality care. Participating in a non-punitive discussion about safety events has resulted in a culture in which events are openly reported. This reporting led to an increase in cases reviewed and a significant number of interventions that have improved nursing practice, patient care, and outcomes. The development of a Patient Safety Solutions that is specific to the cancer service has led to multiple practice innovations, policy changes, and improvements in patient care.

P234 IMPROVING PATIENT OUTCOMES, SATISFACTION AND DECREASING INFECTION RATES UTILIZING PRIMARY NURSING CARE ON STEM CELL TRANSPLANT UNITS

Ami Patel, BSN, RN, Hackensack University Medical Center, Hackensack, NJ; Emily Coiro, BSN, RN, BMTCN®, Hackensack University Medical Center, Hackensack, NJ; Lindsay Cosgrave, BSN, RN, BMTCN®, Hackensack University Medical Center, Hackensack, NJ; Samantha Sagun, BSN, RN, Hackensack University Medical Center, Hackensack, NJ; Jesenia Perez, BSN, RN, Hackensack University Medical Center, Hackensack, NJ

Oncology Nursing Practice

The primary nursing care model is utilized to improve patient outcomes while facilitating strong therapeutic relationships between nurses and their patients. Especially in this new era of severe acute respiratory syndrome-related coronavirus 2 or SARS-CoV-2 (COVID-19), the importance of preventing infection remains an utmost priority. This evidence-based project is an examination of the effectiveness of the primary nursing care model in improving patient outcomes, satisfaction, and decreasing infection rates. A primary nursing model was incorporated into the daily workflow for registered nurses and patient care technicians (PCT) on two stem cell transplant units over a three month pilot period. Charge nurses recorded on paper the patients and the members assigned to their primary nursing care team. Effectiveness of the model was measured through quality indicators including central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), falls, and pressure injury rates. The model was also implemented to prevent the exposure and transmission of COVID-19 amongst this

immunocompromised patient population. Compared to pre-pilot data, the stem cell transplant units had a 100% decrease in CLABSI and CAUTI, 75% decrease in pressure injuries, and 92% decrease in falls. This continuity of care strategy also maintained patient and nursing satisfaction rates on both units. All patients surveyed at discharge agreed that the primary care nursing model benefited their quality of care and improved their outcomes. The results of the nursing satisfaction survey showed that the majority of the nurses found themselves more likely to catch medical errors and quickly address other patient safety concerns, such as identifying significant changes in the patient's condition. The majority of the nurses also agreed that being a part of a small, structured care team facilitated the development of therapeutic, trusting relationships between the patients, their nurses, and their PCTs. The implementation of a primary nursing care model allowed designated nurses to care for the same patients each time to develop stronger patient-staff rapport, address patient concerns, and improve patient outcomes.

P235 **CHEMO SAFE HANDLING**

Jennifer Patullo, BSN, RN, OCN[®], Miriam Hospital, Warren, RI

Oncology Nursing Practice

Another staff nurse and I performed an evidence based quality improvement project on the use of personal protective equipment while administering and disposing chemotherapy on our unit. We noticed a decline in the use of PPE and our objective was to educate the nurse on the importance of using PPE and improve the use of PPE. We began by conducting a literature review, including an article using a quasi-experimental design using a pre and post survey and audited the nurses on the use of PPE pre and post education. We utilized this design for our evidence based improvement project. We distributed a pre survey to staff nurses and performed pre education audits, which included observation of the nurses administering and disposing chemotherapy. We educated nurses with our power point presentation on Chemo Safe Handling. We distributed a post education survey and performed post education audits. We used quantitative methods in calculating our data results. Data collection showed a significant improvement in PPE compliance, from 5% wearing PPE 100% of the time to 60%. Post survey test results showed an improvement in nurses having had the opportunity to be properly trained in the use of PPE, having access to poli-

cies and procedures regarding safety, expectations to comply with safe-handling policies and procedures, an increase of awareness of risk of contamination of other staff members and an increase in agreement that it is necessary to wear PPE past the childbearing years. Graphs were posted on the unit and findings were discussed with staff at nursing and unit council meetings. Feedback was given to nurses following post education audits. Using pre education data, we determined that additional education and peer feedback was necessary in order to improve compliance.

P236 **COLLABORATION BETWEEN ONCOLOGY UNIT AND DISCHARGE LOUNGE: IMPROVING PATIENT THROUGHPUT WORKFLOW**

Trenton Pusag-Weber, BSN, RN, BMTCN[®], Ronald Reagan UCLA, Los Angeles, CA; Nkaj-jab Xiong, MSHM, RN, BMTCN[®], Ronald Reagan UCLA, Los Angeles, CA; Tia Wheatley, DNP, RN, AOCNS[®], BMTCN[®], UCLA Health, Los Angeles, CA; Stephanie Jackson, DNP, RN, AOCNS[®], BMTCN[®], Ronald Reagan UCLA, Los Angeles, CA; Sandra Almoquira-Manalo, MSN, RN, RR-UCLA, Los Angeles, CA; Miriam Gonzalez-Lopez, MSN, RN, NEA-BC, PHN, Ronald Reagan UCLA, Los Angeles, CA
Coordination of Care

Increased institutional occupancy during the COVID-19 pandemic required innovative strategies to reduce bottlenecks and facilitate timely patient throughput. Collaboration between the Observational Unit Discharge Lounge (DCL) and Oncology/SCT Unit facilitates a smoother discharge process, enabling earlier bed availability. Historically, the DCL was not used for the SCT population due to concerns of neutropenia and immunosuppression. However, SCT patients have recovered their counts at discharge and are allowed to return to the community by following required restrictions to prevent infection. To meet the institutional goal for timely discharge, the oncology/SCT unit explored opportunities to increase utilization of the DCL. The goal of this quality improvement initiative is to improve the efficiency of discharges on the SCT unit through increasing the utilization of the DCL. The unit nursing leadership, nurse practitioners, case managers, charge nurses, staff nurses, and unit secretaries used appreciative inquiry to identify causes of discharge delays. Delays were attributed to transportation, time of order entry, and patient teaching. A workflow was created to increase the amount of oncology patients who were eligible to use the DCL. Criteria included patients who were waiting for discharge medications or trans-

portation, as long as the patient was ambulatory and did not require infectious precaution isolation or supplemental oxygen. Required restrictions for oncology/SCT patients were followed. When a discharge order was placed, the unit charge nurse partnered with the staff nurse to facilitate use of the DCL. Active daily management by the unit leadership team and case management ensured barriers to DCL use were mitigated in real time. Preliminary data shows that the number of patients discharged using DCL increased from 82 patients over 12 months to 102 patients over 5 months. Monthly utilization of the DCL is shared with staff routinely to validate successes and identify opportunities for improvement. Data tracking is ongoing to ensure patients are discharged from the SCT unit by 2pm. Utilization of the DCL has been a safe and efficient strategy for SCT patients, even during the COVID-19 pandemic. While data is preliminary, the unit has made improvements in reducing bottlenecks and facilitating timely turnaround. Collaboration between the Oncology/SCT and DCL was essential to meeting the institutional goal for discharge.

P237 IMPROVING HOT FLASH DOCUMENTATION AND KNOWLEDGE OF THERAPEUTIC MODALITIES FOR HOT FLASHES THROUGH NURSE EDUCATION

Harinder Raipuria, DNP, FNP-C, NP Fellow, Johns Hopkins Medicine, Baltimore, MD; Barbara Van de Castle, DNP, OCN®, ACNS, RN-BC, University of Maryland School of Nursing, Baltimore, MD
Symptom Management and Palliative Care

Breast cancer patients and survivors can experience an adverse effect profile from anti-neoplastic treatments. Frequency and intensity of hot flashes, a prevalent adverse event, compromises adherence to cancer treatment. This quality improvement project sought to implement and evaluate the effects of nurse education on evidence-based treatments and assessment for hot flashes using best practice guidelines from the National Cancer Institute (NCI). A pre/posttest intervention design was utilized with a 30-minute one group didactic education intervention for 7 nurse participants on an outpatient oncology unit. Education was delivered on hot flashes, non-hormonal evidence-based treatments and the documentation process using the NCI Common Terminology Criteria for Adverse Events (CTCAE) flowsheet. 86% of nurse participants demonstrated a statistically significant score increase from pre to post intervention, indicating an increase in nurse knowledge ($p < .028$).

A median 21-point (IQR: 12) score improvement was identified. Three patients had documented hot flashes using the NCI CTCAE flowsheet at intervention end, indicating a lack of nurse adherence to documentation. Knowledge of hot flashes, modalities of treatment, and documentation in accordance with best practice guidelines, can be increased with nurse education. Nurses as educators can impart knowledge of treatments upon patients to promote adherence to anti-neoplastic therapies, which may be compromised due to the distressing adverse event of hot flashes.

P238 CREATING A CULTURE OF SAFETY: IMPROVING CLABSI RATES ON AN INPATIENT ONCOLOGY UNIT

Danielle Robertson, BSN, RN, OCN®, Penn Medicine Lancaster General Health and Ann B. Barshinger Cancer Institute, Lancaster, PA; Jenna Storm, BSN, RN, OCN®, Penn Medicine Lancaster General Health, Lancaster, PA; Kyle Wojciechowski, MSN, RN, OCN®, Penn Medicine Lancaster General Health, Lancaster, PA
Oncology Nursing Practice

Over the prior three years, the oncology unit saw a significant increase in central line-associated bloodstream infections (CLABSIs). CLABSIs lead to increased costs, length of stay, delays in treatment, and increased mortality for oncology patients. Quality rounds, root cause analyses, and a literature review revealed several opportunities for the nursing care of central lines on this inpatient oncology unit. In December 2020, the Clinical Nurse Specialist (CNS) Fellow joined forces with the unit's infection prevention nurse champion, Nurse Manager, and IV Team Nurse Manager to conduct a review of past CLABSIs and create an action plan to improve standards of care for central lines and reduce CLABSIs. Key components of this plan included having all preceptors complete a 4-hour shift with an IV Team RN, the creation of a new RN CLABSI class, educational presentations at staff meetings, and in-services for RNs on night shift. The unit prioritized improving adherence to parts of Standard Work including utilization of a Central Line Bundle Order Set and daily assessments of need for a central line. The CNS Fellow also partnered with staff RNs and the Patient Education Specialist to revise the generic central line patient education document that had been used for years. The updated tool emphasized daily CHG treatments, hand hygiene, oral care, and limiting lab draws from central lines. Pre-intervention adherence to Standard Work was 67%. Incremental monthly improvements were made and adherence

rose to 95% 3 months post-intervention. Improvements in Standard Work adherence and the other interventions led to a decrease in CLABSI rates. The oncology unit CLABSI rate was 2.47 in fiscal year (FY) 20 and was 3.23 for the first 6 months of FY21. The rate dropped to 1.66 the second half of FY21 and has been 0 through the first quarter of FY22. The patient education tool was so well received that Infection Control and IV Team are utilizing it throughout the hospital. It has also been beneficial for non-oncology RNs who are not as familiar with central line care. Implementing some fundamental initiatives that were informed by research and evidence helped us change the culture around central lines and become CLABSI-free. These strategies could easily be replicated in other areas to positively impact the culture of quality nursing practice.

P239 IMPROVING PATIENT ACCESS TO NOVEL THERAPIES BY CREATING AND IMPLEMENTING A NEW CLINICAL READINESS MODEL

Eleni Rokakis, RN, BSN, Seattle Cancer Care Alliance, Seattle, WA; Elizabeth Stohr, MSN, RN, Seattle Cancer Care Alliance, Seattle, WA; Leslie Blackwell, RN, BSN, Seattle Cancer Care Alliance, Seattle, WA; Hana Porter, RN, BSN, Seattle Cancer Care Alliance, Seattle, WA; Samson Deal, RN, BSN, Seattle Cancer Care Alliance, Seattle, WA; Rachel Weber, MPH, Seattle Cancer Care Alliance, Seattle, WA

Oncology Nursing Practice

The Seattle Cancer Care Alliance (SCCA) is a comprehensive cancer center supporting translation of research to patients. In 2019 SCCA evaluated their current research study start-up process and identified barriers creating delays opening trials to accrual. Barriers: late feasibility, delayed implementation assessments, and operationalization of complicated research protocols driven by study staff. The median for clinical trial implementation was 238 days far exceeding the institution's benchmark of 100 days. The purpose of this project was to improve patient access to novel therapies by removing barriers to reduce study start-up timelines. The Clinical Readiness pilot was initiated in 2019, involving 18 clinical trials. The role of the clinical trial nurse (CTN) was created to complete an early feasibility assessment and decrease the burden on clinical subject matter experts (SMEs) and study teams. Two main tools were developed and refined to assist this process: the fact sheet and protocol flow. The fact sheet, an existing tool at SCCA, was refined to incorporate pertinent study protocol infor-

mation for patient care. The protocol flow was developed to evaluate the protocol schedule of events and assess clinic implementation. Lastly, two meetings were developed to identify barriers and operationalize the study. Of the 18 studies, 16 were completed utilizing the Clinical Readiness model. The median days to implementation were 164; 25% completed in ≤ 100 days. The innovation of this pilot was the adoption of the Clinical Readiness model as the standard process at SCCA. 171 studies outside of the pilot completed startup within a median of 211 days. The inaugural Clinical Readiness team involved 4 CTNs and 4 clinical research coordinators (CRC). The CTNs were hired based on clinical trial and oncology experience. Each CTN was paired with a CRC and assigned to a disease group to assist with the Clinical Readiness model. The goal is to extend this model across all disease groups at SCCA. The Clinical Readiness model continues to identify trends in study start-up delays. This model has facilitated close partnerships & strong communication between CTNs, CRCs, SMEs, and study teams leading to timely patient access to novel therapeutics.

P240 WHO, WHAT AND WHERE IS THE CLINICAL TRANSLATIONAL RESEARCH CENTER

Lisa Schlarman, BSN, RN, OCN®, University of Pittsburgh Medical Center (UPMC), Pittsburgh, PA

Coordination of Care

The University of Pittsburgh Medical Center (UPMC) Hillman Cancer Center (HCC) houses the Clinical Translational Research Center (CTRC). The CTRC provides a specialized, controlled environment essential for conducting high quality and intensive clinical and translational cancer research. Studies involve administration of sophisticated and experimental cancer therapies, vaccines, and Phase I agents. The CTRC is located on the first floor of the HCC. To access the department, patients require entrance through a locked corridor that houses the CTRC and radiology imaging suites. Throughout 2020, patients were often lost and required escort to the CTRC by second or third floor staff, volunteers, or radiology personnel. During leadership rounding, patients often raised concerns about department location, appointment time awareness, and protocol day details. The purpose of this project was to improve location awareness, update wayfinding resources, reinforce appointment time and review specific details of the protocol day. Wayfinding cards were created and provided to the clinical research coordinators (CRC). CRCs pro-

vided wayfinding cards at the time of patient consent for all CTRC patients. CTRC signage was updated, and courtesy calls were conducted for all new CTRC patients. These calls confirmed appointment time, knowledge of CTRC location, and patient expectations of the protocol day. Over a five-month period, 102 patients started a new clinical trial and received a courtesy call. Of those patients, 88 had never been to the CTRC. Courtesy call results revealed 13.6% of the 88 did not know where the CTRC was located and less than 5% received a wayfinding card. The data indicated that CRCs are not consistently providing wayfinding cards. Reeducation will be conducted to ensure these are provided to at least 75% of patients by the CRCs at the time of clinical trial consent. Additional analysis shows courtesy calls helped with wayfinding and reinforced appointment details. It is estimated that by 2022, more than 180 patients will have received courtesy calls. Eighty six percent, or more than 150 patients, will be first time patients to CTRC and will receive a wayfinding card. The implementation of courtesy calls, wayfinding cards, and updated signage will eliminate confusion and stress for patients who may have trouble finding the CTRC on the first day of protocol treatment.

P241 **ATC AUDIT AVENGERS: IMPROVING THE CHARTING PRACTICES OF NURSES IN THE AMBULATORY TREATMENT CENTER**

Lisa Schomburg, RN, University of Texas- MD Anderson Cancer Center, Sugar Land, TX
Oncology Nursing Practice

The American Nurses Association, major institutional accrediting bodies, and institutional policies all provide scope and standards required for documentation in the ambulatory setting. Accurate and timely documentation by nurses is critical in patient care. The use of an electronic health record (EHR) has allowed clinicians to chart more efficiently; however, it also highlights the importance of completing accurate documentation to comply with institutional requirements. The objective of this quality improvement project was to identify areas of charting deficiencies that needed improvement by nurses in the Ambulatory Treatment Center (ATC) utilizing peer driven observations and coaching. Four specific charting areas were targeted for this project including Eastern Cooperative Oncology Group (ECOG), patient education, pain assessment and medication review with a goal to increase and maintain staff compliance of 90% or greater during FY21 (September 2020-May 2021). Ac-

cess was granted to the EHR report system to monitor the four specific charting areas and included education and instructions provided by nursing leadership. Each month, the data was reviewed by the auditor and shared with the ATC nursing team. Based on the data, a monthly action plan was educated in the form of one on one, small group huddles, and via email with tips and recommendations to help improve deficiencies and charting skills. The individualization of each nurses' charting was also reviewed to allow for positive feedback and an opportunity to allow for questions. A monthly comparative report showed gradual but consistent improvement in the medical record documentation by all ATC nurses. A compliance score of greater than 90% or higher in the charting areas of ECOG, patient education, and medication review. Patient education improved from 72% (September 2020) to 98% in (May 2021). Pain assessment improved from 62% (September 2020) to 86% (May 2021). The introduction of an EHR nursing checklist in February 2021 has also served as a reminder to ensure nurses are documenting all key charting elements. Accurate and prompt documentation of patient information by nurses is very important for successful patient care. This quality improvement project provided a means to identify specific deficiencies in nurses' charting, learn about documentation requirements, and assure accuracy of documentation in the EHR.

P242 **DEVELOPMENT AND PILOT OF AN INPATIENT ONCOLOGY NURSING WORKLOAD AND ACUITY TOOL**

Brenda Shelton, DNP, APRN-CNS, CCRN, AOCN®, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD; Marie Swisher, DNP, RN, APRN-CNS, CWCN, AOCNS®, Johns Hopkins Hospital, Baltimore, MD; Barbara Van de Castle, DNP, OCN®, ACNS, RN-BC, University of Maryland School of Nursing, Baltimore, MD; Janet Briel, BSN, MBA, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD
Oncology Nursing Practice

Oncology inpatient nursing care is more diverse than non-oncology care and different than traditional intermediate (IMC) care. The complexity and level of debilitation of medical oncology inpatients constitute higher numbers of patient care hours. Staffing ratios for care of oncology patients often differ from non-oncology nursing units, and validated workload and acuity tools are not readily available. A nursing workgroup in this 77-bed Comprehensive Cancer Center

was formed to evaluate existing Oncology and IMC nursing workload and Acuity tools in the literature and select one for implementation. Evidence-based literature showed two tools used for inpatient oncology acuity, but they did not address all essential variables. Six non-validated instruments and eight articles were examined to identify key variables and common anchors to develop an organization-specific tool. Unique specialty care such as administration of research drugs, venous access management, and complex discharge planning were considered in tool creation of domains and variables. The first draft had 34 variables within four levels of oncology care. The aim of this series of pilots was to develop content and face validity in preparation for an institutional review board (IRB) approved research study to test construct validity and reliability. The first draft was piloted in summer 2020, then modified for clarity and variable reduction. A second pilot in October 2020 helped reduce it to 24 variables with additional rephrasing. This project reports the results of 4913 entries from February- March 2021. There were appropriate relationships between the staff level assessment and the point distribution. It also defined the number of patients at each level of acuity/workload on the inpatient units and which variables were most prevalent. Descriptive statistics showed the frequency of high acuity technologies, the clinical burden of physical care, blood product and chemotherapy administration volumes, frequent assessments, and need for psychosocial support or discharge planning. The diversity of cancer patients' needs and available resources may indicate necessity for development of an organizational-specific tool for measurement of oncology acuity and workload. This project demonstrates a methodical approach to development of a tool with face validity and the process to create a research study based on pilot data. There is now an ongoing IRB approved research study testing the instrument for construct validity and reliability.

P243 TO ENSURE ZERO HARM TO OUR VETERANS, IT IS ESSENTIAL THAT 100% OF ONCOLOGY RN'S ARE COMPETENT IN PROGRAMMING THE ALARIS PUMP

Sally Shuffler, RN, BSN, OCN®, Bay Pines VA Medical Center, Saint Petersburg, FL; Milva Montes, RN, BSN, OCN®, Bay Pines VA Medical Center, Saint Petersburg, FL

[Patient Education and Safety](#)

The Bay Pines VA Healthcare System cares for many veterans who are receiving chemotherapy treatment

for cancer. In order to ensure patient safety, and optimum treatment outcomes, it is mandatory that our oncology nurses are competent when administering these high-alert medications. It is of utmost importance that infusion pumps software library are up-to-date. The Purpose of this quality improvement project is to ensure that all our oncology RN's are competent in programming the Alaris Pumps, and to bring attention to the fact that the Alaris pump's drug library needs to be updated. Two nationally certified oncology nurses from the Bay Pines VA oncology clinic formulated a measuring tool to assess oncology RN's competency when programming the Alaris Infusion Pumps, utilizing the pump's guardrails library, to administer anti-neoplastic agents. The measuring tool was in the form of a questionnaire, designed to ascertain oncology RN's knowledge of the ALARIS infusion pump, and to ascertain the level of compliance with the above-mentioned Healthcare's Nursing Protocol. 36 RN's from 5B participated (81%), and 5 of chemo clinic RN's participated (100%). The data from the questionnaire was compiled on a graph chart. 94% of survey participants from 5B reported always checking the Alaris pump to ensure that chemotherapy is infusing properly prior to leaving the bedside. 80% of survey participants from the chemo clinic reported doing so. 83% of survey participants on 5B reported having another RN independently verify the pump settings, whereas 40% of survey participants from the chemo clinic reported doing so. Findings demonstrated that the Guardrails Drug Library needs to be updated to include new chemotherapy agents and immunotherapy agents. Infusion pumps are critical in the safe and accurate administration of intra venous medications. Pharmacy department recognizes that the Alaris pump drug library has to be updated; they are actively working to up-date the library. Additionally, it is imperative that 100% of oncology RN's are competent in programming the Alaris pump. In the support of a High Reliability Organization, and promoting a culture of safety, this "Quick Step" presentation will be presented to the oncology nurses, as and in-service educational presentation.

P244 UNIT-BASED MID SHIFT HUDDLES TO PROVIDE TO IMPROVE OUTCOMES: FEASIBILITY AND NEXT STEPS

Nicole Smith, MSN, RN, Roswell Park, Buffalo, NY
[Patient Education and Safety](#)

There is significant evidence that unit-based huddles improve safety by increasing communication and im-

proving overall team performance. Traditionally unit-based huddles occur during the initiation or termination of a shift. There is emerging data that doing the huddle during the shift may improve nursing sensitive indicators on the unit including hand hygiene scores, and patient falls. The purpose of this pilot project was to evaluate the feasibility and implications when implementing unit-based mid-shift huddles in a surgical floor of a dedicated oncology hospital. Following the Agency for Healthcare Research and Quality “Daily Huddle Component Kit” rubric the clinical nurse manager provided education to the charge nurses on how to implement the huddles. There are two components of the huddle including “patient first” and “temperature check”. The focus of “patient first” is patient safety and bed management. This is a time to discuss pending unit admissions, transfers, and discharges. Patients that are at high risk for falls, require an in-person sitter due to cognitive deficiencies, and declining/unstable patients are also discussed. The “temperature check” focuses on staff members workload, stress level, and resiliency including ensuring staff wellbeing, workload, and potential obstacles in providing care. Subjective data was overwhelming positive and within three weeks the mid-shift huddles became engrained in the daily unit operations. Given the positive feedback from staff other units requested to initiate mid-shift huddles. Staff from the initiating surgical unit served as coaches in implementing the huddles. Mid-shift unit-based hospitals were overwhelmingly supported by staff. Moderate term results are currently being collected to assess the impact on employee engagement, nursing satisfaction, and nursing sensitive indicators.

P245 IMPLEMENTATION OF A PATIENT SAFETY INITIATIVE IN THE AMBULATORY SETTING

Sheryl Smolarek, BSN, RN, OCN[®], Karmanos Cancer Center, Detroit, MI; Maryann Sparks, BSN, RN, Karmanos Cancer Center, Detroit, MI; Clara Beaver, MSN, RN, AOCNS[®], ACNS-BC, Karmanos Cancer Institute, Detroit, MI; Deborah Gibbs, RN, MSN, NE-BC, Karmanos Cancer Center, Detroit, MI
[Patient Education and Safety](#)

Over the past year, there has been an increase in patient falls and falls with injury in the ambulatory areas at Karmanos Cancer Center. Reasons for the increased fall rates were thought to include increased patient acuity and visitor restrictions placed due to COVID-19 precautions. In January 2021, a patient fell and sustained a major injury requiring hospitalization

which prompted a root cause analysis (RCA) to be completed. As a response to both the rise in falls and suggestions from the RCA, an ambulatory falls task force was created. The purpose of this initiative was to devise and implement a standardized process to improve ambulatory patient safety. The goals were to improve the identification of patients at risk for falls, create consistent Interventions and methods to communicate fall risk of the patient, as well as to improve patient education around falls. Resources from protocols and interventions used in the inpatient units, literature searches and recommendations from associated organizations were collected for review. The task force used these resources to create a standardized ambulatory processes from patient check-in to discharge. The new standardized ambulatory process included assessing the patient for factors that would determine that the patient was a fall risk, determining the indicator needed to communicate risk of fall, and creation of an “Outpatient Safety Education Sheet” for the nurse to review with patients at first visit and when deemed a risk. The new plan also includes improved communication methods as the patient moves between ambulatory areas and use of a “Preventing Falls” safety brochure. Education of the new standardized process was provided to staff members in all ambulatory areas. All ambulatory staff have been educated on the new standardized process. Fall rates are reviewed each month and any gaps in the standardized process are discussed with leadership and staff involved. The task force will continue to meet quarterly to assess the process. Patients have a risk for falling especially when going to a new place, receiving new treatment, and not having a family member present. As we continue to see the acuity of patient increase in the ambulatory areas and limit family members who can be present; it is important to have standardized safety plans in place to limit injury to these patients.

P246 DATA DRIVEN ONCOLOGY INFUSION CENTER CHAIR OPTIMIZATION PROJECT

Sunny Stirling, PhD, MBA, RN, OCN[®], CMSRN, RN-BC, Sharp HealthCare, San Diego, CA; Nancy Harris, MPA, Sharp Health, San Diego, CA; Eric Miedema, MBA, Cerner, North Kansas City, MO; Arlene Ferrer, RN, Sharp HealthCare, San Diego, CA; Theresa Hermosura, RN, Sharp HealthCare, San Diego, CA; Mary Kerr, RN, Sharp HealthCare, San Diego, CA
[Oncology Nursing Practice](#)

Everyday, oncology infusion nurses juggle with limited resources, such as availability of infusion chairs,

nurses, pharmacists, and limited infusion center hours, and this brings operational challenges. Optimizing utilization of available chair time allows oncology infusion nurses to serve more patients and their medical needs, increase satisfaction for patients and staff, and reduce waste of resources. Currently, three infusion centers have one EHR solution (Cerner), a standardized scheduling practice as scheduling orders are pre-built in infusion regimens. Also, Tracking Shells utilized to manage daily infusion center patients flow. The purpose of this project was to optimize infusion center chair resource utilization by utilizing oncology infusion nursing practice data from Cerner scheduling order and tracking shell usage. HealtheAnalytics is a Tableau based data analytics platform. It provides a comprehensive and integrated access point to Cerner data. Using HealtheAnalytics, the work group designed multiple infusion center dashboards to address operational challenges. One of the dashboards we designed identifies infusion regimens that have significant differences between the actual and scheduled chair time. The actual chair time data is extracted from the Tracking Shell use in Cerner. Change Management processes employed to adjust appointment duration time for regimens with noted variances in scheduled time versus actual infusion times. The work group identified 20 target therapy PowerPlans that have the high total variance time. IVIG regimens scheduling orders had the most significant difference resulting in a total variance of 25,028 min. Those scheduling orders were adjusted to match actual patient chair time data. Loading and Maintenance PowerPlan scheduling orders were updated at the same time. Although the key to successful infusion care depends on the ability of the nurses to individualize the patient care according to the patient conditions, history, medications, and infusion reactions, nursing care is often not measured effectively. Our project embodies the evidence of nursing care in the oncology infusion setting and provides a systematic approach of standardized care. Understanding and utilization of oncology infusion practice data will allow leadership to optimize the limited resources of infusion centers with improved outcomes for patients and staff.

P247 NURSE COORDINATORS TEAM UP WITH NURSE ANALYST TO CREATE ELECTRONIC INTAKE QUESTIONNAIRE FOR BREAST CENTER PATIENTS

Sherri Storms, MSN, RN, GERO-BC™, CBCN®, Smilow Cancer Hospital, New Haven, CT; Sandra Hurd, MPH,

BSN, RN, CBCN®, Smilow Cancer Hospital, New Haven, CT; Valerie Walton, RN, BSN, Yale New Haven Hospital, New Haven, CT; Antonette Graziano, Yale New Haven Hospital, New Haven, CT; Griserl Sterling, BS, Yale New Haven Hospital, New Haven, CT; Gregory Zanieski, MD, Yale University, New Haven, CT

Coordination of Care

EPIC, an electronic medical record (EMR), has the capability for patients to enter their own data through the patient portal, MyChart. However, this function was not utilized. Intake specialists e-mailed paper intake forms, which were returned by fax and scanned into EPIC. The nurse coordinator (NC) also called patients, gathered data by phone, and manually entered it into the EMR. The purpose was to provide patients with an electronic form via MyChart to complete before their visit engaging them to actively participate in their own care. The project workflow was designed to save nursing, administration, and transcription time. An Epic Optimization request was placed to initiate a disease specific fillable form to be added to MyChart for New Patient Intake in the Breast Clinic of Women's Oncology Services. The NC collaborated with the nurse analyst from the EPIC team to develop the form and create a new workflow. They trained the clinical staff on how to access the information and reconcile the medical record. After the electronic forms were developed, the intake staff was trained and a physician champion was identified to pilot the project. A total of 20 female patients participated in the pilot; 13/20 (65%) were diagnosed with breast cancer and 7/20 (35%) had benign breast issues. The age range was from 33-86 with the mean age of 61. A total of 15/20 (75%) completed the two questionnaires. Participants' feedback included ease, speed and simplicity of form completion, and reduction of redundant paperwork. Team member comments revealed major time savings, efficiency, and security of patient information. More nursing time remained to support the patient. After the pilot project was complete, it was presented at breast center leadership and staff meetings. The nurse analyst and NC provided individual and group training for staff. Smart phrases were developed and shared with staff for data input into the EMR. A full roll out was implemented with plans to expand to other disease teams. This workflow fully utilizes the EMR and allows patients to participate in their own care. It ensures that the medical record is accurate, secures patient data, and reduces redundancy. The information can be reviewed prior to the visit and the process saves valuable nursing time.

P248 DESIGNING AMBULATORY WORKFLOWS TO IMPROVE RN UTILIZATION OF A DEDICATED PRE-TREATMENT PATIENT EDUCATION VISIT VIA TELEHEALTH

Catherine Sumpio, PhD, RN, AOCNS[®], Smilow Cancer Hospital, New Haven, CT; Elizabeth Rosenberg, DNP, MA, RN, OCN[®], CNML, Yale New Haven Hospital, New Haven, CT; Nicole Bocchetta, MSN, RN, OCN[®], Smilow Cancer Hospital/Yale New Haven Health, New Haven, CT; Paula Pike, RN, BSN, MSN, MBA-HC, NE-BC, Yale New Haven Hospital, Woodbridge, CT; Mandeep Smith, BSN, OCN[®], Smilow Cancer Hospital Care Center in North Haven - Yale New Haven Health, North Haven, CT; Donna LaPolit, BA, Smilow Cancer Hospital, New Haven, CT

Patient Education and Safety

Our Oncology Delivery Network launched an ambulatory transformation initiative in 2021 that leveraged workflow efficiencies and technology solutions developed during COVID. Telehealth was one major practice adopted widely by providers, but not by nursing. A survey of 684 patients indicated that 25% would prefer a telehealth session with nursing for patient education, yet despite creating the option, nurses continued to schedule patients for in-person teaching. Nursing and access leaders partnered to evaluate scheduling process flow and unit barriers to using telehealth, and revised subsequent action plan. The purpose of this project was to pilot RN telehealth use for first-treatment patient education, with goal of expanding televisit alternative for the right patients and families. Interventions in the initial plan-do-study-act (PDSA) cycle focused on creating and implementing a panel video-visit type (linking space and RN resources); establishing patient eligibility criteria for a telehealth visit; and designating nursing role responsibilities. Chart audit revealed inconsistent communication pathways which prompt RN to schedule education visit. Specifically, providers were finalizing treatment decisions for many patients at times other than the consultation visit, leaving RN coordinators unaware. Instead, providers sent EPIC communication directly to schedulers to book the first treatment (C1D1). In the second PDSA cycle, we instituted an automatic scheduling algorithm, booking by default a telehealth education visit in addition to scheduling C1D1. During PDSA cycle 1 from July 1 to August 16th, 2021, dedicated first teaches were completed at pilot site 1 and 2 on 25% and 33% of new patients respectively. The proportion of telehealth teaches for site 1 was 1% (1 of 11), and 15% (2 of 13) for site 2. In PDSA

cycle 2 from August 17 to September 30th, trends indicate increasing use of telehealth teaches, up to 40% for site 1 (4 of 10) and 45% (5 of 11) for site 2. Nursing satisfaction with televisit education and confidence in the technology is mounting. Using short PDSA cycles allowed us to identify underutilization of nursing telehealth visits and discover a reliable trigger for scheduling dedicated pre-treatment teaches. We added clarity to the scheduling process, eliminated biases about patient telehealth preferences, and reinforced our standard for nurses to provide comprehensive treatment education. Automating workflows are an innovation that improves efficiencies in complex cancer care.

P249 THE IMPLEMENTATION OF PRE-APPOINTMENT GERIATRIC ASSESSMENTS AND SCREENINGS TO IMPROVE EARLY ACCESS TO SUPPORT SERVICES IN THE NEWLY DIAGNOSED GERIATRIC ONCOLOGY PATIENT POPULATION

Christa Sundberg, BSN, University of California San Francisco, San Francisco, CA; Krista Ruff, BSN, University of California San Francisco, San Francisco, CA
Coordination of Care

Cancer is a disease of aging adults with 55% of new cases diagnosed, and 70% of cancer deaths occurring in those who are age 65 and older. The use of geriatric assessments in newly diagnosed oncology patients has been proven to reduce treatment toxicity, unplanned hospital admissions, and improve quality of life and patient and caregiver satisfaction. The purpose of this project is to implement a screening and assessment program for all newly diagnosed geriatric oncology patients in effort to improve early access to support services in this vulnerable patient population. The project engages new patient navigation nurses and practice coordinators within an oncology practice to identify eligible geriatric oncology patients who will receive a pre-new patient appointment assessment and screenings by a trained geriatric nurse navigator or program coordinator. The assessments and screenings evaluate the need for additional supportive resources. The geriatric nurse navigator or program coordinator communicates a summary of the results and recommends supportive care referrals to the oncologist for implementation. This workflow has been adopted by the thoracic medical oncology and gynecology oncology and surgery practices. Since implementation in July 2020, 65 patients were assessed and 71% of lung cancer patients and 56% of gynecology

oncology patients were found to have an impairment warranting a referral for supportive services. 63% of screened lung cancer patients and 39% of gynecology oncology patients were referred to the geriatric palliative care clinic. Over the next year, the geriatric assessment program will be integrated into additional practices within the cancer center. We will continue to collect quantitative data to measure the referral volumes for supportive services within each disease group. We are interested to learn if further expansion and positive patient outcomes from this process will validate the need for a geriatric oncology nurse coordinator to facilitate all the pre-screening and assessments for newly diagnosed geriatric patients. There is more to learn about how existing nurse navigators can integrate early screening and assessments into their established workflows.

P250 **ECONSENT FOR CHEMOTHERAPY**

April Thigpen, MSN, RN, CMSRN, OCN[®], Duke Cancer Institute, Durham, NC; Hope Uronis, MD, Duke Cancer Institute, Durham, NC; Matthew Noonan, MSN, RN, OCN[®], Duke Cancer Institute, Durham, NC; Matthew Ainsworth, MSPS, Duke University Health System, Durham, NC

Patient Education and Safety

In 2008, the Oncology Nursing Society (ONS) and American Society of Clinical Oncology (ASCO) held a workshop that put forth the ASCO/ONS Chemotherapy Administration Safety Standards. Within these standards were recommendations to have both documented informed consent and written information available to the patient on their diagnosis, goals of therapy, planned duration and schedule, information on possible side effects, regimen risks or symptoms that require notification and emergency contact information, and a plan for monitoring and follow-up. In 2016, these standards were updated with adjustments in the language that stated that health care settings must have a policy in place that documents a standardized process for obtaining and documenting chemotherapy consent or assent and that informed consent (with assent optional) for chemotherapy treatment is documented before initiation of a chemotherapy regimen. In 2010, Dr. Hope Uronis began leading a team to bring chemotherapy consent to Duke University Health System. Through her work with multiple departments and disciplines throughout the system, an approved document was crafted for use. In 2020, Dr. Uronis formed an implementation team consisting of two oncology certified nurses

and a Duke Health Technology Solutions analyst. This team was able to transition the chemotherapy consent from a paper-only option to an electronic format available within the electronic health record (EHR) and implement the new process into workflows across all three Duke Health hospitals. In addition, the team was able to coordinate use of the eConsent on iPads which were purchased for use in all oncology areas. Having an iPad available helps with accessibility of patients that are at high-falls risk, that need larger font, and have issues using a computer mouse for signing documents. Since implementation of this process, patient feedback has been positive. Patients are able to view the eConsent in their patient accessed EHR both prior to and after signing. This allows for patients to be able to properly review the eConsent language so that they are able to advocate for themselves or their family members appropriately. Implementing change happens in phases, with a period of opposition to be expected. However, because of the efforts of this implementation team, the new eConsent process was widely successful and met with little resistance from stakeholders.

P251 **THE FIGHT AGAINST SLIPS, TRIPS, AND FALLS IN A COMMUNITY-BASED ONCOLOGY AND HEMATOLOGY SETTING**

Ashley Todd, MSN-Ed, RN-BC, OCN[®], Tennessee Oncology, Nashville, TN; April Weis, RN, BSN, OCN[®], Tennessee Oncology, Nashville, TN

Patient Education and Safety

In a community-based oncology and hematology practice including over 30 clinics across two states, a trend in increased patient falls was noted. Adverse event reporting revealed 21 patient falls in 2019 and 77 falls in 2020. Patient visit flow at each clinic includes check in, visiting lab, meeting the medical assistant and provider, receiving infusion or injection treatment if ordered, and check out or scheduling the next appointment. An investigation into safety gaps in the patient visit flow was undertaken. Previously, the organization asked each patient, "Have you fallen in the last six months?" However, follow up was inconsistent. A lack of screening, assessment, and preventative actions were identified. The need for education amongst patients and their caregivers, ambulation and transfer equipment at each location, and a fall risk assessment tool was acknowledged. A 10-week implementation pilot was conducted at three clinics following an evidenced based quality improvement design to decrease patient falls, improve patient outcomes, and increase patient safety.

The pilot included adult oncology and hematology patients who received intravenous treatment the day of their visit. During initial and subsequent visits, nursing provided patient's and caregivers with fall risk and prevention education. Once completed, nursing assessed and identified fall risk status by completing the Morse fall scale and medication fall risk scale questionnaires. After fall risk was identified, nursing executed interventions that included a fall alert sign, hazard modifications, use of assistive equipment, and assistance with ambulation. The pilot resulted in 2,234 participants and one documented fall. When compared to the same 10-week time frame for 2020, this indicated an 86% decrease in the number of patient falls as a result of this quality improvement program. Nursing staff expressed increased satisfaction and safety while providing patient care. Based on these findings, Tennessee Oncology is working towards integrating a fall prevention program into nursing practice to contribute to the delivery of safe patient care in the outpatient setting.

P252 **A NOVEL EDUCATIONAL ACTIVITY USED TO DECREASE CLABSIS ON A MEDICAL ONCOLOGY STEP-DOWN UNIT AFFECTED BY THE COVID 19 PANDEMIC**

Nicole Turkoglu, MSN, RN, OCN®, BMTCN®, New York Presbyterian, New York, NY; Nadeen Robinson, MSN, RN, OCN®, New York Presbyterian, New York, NY; Lorie Ann Magno, MSN, RN, OCN®, New York Presbyterian, New York, NY; Nataly Young, BSN, RN, OCN®, New York Presbyterian, New York, NY; Archana Shenoy, DNP, RN, FNP-C, OCN®, New York Presbyterian, New York, NY

Oncology Nursing Practice

In an urban NYC academic medical center on a 38 bed medical oncology step-down unit CLABSI numbers increased in the months after the height of the COVID 19 pandemic. During the first wave of COVID 19 in NYC, new nurses were hired and were trained in a stressful environment without many opportunities to care for oncology patients. As a step-down unit in a state of emergency, the main population of patients included COVID 19 patients, hospice patients, and patients who were ICU level of care. The purpose of this project to decrease CLABSI infections on a medical oncology unit after the first wave of the COVID 19 pandemic. An inservice was created in which a mock patient room was set up. Nurses entered and had to identify and correct the breaches in central line maintenance that were observed. Following the nurses then demonstrated the correct practices of

line care, blood culture draws, and dressing changes. CLABSI numbers were significantly increased from July 2020 to Sept 2020 with a total of 6 CLABSI infections during that time. Inservice were conducted with 100% of the nursing staff at the end of September and October 2020. Post implementation in Nov 2020 - Jan 2021 there were 0 CLABSI infections. CLABSI infection incidences: July=2, Aug=2, Sept=2, Oct=1, Nov=0, Dec=0, Jan=0. The incidence of CLABSIs significantly decreased after the inservice. It is acknowledged that there are multiple contributing factors to the incidence of CLABSIs. Patients at that time showed hesitancy in seeking care related to their fear of COVID-19. Oncology nurses were able to take ownership of their practice. Oncology nurses have a key role in maintaining patient safety and decreasing the incidence of CLABSIs in oncology patients. Most education inservices involve direct teaching. The approach used in this inservice was to show the nurses some of the observed wrong practices and have the nurses correct the staff members conducting the inservice. This provided them an opportunity for dialogue and for the nurses to assess their own gaps in knowledge. Nurses expressed that they felt like they were in a non-judgemental learning environment and that the goal was to maintain patient safety.

P253 **ASSESSMENT OF PATIENT REPORTED NEEDS, PREFERENCES, AND EDUCATIONAL OUTCOMES AFTER ATTENDING AN ONLINE SUPPORT GROUP FOR PERSONS WITH LYNCH SYNDROME**

Ashley Hendershot, DNP, FNP-C, RN, University of Rochester, Rochester, NY; Carol Lustig, MS, RN, ANP-BC, Wilmot Cancer Institute, University of Rochester Medical Center, Rochester, NY; Laura Kent, RN, BSN, OCN®, URMC, Rochester, NY; Meghan Underhill-Blazey, PhD, APRN, FAAN, University of Rochester, Rochester, NY; Arthur DeCross, MD, URMC, Rochester, NY

Psychosocial Dimensions of Care

Lynch Syndrome (LS) is characterized by a significantly increased lifetime risk for cancers of multiple organ sites, most especially colon and endometrial cancer. A diagnosis of LS is associated with complex medical recommendations for cancer screening and prevention that may cause stress or worry. Support groups can provide education and encouragement to attendees to help navigate the complexity of cancer early detection, prevention, and treatment in the context of LS. A support group for patients and caregivers/family/support persons of patients with LS was started in 2019 at the

Wilmot Cancer Institute Hereditary Cancer Program at Pluta Cancer Center. This group is led by the programs nurses and is supported by the departments' social worker. It is held four times a year over a Zoom platform. A formal educational session is held with a chance for discussion, reflection, and interaction between participants. Here we report results from a survey to assess participants experience with the support group, so that we can improve and further develop the offerings moving forward. The survey is a thirty-five item self-reported electronic survey assessing demographic information, attitudes and beliefs, satisfaction, worry, self-efficacy, and open-ended items asking for suggestions for content. Eligible participants were those who had previously taken part in the LS support group. Surveys were sent by email and the response rate was 82% (n=9), three of which had previously attended a support group. Of the participants, six identified as female, eight white, and seven married. Four participants had never had cancer and seven responded that they had previously had cancer and/or actively have cancer. Seven unique zip codes were represented. Overall, participants were satisfied with the content and format of the groups, felt that the information was useful, and felt confident that they could apply the information learned. Participants suggested a focus on how to identify a care team with Lynch Syndrome experience, more information about genetic testing, risk for other cancers other than colon cancer, lifestyle interventions such as diet and exercise or reducing alcohol or tobacco use, as well as stress reduction techniques. In conclusion, the support group was very useful and well received by those who attended. Future work will aim to increase attendance and also tailor content based on feedback obtained.

P254 EARLY IMPLEMENTATION OF ADVANCE DIRECTIVES IN ONCOLOGY TO IMPROVE END-OF-LIFE OUTCOMES

Ramsey Valenti, MS, RN, OCN[®], University of Maryland School of Nursing, Baltimore, MD; Michelle Turner, MS, CRNP, Johns Hopkins Hospital, Baltimore, MD; Veronica Gutcheil, DNP, CNS, CRNP, University of Maryland School of Nursing, Baltimore, MD; Priscilla Aguirre, DNP, CRNA, University of Maryland School of Nursing, Baltimore, MD

End of Life

Oncology patients receive information about End-of-Life (EOL) care and advance care planning within the last three months of life. A chart review at a multidisciplinary upper aerodigestive oncology clinic,

of patients undergoing definitive radiation treatment of upper aerodigestive tumors (N=32), revealed three (9.4%) patients had an advance directives on file. The purpose of this quality improvement is to increase the number of patients with advance directives, including Medical Orders for Life Sustaining Treatment or code status, on file in a diverse oncology clinic through introduction of advance directives at initial consultation. A discussion about advanced directives will occur at the patient's initial visit through written and verbal information given by the multidisciplinary coordinator. Patient care technicians will mark in the electronic medical record if the patient has an advance directive or not and if it is on file. Follow up conversations on advance directives will happen by nursing staff and medical providers at future visits. Data collection started September 1, 2021 and will run for 12 weeks. Preliminary findings suggest patients are receptive to receiving information about advance directives at the initial consult visit. After two weeks of data collection, 100% of patients (n=6) received information about advance directives at the initial consult and one patient has brought an advance directive to be filed. The preliminary results suggest advance directives at the initial consult can improve patient satisfaction. Ongoing evaluation includes the use of the advance directive review button in the electronic medical record, tracking advance directive information provided to patients at initial consult, and number of patients who have advance directives on file. We anticipate an increase in the number of patients receiving advance directive information at initial consult as well as the number of advance directives on file. Throughout data collection run charts will be used to demonstrate progress on the use of the electronic health record to document advance directives on file, advance directive information received by patients at their initial consult, patients with advance directives on file following initial consult and patients who are resistant to discussions about advance directives related to psychosocial factors.

P255 USING MUCOADHESIVE HYDROGEL TO REDUCE ORAL MUCOSITIS DURING STEM CELL TRANSPLANT CONDITIONING WITH TOTAL BODY IRRADIATION

Tia Wheatley, DNP, RN, AOCNS[®], BMTCN[®], UCLA Health, Los Angeles, CA

Oncology Nursing Practice

Oral mucositis (OM) is a debilitating side effect of chemotherapy and radiation treatment that is often

associated with pain, infection, increased opioid use, and nutritional compromise. Patients who receive conditioning with total body irradiation (TBI) for stem cell transplant (SCT) are at high risk for developing OM. Oral mucoadhesive hydrogel (MuGard) is a recently approved oral rinse that forms a coating over the oral mucosa to protect against OM during cancer treatment. MuGard has shown clinical benefits when used prophylactically starting at initiation of radiation treatment in patients with head and neck cancer. Currently, clinical evaluation of MuGard as a proactive strategy against OM in the SCT population is limited. The purpose of this quality improvement initiative is to determine if adding MuGard to standard oral care through the duration of TBI for SCT patients will provide a tolerable and cost-effective strategy for decreasing the severity of OM while preserving quality of life. Patients admitted for SCT conditioning with TBI will be instructed to use MuGard, starting on the first day of TBI, and continuing until conditioning has completed. MuGard is an oral swish-and-spit solution that can be used four to six times per day, in addition to standard, evidence-based oral care practices. Patients are instructed to avoid eating or drinking for at least one hour after using MuGard, as recommended by the manufacturer. A workflow between medicine, nursing, pharmacy, and the patient/caregiver will be established and tested. The severity and duration of OM, pain and opioid use, nutritional status, and length of stay will be measured to evaluate the impact of MuGard during TBI conditioning. Feasibility for product acquirement and use will also be measured and evaluated. Since including MuGard to standard daily oral care for patients receiving TBI, anecdotally, patients report the rinse is convenient to use and well-tolerated. Proactively managing OM is essential to preserving quality of life during cancer treatment. MuGard may be an inexpensive, supplemental strategy for patients at risk of severe OM during cancer treatment and SCT. A prospective randomized control trial may provide more definitive conclusions on the role MuGard plays in preventing OM related to TBI conditioning in the SCT population.

P256 **INSTALLING POINT-OF-USE SHOWER FILTRATION ON AN INPATIENT STEM CELL TRANSPLANT UNIT**

Tia Wheatley, DNP, RN, AOCNS[®], BMTCN[®], UCLA Health, Los Angeles, CA; Stephanie Jackson, DNP, RN, AOCNS[®], BMTCN[®], Ronald Reagan UCLA, Los Angeles, CA; Sarah Spaulding, BSN, RN, BMTCN[®], Ronald

Reagan UCLA Medical Center, Los Angeles, CA; Emily Shearon, BSN, RN, BMTCN[®], Ronald Reagan UCLA Medical Center, Los Angeles, CA
Oncology Nursing Practice

Waterborne organisms such as *Legionella pneumophila*, *Pseudomonas aeruginosa*, and *Mycobacterium avium* can colonize hospital water supply systems, despite routine cleaning, surveillance, and disinfection. This is likely due to the formation of biofilms along water pipes and tanks, which can harbor pathogens. Aerosolized shower mist can be a source of opportunistic infection if pathogens are introduced into the breathing zone, particularly for patients who are immunocompromised. Patients who receive stem cell transplant (SCT) are at high risk of acquiring nosocomial infection due to aerosolized shower mist inhalation. Because SCT patients are encouraged to shower daily to prevent infections while hospitalized, efforts should be made to reduce the risk of bacterial exposure through water aerosol. Point-of-use (POU) shower filtration is an additional strategy for reducing waterborne pathogens and inhalation risk. The purpose of this quality improvement initiative is to evaluate the impact of POU shower filtration, in addition to standard institutional water supply maintenance, on an inpatient SCT unit. POU shower filters will be installed in each patient bathroom on the 26-bed SCT unit, after hyper-chlorination of the water system has been performed. Filters will be replaced by the institution's facilities department every 60 days per manufacturer recommendation. The institution will continue to perform quarterly water testing and routine sanitization. Nursing leadership will collaborate with Infection Prevention to monitor clinical outcomes on the unit. POU shower filters cost \$60/filter and require replacement every 60 days. The estimated annual cost for installation and maintenance on the SCT unit is \$9,360. There may be a return on investment when compared to the estimated cost of nosocomial or central line infections⁴. Additional installation and maintenance metrics will be evaluated. Potential rollout to other inpatient oncology units within the healthcare system will be discussed after thorough cost analysis and clinical evaluation. Reducing exposure to pathogens through shower mist in the SCT inpatient environment preserves patient safety and contributes to a culture of zero harm. POU shower filters can reduce the microbial load in shower water and aerosol, in addition to routine surveillance and sanitization. This may be a cost-effective strategy to protect vulnerable SCT patients from waterborne pathogens during hospitalization.

P257 **ONE SIZE DOESN'T FIT ALL—IMPLEMENTING A DISTRESS SCREENING PROGRAM IN AN OUTPATIENT ONCOLOGY SETTING—LESSONS LEARNED**

Amy Wilkins, BSN, RN, OCN®, National Institutes of Health, Bethesda, MD; **Joan Aaron, BSN, RN, OCN®**, NPJ-BC, National Institutes of Health, Bethesda, MD; **Rosemary Miller, MSN, RN**, National Institutes of Health, Bethesda, MD; **Deborah Kolakowski, DNP, MSN, RN**, National Institutes of Health, Bethesda, MD
[Psychosocial Dimensions of Care](#)

National Comprehensive Cancer Network (NCCN) distress screening guidelines provide basic process recommendations for organizations building distress screening programs (DSP). These guidelines require refinement to ensure the proper fit for the setting. Distress screening is an essential component of patient-centered care, especially in the outpatient setting, where patient volume and visit brevity serve as a barrier to more in-depth patient evaluation, care and support. A nurse-driven DSP was developed and implemented in an outpatient oncology research institution. Unique setting characteristics impacted process development and integration. Nurses used the “Plan, Do, Check, Act” framework to guide quality improvement activities and ensure feasibility and acceptability. Describing lessons learned during the integration of key DSP components from each clinic helped to improve the implementation to subsequent clinics. Nurses initiated a DSP that included screening, assessment, and distress education. If indicated, nurses provided referral consultation and collaborated with interdisciplinary teams. Despite the additional workload, nurses reported benefits from including the DSP tasks in their scope of practice. Lesson: Simplify your DSP to facilitate partner acceptability. From a process integration perspective, each clinic cared for populations with variable acuity and staffing, resulting in the utilization of different DSP components. Problem-solving around these components provided an opportunity for process innovation, particularly from nursing leaders within each clinic. Lesson: Work closely with clinic partners to understand the environment and workflow before implementing a DSP and be willing to adapt the process to meet the needs of the clinic. Identifying the optimal timepoints for screening provided an additional challenge. Based on partner feedback and rapid cycle testing, a simple timepoint like screening at every medical visit was optimal, but the high volume of screening proved unfeasible. Instead, each clinic screened patients at unique timepoints. Lesson: One size doesn't

always fit all. To ensure best possible fit, screening timepoints may need to be customized across clinics but should remain simple and generalizable across the population of patients. Successful implementation of a nurse-driven DSP requires a dynamic approach to integration. Feedback based on nursing collaboration with interdisciplinary teams provides problem-solving opportunities to address challenges such as variable clinic workflow, varying patient populations, acuity levels and staffing models. These challenges provided opportunities for innovation, particularly from nursing leaders within each clinic.

P258 **SCHEDULING OPTIMIZATION IN AN OUTPATIENT INFUSION CENTER**

Chermaine Wulff, BSN, RN, OCN®, UW Medicine | **Valley Medical Center, Renton, WA**; **Kelley Blake, RN, MSN, AOCNS®**, NPJ-BC, UW Medicine Valley Medical Center, Renton, WA
[Coordination of Care](#)

Optimal scheduling in an outpatient Infusion Center is a complex process that is driven by the need to focus on safety while accommodating a high degree of variability and complexity. Primary constraints are: infusion times, staffing resources, chair availability and unit hours. The purpose of this project was to accomplish the following objectives: (a) create a balanced schedule that supports appropriate RN to patient ratio, (b) improve patient access to care, (c) improve interval of patient appointments promoting patient safety and quality of care, (d) improve patient and staff satisfaction, (e) reduce RN burnout by building a time for meals and breaks, (f) improve employee engagement, and (g) increase productivity by allowing for increased patient volume. Leadership utilized a systematic approach to first identify gaps in the current system. They conducted site visits to other Outpatient Infusion centers to gather data and compared with current model of scheduling. A multidisciplinary team was created to analyze the data using a multi-faceted approach. A new scheduling model was developed which resulted in improvements. Streamlining the scheduling workflow resulted in: improved chair utilization and appropriate level loading of patients across hours of operation. The new schedule template allowed for increased patients' access to care and additional same day appointments. The new scheduling model allowed for appropriate level loading and maximizing chair utilization. This improved both patient experience and staff satisfaction. It also improved financial performance by improving productivity, increased volume, and optimized chair utilization.

P259 **UNDERSTANDING THE NEEDS OF BREAST CANCER PATIENTS FROM DIAGNOSIS TO SURVIVORSHIP**

Linda Yoder, PhD, MBA, RN, AOCN®, FAAN, 1710 Red River, Austin, TX

Patient Education and Safety

Breast cancer patients (BCPs) have a variety of needs from the time of diagnosis to survivorship. These needs span across physical, psychological, spiritual, and financial areas. To improve their services for BCPs, the Breast Cancer Resource Center (BCRC) of Austin, Texas conducted focus groups to determine areas where they could improve their services to this community of patients. Based on the needs assessment, two data elements were incorporated into the existing intake database to better understand the needs of BCRC patients. Elements of the database included the NCCN distress thermometer (range=0-10) and problem list, and the COST-Functional Assessment of Chronic Illness Therapy (FACIT). Initial data from the intake profiles were evaluated to determine needed quality improvement interventions. The database included 417 BCPs, their average age at diagnosis was 53 and most of them were White women with private insurance. Their mean NCCN distress thermometer score was 5.5 (moderate distress) and their greatest concerns dealt with making treatment decisions (37%), and experiencing worry (54%), nervousness (46%), fear (37%), and sadness (31%). The mean FACIT score was 22 indicating the BCPs believed cancer to have a mild impact on their financial status. But 42% were quite worried about the financial problems they might have in the future because of the cancer and 43% believed they had no choice in the amount of money they would need to spend on their care; 72% felt they were not in sufficient control of their financial situation. The intake data are being used by the BCRC to create one page fact sheets for patients, create resource lists for mental health services, and develop topics for subject matter experts to present. The BCRC staff have involved patients in all aspects of data gathering to create quality interventions that patients believe meet their needs and desires. Longitudinal data collection continues as interventions and resources are introduced to patients. It is imperative to gather data from patients to determine their needs rather than creating interventions based on care providers' assumptions. Using quality improvement data to track the effects of interventions over time allows oncology care team members to assess if BCPs' needs are being met and care is being coordinated in the best manner possible.

RESEARCH

P260 **COMPARISON OF CLINICAL UTILITIES OF THE PLATELET COUNT AND PLATELET- LYMPHOCYTE RATIO FOR PREDICTING SURVIVAL IN PATIENTS WITH PANCREATIC CANCER STAGE 2: A RETROSPECTIVE STUDY**

Fatmah Alamoudi, PhD Candidate, University of Florida, Gainesville, FL; Saunjo Yoon, PhD, RN, University of Florida, Gainesville, FL

Research

Pancreatic Cancer (PC) is the fourth leading cause of cancer-related death in United States. The 5-year survival rate is 10% and the lowest among cancer types. Platelets counts and platelets lymphocyte ratio (PLR) may predict inflammation; however, clinical utilities in predicting the survivorship of platelet counts and PLR have not been fully explored. The purpose of this study is to compare the clinical utilities of the platelet count and platelet-lymphocyte ratio (PLR) for predicting survival in patients with PC stage 2 at time of diagnosis. We conducted a survival analysis using existing data obtained from the UF Integrated Data Repository (IRB#202001897). One hundred ninety-nine patients with PC stage 2 (18 years or older), who visited UF Health between Jan. 1, 2012, and July 31, 2020, were included in the study. Receiver operating characteristic curve analysis and the Youden index (*J*) indicated that the optimal cut-off value of the platelet was 218,000 and PLR was 152. Statistical significance was set at $p < 0.05$. Of those 199 patients, 56% males, and 52% were 73 years. 41% had tumors originating in the head of the pancreas, and 88 % white. 43% underwent surgery, 43% received chemotherapy, and 16% received aggressive treatment (combination of chemotherapy and surgery). Multivariate Cox proportional hazards model demonstrated that platelets and PLR were not independent prognostic factors for overall survival ($p = 0.443$, $p = 0.07$, respectively). However, the multivariate analysis showed that surgery was an independent prognostic factor for survival ($p = 0.03$). Platelet count and PLR did not predict survival in our sample. Our predictive model indicated that surgery offers individualized survival estimates ($p = 0.047$) in PC stage 2. This result suggests that resectable surgeries may improve the survivorship of some patients with pancreatic cancer stage 2 if the cancer is still localized without spreading to nearby lymph nodes or distant sites. Our findings have limited generalizability due to a single data collection site in Florida

and the inclusion of PC stage 2 only. Future studies are warranted by examining other biomarkers affecting the overall survival and within-group differences. It's the first time to compare the clinical utilities of different biomarkers that are clinically available for predicting survival in a homogeneous sample.

P261 **HOLISTIC NEEDS ASSESSMENT AND COPING STRATEGIES OF CANCER PATIENTS**

Arvin Baes, MAN, Calamba Medical Center, Calamba City, Laguna, and De La Salle Health Sciences Institute, Dasmariñas City, Cavite

Research

This study was conducted to assess the holistic needs of cancer patients in terms of physiological, psychological, social, and spiritual needs and to determine how they respond through coping strategies. The study utilized a quantitative descriptive approach as a research design and adapted the Sheffield Profile for Assessment and Referral to Care (SPARC) for holistic need assessment and adopted the Situational Version of the Brief COPE for coping strategies with 14 theoretically coping responses by measuring the 28-item self-report questionnaire. The study includes 20 diagnosed cancer patients from the early stage to stage 3 except for those who were not able to participate due to extensive progression of the disease and those who received palliative treatment. Purposive sampling was used in the selection of the subjects. It was found out that in terms of physiological needs, "Fatigue" is the most common symptom they experienced. In terms of psychological, social, and spiritual needs, most of the patients experienced a significant concern. Meanwhile, in coping, "Religion" dominates among the 14 strategies followed by "Use of Emotional Support" and "Positive Reframing", and, "Substance Use" obtained the lowest response. Most of the respondents were female and its significant relationship in terms of "Positive Reframing" agrees significantly. Moreover, in coping and civil status, "Positive Reframing" and "Humor" are significant among married respondents. In coping and stage of cancer, "Positive Reframing" and "Humor" are significant with the stage of cancer. In coping and treatment modalities, "Active Coping", "Use of Emotional Support" and "Religion" are significantly related to patients' treatment modalities. There is also a significant relationship between "Active Coping and Physiological Needs"; "Religion and Psychological Needs", and, "Self-blaming and Psychological, Social and Spiritual Needs". Holistic needs and coping strategies are related to one another

to achieve the goal of healing & coping. Spirituality & the presence of strong support system manifest a positive coping response in their journey to healing regardless of the stage and diagnosis. A formulated care intervention program "My Cancer Journey" would be beneficial among cancer patients. The paper is written based on scholarly work and all errors has been corrected and followed the appropriate format. The research follows and adopted the appropriate methods of research inquiry.

P262 **IMPLEMENTING SYSTEMATIC FINANCIAL SCREENING IN AN OUTPATIENT ONCOLOGY SETTING**

Melissa Beauchemin, PhD, RN, MSN, Columbia University, New York, NY; Rohit Raghunathan, MS, Columbia University, New York, NY; Justine Kahn, MD, MS, Columbia University Irving Medical Center, New York, NY; Elena Elkin, PhD, Columbia University, New York, NY; Dawn Hershman, MD, MS, Columbia University, New York, NY

Research

Routine screening for financial hardship may identify patients at risk of financial crisis, such as bankruptcy or inability to afford food or medication and facilitate mitigation of financial toxicity. We describe our implementation of systematic financial hardship screening using the electronic health record (EHR) in an outpatient cancer center in New York City. Our process was developed previously with stakeholder input to screen all breast cancer patients for financial hardship risk using 2 items (Q1 and Q3) from the Comprehensive Score for Financial Toxicity. Patients complete the 2 items either through: online patient portal during appointment check-in; or English or Spanish paper form distributed to patients by front desk staff during check-in and entered into the EHR during vital signs assessment. The EHR prompts survey completion again after 1 month. Using descriptive statistics, we evaluate implementation feasibility as the rate of completion; and we describe the financial hardship and worry experienced by respondents. From March to July 2021, 1,109 patients were seen in the breast oncology clinic, 23% were Hispanic/Latino and 14% were Black/African American; the mean age was 58 years ($s=14$). These patients represented 2,678 clinical encounters with an average of 2.6 visits per patient, and 864 (78%) patients completed at least one assessment using the online portal. There were 1,106 (41%) responses to Q1: "I know that I have enough money in savings, retirement, or assets to cover the costs of my

treatment;” and 1,109 (41%) to Q2: “I worry about the financial problems I will have in the future as a result of my illness or treatment.” For Q1, 517 (47%) responded “not at all” or “a little bit.” For Q2, 455 (34%) responded “quite a bit” or “very much.” Our study highlights two findings: first, implementing systematic financial screening in oncology clinics is complex; and second, financial hardship and worry are prevalent and require interventions to mitigate this devastating adverse effect of cancer care. Future research will focus on assessing patient perspectives to improve acceptability of current procedures, and developing interventions and referrals for patients most in need.

P263

LIFT THE SPIRIT: AN ONLINE EDUCATIONAL COMMUNICATION INTERVENTION TO INCREASE ONCOLOGY NURSE SELF-EFFICACY WHEN FACILITATING SPIRITUAL HISTORIES WITH ADVANCED CANCER PATIENTS

Monica Beck, PhD, RN, OCN[®], CNE, The University of Alabama in Huntsville, Huntsville, AL

Research

The learner will be able to describe Lift the Spirit intervention in terms of design, feasibility, and acceptability. Having advanced cancer can raise existential and spiritual questions for patients and their families. Nurses can discover sources of spiritual distress and well-being by conducting spiritual histories. Yet nurses report avoiding spiritual histories with patients, citing lack of practice, knowledge, confidence, and time constraints as barriers. With support and practice, nurses can activate cancer patients' spiritual resources to relieve suffering. The purpose of this quasi-experimental, mixed-methods pilot study was to develop and pilot test an enhanced education communication intervention, Lift the Spirit, assess outcome measures, and assess the feasibility of Lift the Spirit in the areas of acceptability and limited-efficacy testing. This intervention, informed by Bandura's social learning theory, combined knowledge and skills practice to increase nurses' self-efficacy in conducting spiritual histories. A purposive sample of nurses (n = 17; RNs = 14, APRNs = 3) viewed an educational module, role-played conducting spiritual histories using the Faith, Importance, Community, Address (FICA)[®] tool, and completed debriefing interviews. Measures included pre- and postmeasures of Spiritual History Knowledge and Spiritual History Self-Efficacy. Pre/post outcome measures were analyzed using a Wilcoxon paired signed-rank test. Debriefing interview data were content analyzed to identify acceptability-

ty-related content. Deductive coding was used to categorize data according to the Theoretical Framework of Acceptability: 1) affective attitude, 2) burden, 3) ethicality, 4) intervention coherence, 5) opportunity costs, 6) perceived effectiveness, and 7) self-efficacy. There were significant differences between pre and post knowledge and self-efficacy scores respectively (Wilcoxon Signed-Ranks: $Z = -3.18, p = 0.002$; and $Z = -3.20, p = 0.001$). Qualitative findings supported the feasibility and acceptability of Lift the Spirit. Among the components of the Lift the Spirit, participants identified the FICA[®] tool and role-playing as the most helpful. Preliminary findings suggested Lift the Spirit was feasible, acceptable, and positively impacted knowledge, skills, and self-efficacy. Outcome measures performed as theorized. The online format was effective, convenient, and readily accessible. The potential utility of Lift the Spirit in educating nurses to conduct spiritual histories was demonstrated. Equipping nurses to conduct spiritual histories through an intervention like Lift the Spirit is crucial to overcoming a significant barrier to providing spiritual care and relieving suffering.

P264

OPPORTUNITY TO COMPLEMENT AND ENHANCE PRE-TREATMENT EDUCATION FOR CAREGIVERS USING VIRTUAL REALITY

Susan Birkhoff, PhD, RN, University of Pittsburgh, Pittsburgh, PA; Heidi Donovan, PhD, RN, National Rehabilitation Research & Training Center on Family Support, Pittsburgh, PA; Young Ji Lee, PhD, MSN, RN, University of Pittsburgh School of Medicine, Pittsburgh, PA

Research

Educating patients and their caregivers before oncology treatment commences is an accepted standard of care that typically consists of in-person oral and written information. However, caregivers may have different learning requirements in which they may benefit from an additional educational approach. Virtual reality (VR) could be an innovative educational modality to complement the delivery of standard pre-treatment information by offering an immersive experience. The purpose of this study was to describe caregivers' pre-treatment oncology education experiences and whether the addition of visual aids could improve their experiences. A qualitative descriptive study was conducted to guide the future development of a VR experience for caregivers. Participants responded to anonymous demographic and qualitative surveys posted on social media sites. These open-ended surveys

were designed to elicit caregivers' experiences receiving pre-treatment education and whether visual aids, described as a video or model, could complement and enhance standard education. Demographic data were calculated using descriptive analyses and qualitative data were analyzed using an inductive coding approach. Participants (N=12) were mostly female (n=10, 83%), white (n=9, 75%), married (n=10, 83%), and well-educated (n=8, 67%). They categorically ranged in age from 26 years to above 65 years. Types of pre-treatment education received were in-person, oral, and written information. One participant received an immersive VR experience to complement pre-treatment preparation. Participants responded that visual aids could improve their experience receiving pre-treatment education by facilitating a better understanding of various procedures, creating a reduction of paperwork, and assisting them with the organization of information. The types of pre-treatment education caregivers received, such as in-person oral and written information, were congruent with standards of pre-treatment care. However, caregivers expressed a visual component could improve their ability to comprehend and organize information. This finding highlights the need to test different visual modalities that could better prepare and provide an enhanced experience for caregivers. VR could be an innovative visual aid immersing both patients and caregivers in the treatment environment. Incorporating different forms of visual technology could offer a robust and enhanced approach to standard pre-treatment education. In alignment with ONS' strategic priorities, exploring caregivers' pre-treatment experiences leads to opportunities to cultivate a spirit of inquiry in which VR could transform how educational content is delivered and reinforced.

P265 THE BENEFITS OF FASTING USED TO ENHANCE CANCER TREATMENT FOR PATIENTS WHO ARE IMMUNOCOMPROMISED AND/OR UNDERGOING TREATMENT: AN INTEGRATIVE RESEARCH REVIEW

Lorrie Burnett, MSN, RNIII, MEDSURG-BC, Covenant Medical Center, Lubbock, TX

Research

Looking for new and improved treatments for cancer has been ongoing for many years. Even though in just the past decade we have made remarkable advances in cancer treatment, there still remains the need for more effective approaches for not only the cancer itself but the side effects of the treatments. This problem still remains one of the major hurdles in medical

oncology. Chemotherapy and radiation therapy generally come with a multitude of side effects including severe immunosuppression, development of secondary tumors, and toxicity to multiple organ systems. These side effects can be acute or long-term that can have a profound effect on the quality of life for the patient, for example chemotherapy-induced peripheral neuropathy. Evidence suggests that fasting may have a profound benefit to the immune system and may be a feasible approach to enhance the efficacy and tolerability of chemotherapy. This review aims to answer the question of whether fasting will help protect the immune system against the toxicity of cancer treatment and increase efficacy of treatment as well as decreasing some of the side effects. This review was created using Whittemore's Methodology of Integrated Research Reviews (2005). A search of the articles was completed using five of the major literature databases: Cochran Library, PubMed, Medline, CINAHL, and Health Source: Nursing/Academic Edition. The key words used to perform the search were: "fasting" and "immune system" and "chemotherapy". Search criteria was limited to "free full text articles" between the years of 2015 and 2020 except for PubMed. A total of sixteen articles were located and ten were found by bibliographic mining. All articles were critically appraised using evaluative checklists and the EBR tool created by Long and Ganaway. From the twenty-seven articles found, one was a duplicate and twelve were considered to be appropriate and useful evidence for this review. The overall literature review unequivocally concludes that fasting not only has a beneficial effect on the immune system but also can help to mitigate some of the side effects caused by chemotherapy and increase its efficacy on the tumor itself. Each piece of literature stated that further clinical trials were needed before incorporating into practice.

P266 THE EFFECTS OF AN EVIDENCE-BASED ONCOLOGY SYMPTOM MANAGEMENT STANDARDIZED PATIENT SIMULATION ON PRELICENSURE NURSING STUDENT OUTCOMES

Sherry Burrell, PhD, RN, CNE, Villanova University, Villanova, PA; Jennifer Ross, PhD, RN, CNE, Villanova University, Villanova, PA; Christine D'Annunzio, MSN, RN, OCN®, Villanova University, Villanova, PA; Mary Ann Heverly, PhD, Villanova University, Villanova, PA

Research

A critical role of the professional nurse is to manage symptoms associated with cancer and its treatments.

Currently, prelicensure nursing curricula lack adequate oncology content and associated opportunities for clinical application. Thus, many graduate nurses do not possess the requisite knowledge and skills required to effectively manage cancer-related symptoms upon entry to practice. The purposes of this study were to evaluate the effect of standardized patient simulation on nursing students' knowledge, confidence, and competence (objective and self-perceived) related to oncology evidence-based symptom management principles, and to determine nursing students' perceptions, satisfaction, and self-confidence with learning using standardized patient simulation in a seminar-style course. A longitudinal, one-group, convergent mixed-methods design with questionnaire variant was used. Data were collected at three time points: T1) pre-seminar, T2) pre-simulation, and T3) post-simulation. A convenience sample of sixty-three senior baccalaureate nursing students in an oncology symptom management seminar participated in two 20-minute standardized patient simulation scenarios that included a 40-minute structured debriefing led by the seminar faculty. The scenarios portrayed a female patient with breast cancer undergoing radiation therapy and a male patient with colorectal cancer receiving chemotherapy. Scenarios were reviewed by two certified oncology nurses for content and two simulation experts for pedagogy. Quantitative data were analyzed using one-way repeated measures analysis of variance. Qualitative responses were analyzed using conventional content analysis. There was a significant increase in students' knowledge, confidence, and self-perceived competence over time with a large effect size. All student groups (n=14) demonstrated objective competence in the colorectal cancer scenario and all participants, with the exception of one student group, demonstrated objective competence in the breast cancer scenario. Participants also reported positive perceptions of, a high-level of satisfaction with, and self-confidence in learning with the standardized patient simulations. Qualitative themes identified included: unique focus, realism, and application of knowledge. This was the first study to examine the effectiveness of SP simulation, as an active teaching strategy in a seminar-style course, in assisting prelicensure nursing students to apply evidence-based symptom management principles gained in oncology theory learning sessions. Findings provide preliminary evidence that standardized patient simulation holds promise to enhance nursing students' knowledge, confidence, and competence related to oncology evidence-based symptom management principles.

P267 **CO-OCCURRENCE OF DEPRESSION AND SLEEP DISTURBANCE AND ASSOCIATIONS WITH STRESS IN OUTPATIENTS RECEIVING CHEMOTHERAPY**

Alejandra Calvo-Schimmel, RN, PhD, University of California San Francisco, Gerton, NC; Christine Miaskowski, RN, PhD, FAAN, University of California, San Francisco, San Francisco, CA; Kate Oppegaard, MS, RN, ACCNS-AG, OCN®, University of California San Francisco, San Francisco, CA; Bruce Cooper, PhD, University of California, San Francisco, San Francisco, CA; Steven Paul, PhD, University of California, San Francisco, San Francisco, CA; Joosun Shin, MSN, RN, OCN®, AGACNP-BC, School of Nursing, University of California, San Francisco, San Francisco, CA; Carolyn Harris, BSN, RN, BMTCN®, OCN®, University of California, San Francisco, San Francisco, CA; Kord Kober, PhD, University of California, San Francisco, San Francisco, CA

Research

The purpose of this project was to identify subgroups of patients with distinct depression AND sleep disturbance profiles and evaluate for differences in demographic and clinical characteristics and measures of stress and resilience among these subgroups. Depression and sleep disturbance occur in up to 45% and 88% of oncology patients, respectively. While previous research focused on an evaluation of these two symptoms individually, little is known about their co-occurrence and associated risk factors. Outpatients (n=1331) were recruited during their first or second cycle of chemotherapy. Center for Epidemiologic Studies Depression Scale (CES-D) and General Sleep Disturbance Scale (GSDS) assessed depression and sleep disturbance, respectively. Measures were completed six times over two cycles of chemotherapy. Stress and resilience measures were: Perceived Stress Scale (PSS), Impact of Event Scale-Revised (IES-R), Life Stressor Checklist-Revised (LSC-R), and Connor Davidson Resilience Scale (CDRD). Latent profile analysis was used to identify subgroups of patients with distinct depression AND sleep disturbance profiles. Five classes were identified: None (21.4%), No Depression and Moderate sleep disturbance (No DEP+Mod SD (32.3%)), Subsyndromal Depression (SubS DEP)+Very High sleep disturbance (SD) (20.4%), Both Moderate (17.7%), and Both High (8.2%). Compared to the None class, the other four classes were more likely to be female, less likely to be employed, had lower functional status and higher level of comorbidity, and were more likely to self-report

a diagnosis of depression. For the total PSS and IES-R scores, significant differences among the five classes followed the expected pattern (i.e., None < No DEP+Mod SD < SubS DEP+Very High SD < Both Moderate < Both High). Compared to the None and the No DEP+Mod SD classes, the other three classes reported a higher LSC-R affected sum score. Compared to the None class, patients in the SubS DEP+Very High SD, Both Moderate, and Both High classes reported lower CDRS scores. This study identified five subgroups of patients and risk factors for the co-occurrence of depression AND sleep disturbance. For the Both Moderate and Both High classes CES-D and GSDS scores suggest clinically meaningful levels of both symptoms and IES-R total scores were suggestive of post-traumatic stress disorder. Clinicians need to assess for the co-occurrence of both symptoms and causes of stress.

P268 **THE CANCER JOURNEY—CAREGIVER AND PATIENT PERSPECTIVES**

Patricia Carter, PhD, RN, CNS, The University of Alabama, Tuscaloosa, AL; Kristi Acker, DNP, PhD, FNP-BC, AOCNP®, ACHPN, The University of Alabama, Tuscaloosa, AL; Teresa Welch, EdD, MSN, RN, NEA-BC, The University of Alabama, Tuscaloosa, AL

Research

More than 1.8 million new cases of cancer are expected to be diagnosed in 2020; 28,570 of those will be in Alabama. Linked to cancer, cancer therapies, and the stress of the cancer journey, both caregivers and patients report high levels of insomnia, depression, anxiety and stress. Which may lead to poor symptom management and inappropriate utilization of healthcare resources. However, no study to date has explored the relationships between sleep, anxiety, depression, stress, home symptom management, and healthcare utilization in cancer patients and family caregivers. This cross-sectional study is collecting data to support the development and testing of a potential model of these relationships using a community engaged research approach. Caregiver-patient dyads are recruited from a rural community based oncology clinic. A single survey is administered to each the dyad member. Well-established instruments are used to assess Sleep (PSQI and ISI), Depression (PHQ-9), Anxiety (GAD-7), and Stress (PSS). Healthcare resource utilization is also captured by self-report for caregivers and patients. Additionally, caregivers report their level of confidence with symptom management at home. We anticipate enrolling 50 dyads for the full study. To date we have enrolled five patient-caregiver dyads

(10% of target) from a rural community based oncology clinic. Sleep quality (PSQI) and insomnia levels (ISI) ranged from no difficulties to significant difficulties for both groups. Similar variances in depression (PHQ-9), Anxiety (GAD-7), and perceived stress (PSS) were reported. Congruence on these measures was not a given between dyad member reports. Some dyads appeared to mirror each other, whereas others reported vast differences in outcomes. Caregivers who reported a greater number of patient symptoms tended to report lower levels of confidence in symptom management at home. Healthcare resource utilization was only reported by 3 of the 5 dyads. Data collection is ongoing. Patients and caregivers experience the cancer journey together and as such are both impacted by this diagnosis. The impact shows differently in each member of the dyad. Future work is needed to explore the individual and dyadic experiences along the cancer journey. This will support the development of effective interventions to smooth the journey for both.

P269 **DEVELOPMENT OF A CLINICAL DECISION SUPPORT TOOL FOR DOSING RECOMMENDATIONS FOR ONCOLOGY MEDICATIONS USING PHARMACOGENETIC TESTING: AN INTERPROFESSIONAL APPROACH**

Crystal Dodson, PhD, RN, MSN, CNE, University of North Carolina at Wilmington, Wilmington, NC

Research

Prescription treatments are linked to adverse drug reactions, but the field of pharmacogenomics provides a way to personalize appropriate drug therapies. To enhance understanding and utilization of pharmacogenetic testing, the Clinical Pharmacogenomic Implementation Consortium (CPIC) created evidence-based guidelines for the prescribing of various medications. The consumption of smartphones and mobile apps for prescribing medications has increased since the initiation of physician order entry and other digital decision support tools. Nurses are at the forefront of patient care, making them well-positioned to inform patients about new and innovative technologies associated with their health. A clinical decision support mobile application that offers knowledge and rationales for the prescription of certain oncology medications based on a patient's genomic profile was previously created and tested by healthcare providers in the oncology field. The purpose of this study was to gather data to refine the mobile app to improve usability

ity and quality. A heuristic evaluation was conducted by 20 computer science students and faculty after initial refinements were made based on the outcomes of an initial field study. This evaluation examined the user interface, comparing its components and aspects to a set of principles as a guide to appraise the mobile app's usability. Furthermore, qualitative feedback was gathered from an expert in the area of pharmacogenetic testing. The data collected led the computer scientists and the digital artist to refine the mobile app. Several areas of refinement were identified, including prioritization of most commonly seen alleles, color gradients, and ability to save/print recommendations. Overall, a working mobile app founded on the CPIC guidelines to address the most frequent gene variants seen in oncology patients was refined. The addition of digital art, animation, and printable PDFs established by the results of the pharmacogenetic testing guidelines were finalized. The expansion of this mobile app is applicable to nurses who have prescriptive privileges, as well as an educational tool for all nurses to grasp the rationale for prescribing certain medications and alternate dosages. Translation of pharmacogenomics into practice will benefit patients by improving care, reducing adverse drug reactions, and potentially lowering costs.

P270 CAREGIVERS OF OLDER ADULTS WITH ADVANCED CANCER PARTICIPATION IN SYMPTOM DISCUSSIONS DURING OUTPATIENT ONCOLOGY VISITS

Marie Flannery, PhD RN, University of Rochester School of Nursing, Rochester, NY; Zhihong Zhang, MS, RN, University of Rochester School of Nursing, Rochester, NY; Yu-ching Chuang, RN, MS, University of Rochester School of Nursing, Rochester, NY; Supriya Mohile, MD, MS, University of Rochester Medical Center, Rochester, NY; Eva Culakova, PhD, University of Rochester Medical Center, Rochester, NY; Melanie Bobry, BS, RN, OCN®, University of Rochester School of Nursing, Rochester, NY

Research

Caregivers of older adults with advanced cancer engage in many care-taking responsibilities including supporting physical and emotional needs. Caregivers of older adults with cancer may be involved in symptom reporting and management. To date this involvement has primarily been examined in the home care setting and with self-report data. The purpose of this analysis was to identify the extent and types of caregiver participation in symptom discussions during an

outpatient oncology appointment using visit transcripts. Descriptive content analysis was conducted using transcripts obtained from patients enrolled in a national geriatric oncology assessment and management clinical trial (clinicaltrials.gov NCT02107443). Patient enrollment criteria were > 70 years old, advanced non-curable cancer, and impairment in at least one geriatric domain. Patients were asked to identify a caregiver to enroll. For this analysis, a convenience sample of 50 transcripts were selected. No more than 2 transcripts were selected from visits with the same oncologist and transcripts were of varying length. A code-book for extracting items of symptom discussions was pre-established. The coding identified all symptoms discussed, which individuals initiated and participated in the symptom conversation (oncologist, patient, and caregiver), whether a symptom management plan was discussed, and participation in symptom management of care discussions. All transcripts were double coded. Descriptive statistics were used to analyze data. Caregivers were on average 66 years old (Range 27-88), 73% female, 90% Caucasian, 66% partner of patient, and 73% living with patient. Caregivers were present in 48/50 visits, symptoms were discussed in 47/48 visits. Overall, caregivers participated in 29/47 (62%) visits during symptom discussions. Caregivers initiated symptom discussions in 15 visits and reported discussed 1 to 5 different patient symptoms (median=2). Also, caregivers participated in discussions of symptoms raised by the patient/oncologist in 24 visits, discussing 1-6 symptoms (median=3). Symptom management plans were discussed in 44 visits. Caregivers provided specific symptom management recommendation(s) in 15 visits, discussing 1-5 recommendations. Further, caregivers initiated symptom management discussions in 6 visits and acknowledged/discussed symptom management recommendations raised by the patient/oncologist in 25 visits. Findings provide evidence of active caregiver participation in discussions of symptoms and symptom management along with the patient and oncologist. Given the level of involvement, clinicians can encourage and solicit caregiver input during ambulatory visits.

P271 THE IMPACT OF THE COVID-19 PANDEMIC ON POST-TREATMENT FOLLOW-UP CARE FOR SURVIVORS OF LUNG AND COLORECTAL CANCER: A QUALITATIVE ANALYSIS

Suzanne P. Graf, MSN, RN, AGCNS-BC, OCN®, City of Hope, Duarte, CA; Maricela Haj, BSN, RN, City of Hope, Duarte, CA; Evelyn Leyva, BSN, RN, City of

Hope, Duarte, CA; Jennifer Tee, BSN, RN, City of Hope, Duarte, CA; Helen Truong, BSN, RN, City of Hope, Duarte, CA; Virginia Sun, PhD, RN, City of Hope, Duarte, CA

Research

The SARS COVID-19 pandemic poses a higher risk for individuals that are immunocompromised and with other pre-existing conditions, including cancer. Due to the risk of infection, survivors with cancer report high levels of emotional burden as well as employment and financial difficulties. Additionally, challenges in post-treatment follow-up care may be exacerbated. The purpose of this study was to explore the impact of the pandemic on lung and colorectal cancer survivor's perceptions of post-treatment follow-up care and quality of life. Between spring 2020 to summer 2021, survivors participating in a randomized trial of a self-management survivorship care intervention completed three questions on COVID's impact on healthcare delivery and quality of life domains following informed consent and as part of baseline assessment. The three questions explored the survivor patients' perception of the impact of COVID-19 on their care after cancer treatment, physical health, emotional well-being, and work/income/finances/housing. Written comments were consolidated into an Excel document and a content analysis approach was used to identify themes. Comments were coded by all investigators and discrepancies were reconciled through meetings. A total of 93 survivors participated in this study (68 colorectal and 25 lung). Their mean age was 62 and the majority (53%) were men. Care delivery was impacted in terms of the inability to have a significant other in attendance during appointments, delay of appointments, and the need to adapt to telehealth. Themes of isolation, decreased physical activity, fear of COVID-19 infection, and increased anxiety predominated. For the questions regarding care impact and work/income/finances/housing, approximately half the respondents stated there was little to no impact on their lives. COVID-19 impacted patients in the areas of care delivery, mental health, physical activity, and employment. As we continue to move through the pandemic, this data will help providers and health care systems understand patients' on-going needs in these unprecedented times.

Disclosure: Research reported in this paper is supported by the National Cancer Institute of the National Institutes of Health under award number R01CA249501-01. The statements presented in this article are solely the responsibility of the author(s) and do not necessarily represent the official views of the National Institutes of Health.

P272

TOWARDS PATIENT-CENTERED BONE CANCER PAIN MANAGEMENT USING MACHINE LEARNING TECHNIQUES

Jia-Wen Guo, PhD, RN, University of Utah College of Nursing, Salt Lake City, UT; Katherine Sward, PhD, RN, University of Utah, Salt Lake City, UT; Susan Beck, PhD, APRN, FAAN, AOCN®, University of Utah, Salt Lake City, UT

Research

Bone cancer pain is severe pain with complicated pathogenesis and remains challenging to treat. The ability to understand the phenotype of pain is critical for developing an effective care plan. Large-scale electronic health record (EHR) data can be leveraged to identify different patterns or trajectories of pain. According to the Dynamic Symptoms Model (DSM), cancer pain can be influenced by demographic, clinical, and social or environmental factors. Data presenting some of these factors have been collected in EHRs. Therefore, this study aimed to EHR data to identify specific pain trajectories of bone cancer patients and then extract predictors for each pain trajectory. This secondary data research used data from the Veterans Affairs healthcare system. The EHR data were included in-patients with bone cancer diagnosed between 2000 and 2019. Their first two years of pain data were used to identify different pain trajectories using growth mixture modeling (GMM). Guided by the DSM model, we included demographics (e.g., sex, race), clinical parameters (e.g., cancer therapies, the use of pain medication), and social factors (e.g., marital status or religion) to predict individual pain trajectories. A total of 201 bone cancer patient data were included in this study. The majority of patients were male (n = 193) and White (n = 145). The mean age at diagnosis was 62.1 years (SD = 14.9, range = 20 - 92). The mean pain score was 3.5 (SD = 2.2, range = 0-10). Two distinct pain trajectory patterns were identified: stable/consistent mild pain (60.7%) and decreasing from moderate to mild pain (7.8%), and consistent moderate pain (39.3%). Decision tree, a machine learning technique, indicated that race, marital status, opioid pain medication use, and smoking or drinking status were important to classify bone cancer patients to their pain trajectories with an accuracy of 70.3%. The findings can support personalized pain care by helping patients understand their potential pain trajectories and facilitating patient and clinician communications in discussing pain care plans. Future studies can consider including more comprehensive factors to improve the accuracy of model prediction. The in-

novation of this study is to demonstrate an approach to developing patient-centered pain management by using EHR data and machine learning techniques.

P273 ADAPTIVE OR PATHOLOGICAL FATIGUE IN ALLOGENEIC HEMATOPOIETIC CELL TRANSPLANT SURVIVORS?

Eileen Hacker, PhD, APRN, AOCN®, FAAN, Indiana University, Indianapolis, IN; Rae Lee Richards, MS, Indiana University School of Nursing, Indianapolis, IN; Deb Sipes-Fears, DNP, RN, Indiana University School of Nursing, Indianapolis, IN; Susan Pressler, PhD, RN, FAAN, Indiana University School of Nursing, Indianapolis, IN

Research

Clearly demarcating the differences between adaptive fatigue, a normal physiological phenomenon, compared to pathological fatigue, a symptom that requires treatment, is vital for phenotypic symptom characterization and sets the stage for intervention. There are no clear criteria for determining whether fatigue in allogeneic hematopoietic cell transplantation (alloHCT) survivors is adaptive or pathological. This paper reports on the classification of the fatigue experience in alloHCT survivors (adaptive versus pathological) using two different methods. Allogeneic HCT survivors in complete remission for at least one year following transplantation were recruited via a web posting on BMT InfoNet. During the screening process, participants responded to questions related to occurrence and duration of fatigue after alloHCT and whether fatigue resolved with rest (Method 1). Participants also completed the Fatigue Severity Scale (Method 2). Descriptive statistics were used to report the categorization of the fatigue (adaptive versus pathological) using both methods. Chi-Square test of independence was used to test for association between the two methods. Forty-one participants completed the screening. The mean age was 53 (SD = 13). Twenty-one participants were male (51%) and 20 female (49%). Thirty-one participants (75.6%) reported persistent fatigue in the past six months and forty (97.6%) reported that they tire more easily since the transplant. Twenty-three participants (56.1%) reported that the fatigue generally resolved with rest. Twenty-two participants (53.7%) were classified as experiencing adaptive fatigue using the standard questions. Conversely, only 26.8% (n = 11) were classified as experiencing adaptive fatigue when using scores less than 4 on the Fatigue Severity Scale. Thirty participants (73.2%) would be classified as having

pathologic fatigue. $X^2 (1, N = 41) = 8.39, p < .05$. The method of determining adaptive versus pathological fatigue influences classification. Participants are less likely to be classified as having pathological fatigue when answering standard questions regarding occurrence, duration, and resolution with rest. The Fatigue Severity Scale is more likely to identify cases of pathological fatigue. These findings are significant as determining who has adaptive versus pathological fatigue is influenced by the method chosen. Clear definitions of adaptive and pathological fatigue are needed for alloHCT survivors to advance oncology science and practice, particularly resources are to be allocated appropriately to those who may need intervention.

P274 INFORMING THE PROFESSIONAL IMPROVEMENT OF SKILLS AMONG ONCOLOGY PROVIDERS EDUCATING PATIENTS WITH HER2+ BREAST CANCER

Nalo Hamilton, PhD, MSN, WHNP, APRN-BC, University of California–Los Angeles, School of Nursing, Los Angeles, CA; Ginny Jacobs, PhD, MEd, CHCP, FSACME, AXDEV Global Inc., Virginia Beach, VA; Monica Augustyniak, MPH, AXDEV Group Inc., Brossard, QC; Susan Fineberg, MD, Albert Einstein College of Medicine, Department of Pathology, Montefiore Medical Center, Bronx, NY; Virginia Kaklamni, MD, UT Health San Antonio MD Anderson Cancer Center, San Antonio, TX; Pam McFadden, FACEHP, FSACME, AXDEV Global Inc., Virginia Beach, VA

Evidence-Based Practice

Numerous targeted therapies are currently available in breast cancer (BC) with gene amplification of the human epidermal growth receptor factor 2 (HER2), while those targeting HER3+ BC are still under clinical investigation. Oncology nurses and advanced practice providers are expected to stay abreast of these advancements to ensure patients with BC receive appropriate therapeutic education. The purpose of this study was to identify the challenges and barriers affecting the care of patients with HER2+ BC, with a focus on the preparedness of oncology providers to educate and counsel patients on their diagnosis, treatment, and management options. A mixed-methods research study was conducted with semi-structured interviews followed by a quantitative survey. Participants included registered nurses (RNs), nurse practitioners (NPs), physician assistants (PAs), medical oncologists (MOs), and pathologists (PATHs) practicing in the United States. RNs, NPs and PAs were required to have an oncology specialization or a minimum of 2

years of practice in oncology. Interviews transcripts were coded and thematically analyzed in NVivo. Chi-square statistical tests were performed on survey data in SPSS to compare responses by demographic (e.g., profession). Thirty-two (32) interviews and 258 surveys were completed with similar breakdowns by profession. Interviews indicated that RNs, NPs/PAs experienced challenges in educating patients about their molecular diagnosis and available treatment options. Surveys indicated that 70% of RNs rated their skill at sub-optimal levels for explaining to patients the role of HER2+ gene amplification. Sub-optimal skills were reported among 43% of NPs/PAs for realigning patients' assumptions about HER2+ metastatic BC. In addition, 38% and 35% of NPs/PAs rated their skill sub-optimally in explaining to patients the risks and benefits of HER2 monoclonal and HER2-directed antibody drug conjugates, respectively. A similar proportion (33%) rated their skill sub-optimally in assessing patients' level of comprehension for available treatment options. To the co-authors' knowledge, this is the first study assessing the educational needs of oncology nurses in their communications with HER2+ BC patients. Oncology nurses and advanced practice providers would benefit from innovative and impactful professional development interventions designed to help them better understand, interpret/translate, and effectively communicate to patients the continually evolving scientific evidence related to HER2+ BC treatment options and their associated risks/benefits.

P275 **SYMPTOM CLUSTERS IN PATIENTS WITH** **CANCER USING DIFFERENT DIMENSIONS** **OF THE SYMPTOM EXPERIENCE**

Carolyn Harris, BSN, RN, BMTCN[®], OCN[®], University of California, San Francisco; Kord Kober, PhD, University of California, San Francisco; Bruce Cooper, PhD, University of California, San Francisco; Steven Paul, PhD, University of California, San Francisco; Yvette Conley, PhD, FAAN, University of Pittsburgh, Pittsburgh, PA; Anand Dhruva, MD, University of California, San Francisco; Marilyn Hammer, PhD, DC, RN, FAAN, Dana-Farber Cancer Institute, Boston, MA; Christine Miaskowski, RN, PhD, FAAN, University of California, San Francisco

Research

Patients with cancer undergoing chemotherapy experience multiple symptoms that appear to cluster together. However, relatively few studies have evaluated for symptom clusters across different dimensions of the symptom experience (i.e., occurrence, severity, dis-

tress). It is unknown whether the dimension used to create the clusters influences the number and types of symptom clusters that are identified. Study purposes were to identify symptom clusters using three symptom dimensions (i.e., occurrence, severity, distress) and assess the stability and consistency of the clusters across the three dimensions in a heterogeneous sample of oncology patients undergoing chemotherapy. Outpatients with breast, gastrointestinal, gynecological, or lung cancer (n=1329) were recruited during their first or second cycle of chemotherapy. A modified version of the Memorial Symptom Assessment Scale was used to assess the occurrence, severity, and distress ratings of 38 symptoms in patients the week prior to their second or third cycle of chemotherapy. Symptom clusters for each dimension were identified through exploratory factor analysis using unweighted least squares. GEOMIN rotated factor loadings with absolute values ≥ 0.40 were considered meaningful. Two- through five-factor solutions were assessed for simple structure and clinical relevance. Clusters were determined to be stable if they appeared across each dimension. Consistency of the symptoms within each of the clusters was determined by evaluating the percentage agreement across dimensions. Patients reported 13.9 (± 7.2) concurrent symptoms. Lack of energy was the most common and severe symptom while "I don't look like myself" was the most distressing. A five-factor solution was selected for occurrence, severity, and distress. For all three dimensions, five symptom clusters (i.e., gastrointestinal, hormonal, psychological, respiratory, and weight gain) were identified. The number of symptoms and the specific symptoms were consistent across all three dimensions for the hormonal, respiratory, and weight gain clusters (100% agreement). Symptoms within the gastrointestinal and psychological clusters were relatively consistent across the three dimensions, with 75% and 83% agreement, respectfully. Our findings suggest that gastrointestinal, hormonal, psychological, respiratory and weight gain clusters are stable across occurrence, severity, and distress in oncology patients receiving chemotherapy. Given the stability of these clusters and the consistency of the symptoms across dimensions, use of a single dimension to identify these clusters may be sufficient.

P276 **RECOMMENDATIONS TO ACHIEVE EQUITY** **IN THE ONCOLOGY NURSING WORKFORCE** **AND HEALTHCARE**

Rachel Hirschey, PhD, RN, University of North Carolina at Chapel Hill, Chapel Hill, NC; Randy Jones, PhD,

RN, FAAN, University of Virginia, Charlottesville, VA; Grace Campbell, PhD, MSW, RN, CRRN, University of Pittsburgh Schools of Nursing and Health & Rehab Sciences, Pittsburgh, PA; Mary Cooley, PhD, RN, FAAN, DFCI, Cohasset, MA; Robin Lally, PhD, MS, RN, AOCN®, FAAN, Fred & Pamela Buffett Cancer Center, Omaha, NE; Darryl Somayaji, PhD, RN, CNS, CCRC, University at Buffalo, Buffalo, NY; Erik Rueter, PMP, PMI-ACP, Pittsburgh, PA; Mary Gullatte, PhD, RN, ANP-BC, AOCN®, FAAN, Emory Healthcare, Atlanta, GA

Research

The Oncology Nursing Society (ONS) charged a rapid response research team to identify priorities focused on increasing equity in development of the oncology nursing workforce and clinical care. Nursing developed during a time of segregation in the United States. The effects of segregation in early nursing education persist as people of color remain underrepresented in the nursing workforce with less than 20% of registered nurses self-identifying as members of underrepresented racial/ethnic groups despite making up about 40% of the U.S. population. Underrepresentation of nurses of color in oncology nursing has significant negative impacts on both the nursing profession and patient outcomes. A team of experts in equity and oncology nursing science were convened by ONS to update the ONS 2019-2022 research priorities and make recommendations to achieve equity in the nursing workforce and healthcare. In line with critical race theory, the team considered how racism is operating in the routine aspects of oncology nursing education and practice. Team members discussed their personal experiences and race consciousness. A rapid literature review was conducted to synthesize the state of the science on racism in oncology, the nursing workforce, and healthcare. A list of potential priorities focused on equity in oncology nursing were drafted and shared with oncology nurse scientists via electronic survey for additional input. Survey findings were applied to generate key priority areas and specific recommendations related to each area. Strategies to improve equity and diversity in clinical practice and the oncology workforce are outlined in two key areas: (1) increase racial and ethnic representation in academia and the oncology nursing workforce; and (2) promotion of equity in oncology nursing and healthcare. Specific recommendations related to each area are presented. Application of recommendations can be applied to work toward achieving equity and deconstruct racism in clinical and academic settings. This project employed a rapid response approach that can be used to address critical concerns that need

timely and thoughtful solutions. This work builds upon the 2019-2022 research priorities to make recommendations that are specific to academic and clinical oncology settings.

P277 MANAGING INFORMATION AND COMMUNICATION WITH OTHERS THROUGHOUT THE COLORECTAL CANCER TRAJECTORY: A PRIORITY FOR CAREGIVER-REPORTED OUTCOMES

A. Fuchsia Howard, PhD, RN, The University of British Columbia, Vancouver, BC; Kelsey Lynch, MSc (Genetic Counselling), The University of British Columbia, Vancouver, BC; Scott Beck, BSN, RN, BC Cancer, Vancouver, BC; Leah Lambert, PhD, RN, BC Cancer, Vancouver, BC; Sally Thorne, PhD, RN, DSc (Hon), FAAN, FCAHS, FCAN, The University of British Columbia, Vancouver, BC; Michael McKenzie, MD, FRCPC, The University of British Columbia, Vancouver, BC

Research

The cancer journey includes a long series of stressful events wherein primary caregivers (e.g., spouse/partner, family member, or close friend) often experience high levels of caregiver burden and poor mental and physical health. Despite growing recognition of the importance of caregiver-reported outcomes (CROs) (a caregiver's assessment of their own health status related to supporting a patient with cancer), it is unknown which outcomes matter most to caregivers, and how and when screening for these CROs would best be done. As part of a larger study on CROs, the purpose of this analysis was to identify and describe the caregiver role in managing information and communication with others and the related obstacles that were important to caregivers of a person with colorectal cancer (CRC). In this qualitative, Interpretive Description study, our multidisciplinary team conducted and analyzed semi-structured interviews with 25 caregivers, 37 patients with CRC, and 16 healthcare providers. Data analysis consisted of inductive coding, constant comparative techniques and ongoing team deliberations. According to the study participants, caregivers played a central role in managing patient-related information and communication with others. Managing and communicating information was often complex, with tensions and obstacles for caregivers arising from key contextual factors: the phase of the cancer trajectory, medical literacy and English proficiency, ethnocultural background, geographic location and travel requirements, and health service disruptions from the COVID-19 pandemic. Five main

themes depicted caregiver obstacles: 1) making sense of the situation and information, 2) navigating patient preferences and autonomy, 3) managing and communicating information as a form of advocacy, 4) facing a collapse in the flow of information, and 5) requiring assistance to navigate the medical world. These five obstacles represent experiences or outcomes of importance to caregivers that require consideration in future CRO development and implementation in CRC care. CRO development, assessment and implementation would benefit from recognition of the varied roles caregivers play in managing information and communication with others at different times in the CRC trajectory. Oncology nurses are ideally situated to assess CROs as part of their care. We recommend that the integration of CROs into oncology care ought to reflect on the necessity of informational support and resources specific to caregivers.

P278 ASSOCIATION BETWEEN SYMPTOM DISTRESS AND QUALITY OF LIFE AMONG BREAST CANCER SURVIVORS: A MODERATED MEDIATION MODEL OF RESILIENCE AND MARITAL STATUS

Li-Ting Huang, PhD, DPH, RN, University of Illinois Chicago, Chicago, IL; Wei-Wen Wu, PhD, RN, National Taiwan University, Taipei; Chung-Jen Wei, PhD, Fu-Jen Catholic University, New Taipei City; Ardith Doorenbos, PhD, RN, FAAN, University of Illinois at Chicago, Chicago, IL

Research

Breast cancer survivors are often challenged to cope with distressing symptoms as soon as their cancer treatment starts. To overcome the impact of symptom distress, some breast cancer survivors may increase their resilience during the new normalcy caused by cancer; however, others may have difficulty in managing symptom distress and maintaining their quality of life (QOL). This study aimed to investigate factors that affect the effect of resilience on the association between symptom distress and QOL among breast cancer survivors in Taiwan. A descriptive, cross-sectional study design was conducted to examine moderated mediation using IBM SPSS PROCESS models. Convenience sampling was used to recruit participants by sending a survey that consists of the Symptom Distress Scale, Resilience Scale, and World Health Organization Quality of Life to examine symptom distress, resilience, and QOL, respectively. Demographic and clinical characteristics were also collected. A total of 91 participants were included in the analysis,

with a mean age of 49 years (SD = 9.07 years). The majority of the participants were married (63.70%), unemployed (48.35%), and had a high school diploma (35.16%). About half the participants were diagnosed with stage II breast cancer, and 60.44% had completed their treatment. The results of the simple mediation model confirmed the indirect effect of symptom distress on QOL through resilience (point estimate = -0.26, 95% CI [-0.49 to -0.09]). Using conditional process analysis, the effect of symptom distress on resilience was moderated by participants' marital status. The strength of resilience on the association between symptom distress and QOL was statistically significant among married participants (point estimate = -0.44, 95% CI [-0.75, -0.14]). Resilience significantly mediated the association between symptom distress and QOL. Interestingly, this indirect effect of resilience was only present among married breast cancer survivors, suggesting the importance of having a support system from significant others to become more resilient to reduce the impact of symptom distress on QOL. Resilience is an important means of helping breast cancer survivors to improve their QOL. Nurses and other health care professionals should assess the support system of breast cancer survivors and help them strengthen their resilience by identifying available internal and external resources, specifically among those lacking support from significant others.

P279 ONCOLOGY NURSING RESEARCH PRIORITIES FOCUSED ON STRUCTURAL RACISM AND HEALTH EQUITY

Randy Jones, PhD, RN, FAAN, University of Virginia, Charlottesville, VA; Rachel Hirschey, PhD, RN, University of North Carolina at Chapel Hill, Chapel Hill, NC; Grace Campbell, PhD, MSW, RN, CRRN, University of Pittsburgh Schools of Nursing and Health & Rehab Sciences, Pittsburgh, PA; Mary Cooley, PhD, RN, FAAN, DFCI, Cohasset, MA; Robin Lally, PhD, MS, RN, AOCN®, FAAN, Fred & Pamela Buffett Cancer Center, Omaha, NE; Darryl Somayaji, PhD, RN, CNS, CCRC, University at Buffalo, Buffalo, NY; Erik Rueter, PMP, PMI-ACP, Pittsburgh, PA; Mary Gullatte, PhD, RN, ANP-BC, AOCN®, FAAN, Emory Healthcare, Atlanta, GA

Research

The Oncology Nursing Society (ONS) recognized a need to reaffirm its commitment to diversity, equity, and inclusion. ONS commissioned nurse scientists and experts in equity to update the ONS 2019-2022 research priorities to expand foci addressing structural racism and health inequities in oncology nursing. Dis-

parities persist in cancer screening, incidence, treatment, mortality, and quality of life outcomes between Black and White patients, despite efforts to provide culturally responsive care to all patients. A new approach of examining how oncology nurse scientists can intervene on structural racism to achieve equitable health outcomes for patients is needed. Guided by critical race theory, an ONS appointed rapid response research team discussed the pervasiveness of racism and how it operates in oncology nursing. Personal race consciousness and experiences as people of color and, or individuals working for equity were shared. These conversations were guided by emergent findings from a rapid literature review focused on synthesizing the state of the science on oncology nursing and cancer health disparities. The team generated and disseminated a list of potential research priorities through an ONS nurse researcher database to obtain input via electronic survey. Survey findings were applied to generate key priority research areas and recommendations related to each area. Three key research priority areas were identified including the design and testing of interventions that (1) build trust in cancer research (2) focus on the social determinants of health and (3) use community-based approaches. Several recommendations related to each area will be presented. Application of these research priorities and specific recommendations provide a blueprint for oncology nurse scientists, clinicians, and organizations to intervene on racism and improve health equity for all patients. The rapid response approach was employed by this expert panel and provides a model for organizations to respond to urgent concerns that arise in oncology nursing science and practice. This team was appointed to build upon the 2019-2022 research priorities and expand the priorities related to racial and ethnic diversity in research, studying the social determinants of health, and interventions focused on modifiable behaviors. A second phase of this work focused on recommendations to achieve equity in the oncology nursing workforce and health care.

P280 ROLE OF FINANCIAL TOXICITY AND SOCIAL SUPPORT IN PSYCHONEUROLOGICAL SYMPTOM BURDEN AMONG PATIENTS WITH CHRONIC MYELOID LEUKEMIA

Haerim Lee, MSN, RN, Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, GA; Stephanie Lee, RN, BS, BSN, OCN®, Emory University Nell Hodgson Woodruff School of Nursing, Atlanta, GA; Nisha Patel, BSN, RN, Emory University Nell Hodgson Woodruff

School of Nursing, Atlanta, GA; Emily Burns, MS, Emory University Nell Hodgson Woodruff School of Nursing, Atlanta, GA; Katherine Yeager, RN, PhD, FAAN, Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, GA

Research

Most patients with chronic myeloid leukemia (CML) experience fatigue and pain related to the disease or its treatment, which often co-occur with other psychoneurological symptoms (PNS). Literature found PNS burden can be aggravated by stress but alleviated by social support in cancer patients. Although financial toxicity (FT) is a leading cause of stress during cancer treatment, little is known about how FT affects PNS and whether social support alleviates the negative consequences of FT on PNS among CML patients treated with tyrosine kinase inhibitors (TKIs). This study examined the association between FT and PNS burden and the moderating effect of social support among CML patients taking TKIs. A secondary analysis was conducted for 81 CML patients taking TKIs. PNS burden was assessed using the average of the Patient-Reported Outcome Common Terminology Criteria for Adverse Events (PRO-CTCAE) composite grades of eight symptoms (the higher, the worse): pain, fatigue, insomnia, concentration problems, memory problems, anxiety, discouragement, and sadness. FT and social support were assessed by Comprehensive Score for Financial Toxicity (COST) (the higher, the better) and Interpersonal Support Evaluation List-12 (ISEL-12) (the higher, the better). To determine the associations among FT, PNS burden, and social support, we performed Spearman correlation analysis and regression-based moderation analysis with mean-centered COST and ISEL-12 total scores. About half were male (55.6%), White (55.6%), married (49.4%), and currently employed (56.8%). The median year since CML diagnosis was 5.5. Overall, patients reported low FT (mean = 26.9, standard deviation [SD] = 10.9), low PNS burden (mean = 0.7, SD = 0.6), and moderate social support (mean = 28.2, SD = 7.3). Increased FT was associated with increased PNS burden ($\rho = -.49, p < .001$) and increased social support ($\rho = .47, p < .001$). We found no moderating effect of social support between FT and PNS burden. Only when patients' ISEL-12 total score was greater than 18.7, FT had a significant association with PNS burden. The association between FT and PNS burden suggests a need for assessing and addressing FT as a part of symptom management among CML patients taking TKIs. Social support may not buffer the association between FT and PNS burden in CML patients taking TKIs, but it may play a role in alleviating FT.

P281
“DO NOT RESUSCITATE,” ONCOLOGY NURSES’ INTERPRETATIONS AND MISCONCEPTIONS: A MIXED-METHODS STUDY

Joyce Lee, MSN, RN, NEA-BC, OCN®, Texas Health Presbyterian Hospital Dallas, Dallas, TX; Kathy Baker, PhD, APRN, ACNS-BC, FCNS, FAAN, Texas Christian University, Fort Worth, TX; Karen Hodges, BSN, RN, OCN®, Texas Health Presbyterian Hospital Dallas, Dallas, TX; Patricia A. Kelly, DNP, APRN, CNS, AGN-BC, AOCN®, Texas Health Presbyterian Hospital Dallas, Dallas, TX; Suzy Lockwood, PhD, MSN, RN, OCN®, FAAN, Texas Christian University, Fort Worth, TX; Ellen Vuong, MSN-Ed, RN, Texas Health Presbyterian Hospital Dallas, Dallas, TX

Research

The purpose of this project was to explore oncology nurses’ understanding of “do not resuscitate (DNR)” orders and describe their interpretations and experiences in caring for patients with DNR orders. The definition of DNR is “no cardiopulmonary resuscitation (CPR)”; however, DNR interpretations vary widely including suggestions of “do not treat.” Previous DNR nursing research is limited to dated studies, pediatric populations, and data from countries with different traditions and cultures. This mixed-methods study is a secondary analysis of adult inpatient oncology nurses who participated in a larger DNR study including medical-surgical and cardiac step-down nurses. Participating oncology nurses were asked to prioritize care by responding to an online case study of a patient with a DNR order. Participants were then invited to one-on-one interviews with a qualitative nurse researcher. Interviews were audiotaped, deidentified, transcribed, and analyzed. Seven of 13 case study participants (53%) chose palliative or end-of-life care as priorities although there was no context for this in the patient scenario. Eight nurses participated in the interviews. The overarching theme of “varying interpretations of DNR orders” and subthemes were consistent with the larger study interview findings. Subthemes included ambiguity with interpretations in nursing practice, identification of situations where other healthcare team members did not agree on clinical implications, and confusion among family members about DNR orders. Examples involved team members questioning Rapid Response Team (RRT) calls or treating patients with DNR orders as “being put on the back burner.” Oncology nurses shared a consistent message: “just because the patient is a DNR doesn’t mean you don’t

do anything.” Interviewees relayed situations where family members did not understand DNR orders or were conflicted with a patient’s changing status. This study highlights DNR disparities and misconceptions within the current healthcare delivery model. Our case study results indicate that some oncology nurses equate DNR orders with palliative or end-of-life care. The interviews suggest oncology nurses do understand that DNR orders are not a substitute for a plan of care. Using team and implementation science, oncology nurses have unique opportunities to educate patients, family members, and other healthcare team members about DNR meaning and misconceptions. DNR means “do not resuscitate” and is not cause to diminish care.

P282
A QUALITATIVE ANALYSIS OF ORAL ONCOLYTIC AGENT MEDICATION BELIEFS AMONG METASTATIC BREAST CANCER PATIENTS

Victoria Marshall, PhD, RN, University of South Florida, Tampa, FL; Constance Visovsky, PhD, RN, ACNP, FAAN, University of South Florida–Nursing, Tampa, FL; Pooja Advani, MD, Mayo Clinic, Jacksonville, FL; Dawn Mussallem, DO, Mayo Clinic, Jacksonville, FL; Cindy Toftagen, PhD, APRN, AOCNP®, FAANP, FAAN, Mayo Clinic, Jacksonville, FL

Research

Medication beliefs are a critical factor of medication taking behavior and have been linked to patient outcomes including symptoms, side effects, and adherence. This work is timely given the increased use of oral oncolytic agents (OAAs) among patients with metastatic breast cancer (MBC), who must self-manage care in the home environment. Currently, medication beliefs have been studied among early-stage cancers and those on hormone treatment. There is gap in the literature examining medication beliefs among those with advanced disease who have experienced other failed cancer treatments. This study aimed to examine the medication beliefs of OAAs among women undergoing treatment for MBC to identify opportunities for patient care improvement. This qualitative study used semi-structured interviews that were audio recorded and transcribed verbatim. A thematic analysis was conducted using Atlas.ti 8.0 software. Inter-rater reliability was set at a threshold of 0.80. Using purposive sampling techniques, participants were recruited from a National Cancer Institute (NCI)-designated comprehensive care center. Eligibility included: ≥18 years old, English speaking, confirmed MBC diagno-

sis, and able and willing to complete interviews via telephone or Zoom. Interviews were conducted until saturation was met. Participants (n=16) were largely Caucasian (86.7%), non-Hispanic (93.3%). Mean age was 55.6 years. Patients held dialectical medication beliefs. Positive medication beliefs included the convenience of receiving cancer treatment at home, wide availability, and scientific advances of new OAAs, relief of cancer-related symptoms, and delayed disease progression. Negative medication beliefs included concern regarding OAA cost, side effects, and long-term medication efficacy. Overall, participants were willing to accept the negative consequences of OAAs in exchange for prolonged survival. However, patients also expressed not knowing when to end treatment and transition to end of life care. Examining and addressing medication beliefs are important to determine areas that oncology nurses may intervene across the OAA treatment trajectory. Evaluating medication beliefs may help initiate conversations regarding uncontrolled symptoms, quality of life, or serve to address ethical issues regarding continuing or ending treatment among patients with advanced disease who experience severe symptoms, side effects, and toxicities. Nurses are positioned to advocate for health policies that improve the quality of care of individuals with cancer, which should include early consultations with palliative care services.

P283 MORAL DISTRESS IN ONCOLOGY NURSING, A CROSS SECTIONAL STUDY OF NURSES IN A COMPREHENSIVE CANCER CENTER

Pamela McLaughlin, MSN, RN, OCN[®], Roswell Park Comprehensive Cancer Center, Buffalo, NY; Melissa Hiscock, BSN, RN, CWOCN[®], OCN[®], CPPS, Roswell Park Comprehensive Cancer Center, Buffalo, NY

Research

Oncology nursing care frequently involves a delicate balance between aggressive therapies and the patient's quality of life. Moral distress (MD) is experienced as a result of knowing the ethical measure to pursue but lacking the ability to, due to external constraints. Caring is affected by a nurse's personal experiences as well as the limitations and demands brought on by their professional environment. In a market driven healthcare system, human caring may be devalued which results in the ethical distress felt by nurses. The current state of MD evidence is primarily focused on critical care and emergency room nursing. The purpose of this study is to determine if MD exists among nurses in the oncology setting at a comprehensive

cancer center and determine if it compares to the MD described in previous research. The Moral Distress Survey-Revised (MDS-R) was administered to 100 nurses from nine inpatient oncology units at a comprehensive cancer center. The MDS-R is a questionnaire in Likert-scale format, measuring moral distress in terms of frequency (how often a situation arises) and intensity (how disturbing the situation is when it occurs). The results were analyzed using a multivariate general linear model, utilizing 10 covariates. Forty percent of nurses reported low MD, 49% experience moderate MD, only 11% report high moral distress and none of the nurses relayed very high MD. The highest overall scores were exhibited among nurses with 11-20 years of oncology experience. Nurses between the ages of 40-49 reported the highest scores of moderate to high moral distress (n=70.6%). One-third of the nurses considered leaving their position due to moral distress. Of these, 94% logged moderate to high moral distress. The unit with the lowest scores was BMT Unit, while the ICU scored the highest levels of MD. Understanding nurse's moral distress will support an organization to mobilize resources to areas where nurses are experiencing a high level of distress. Addressing oncology nurses' moral distress could alleviate costly gaps in staffing.

P284 USING THE PEDIATRIC PATIENT-REPORTED OUTCOMES-COMMON TERMINOLOGY CRITERIA FOR ADVERSE EVENTS (PRO-CTCAE) TO LONGITUDINALLY MEASURE SYMPTOM EXPERIENCES OF CHILDREN WITH ADVANCED CANCER

Kitty Montgomery, PhD, RN, PCNS-BC, CPHON[®], University of Wisconsin-Madison School of Nursing, Madison, WI; Jennifer Raybin, PhD, MSN, RN, CPNP, Children's Hospital Colorado; University of Colorado, Aurora, CO; Jessica Ward, PhD, MPH, CPNP, RN, Children's Hospital Los Angeles, Los Angeles, CA; Roger Brown, PhD, University of Wisconsin-Madison School of Nursing, Madison, WI

Research

The Food and Drug Administration Advisory Committee recently endorsed inclusion of patient-reported outcomes in pediatric cancer trials to illuminate the patient's voice and monitor for adverse effects of treatment. Children with relapsed, progressive, or refractory cancer are often enrolled on clinical trials and experience a spectrum of distressing symptoms. The purpose of this study was to 1) determine the feasibility and acceptability of administering the

newly validated Pediatric PRO-CTCAE biweekly over a 6-month period to children with advanced cancer, and 2) describe symptom experiences. A multisite longitudinal prospective repeated-measures design was employed. Children aged 2-18 with a diagnosis of advanced cancer (any type) who spoke English or Spanish were eligible to participate. The Parent-Proxy (children aged 2-7) and Pediatric (children aged 8-18) versions of the PRO-CTCAE were used to measure symptom frequency, severity, and interference, and administered electronically every two weeks for up to six months. Participants received a \$10 electronic gift card for each completed survey. At the end of the study, participants were asked to complete a brief 7-item acceptability survey. Forty-nine children participated in the study with a mean age of 11.1 years (range: 2-18). The sample included diverse cancer diagnoses (leukemia/lymphoma 37%, solid tumor 45%, central nervous system tumor 18%), was mostly male (67%), white (71%), and non-Hispanic or Latino (65%). Participants completed 85% of administered symptom measures (n=441/515) over an average of 16 weeks (range 2-24 weeks). Five children experienced a cancer-related death while on study, providing self-report data within the last 12 weeks of life for 85% of administered surveys (n=22/26). Most symptom measures were completed at home (71%). The acceptability survey demonstrated most participants (88%) completed data collection using a smartphone, almost never experienced technology problems (88%), and experienced little difficulty with completing symptom measures biweekly. Half (51.6%) wanted to report symptoms every two weeks, followed by monthly (25.8%), and weekly (22.6%). Participants reported the highest mean scores (scale 0-3) for symptom severity attributes of pain (1.35), nausea (1.31), headache (1.26), and abdominal pain (1.24). Biweekly electronic administration of the Pediatric PRO-CTCAE to longitudinally measure symptom frequency, severity, and interference in children with advanced cancer may support clinicians and researchers alike to understand patient-reported symptom experiences and toxicities from treatment across the continuum of care, including at end-of-life.

**P285
FEASIBILITY OF A COMMUNITY-BASED
WELLNESS EVENT FROM THE PARTNERING
IN NEGATING STATISTICS (P.I.N.S.) FOR
BLACK WOMEN INITIATIVE**

Timiya Nolan, PhD, APRN-CNP, ANP-BC, The Ohio State University Wexner Medical Center, Columbus,

OH; Stephanie Ogonuwue, BSc, The Ohio State University, Columbus, OH; Sarah Addison, BS, The Ohio State University, Columbus, OH; Faith Metlock, BSc, The Ohio State University, Columbus, OH; Jing Zhang, BS, The Ohio State University, Columbus, OH; Joshua Joseph, MD, MPH, FAHA, The Ohio State University Wexner Medical Center, Columbus, OH

Research

Black Americans have the highest rate of cancer mortality among all races and ethnicities. About 70% of health outcomes are influenced by social determinants of health (SDH) and lifestyle behaviors. Unfortunately, Black Americans are more likely to face negative SDH and less likely to engage in healthy lifestyle behaviors than their White counterparts. Black Americans with cancer are less likely to obtain treatment at comprehensive cancer centers (CCC), where patients generally experience better outcomes than community cancer centers. Further, higher attainment of ideal cardiovascular health, as indicated by American Heart Association Life's Simple 7 metrics (LS7; glucose, cholesterol, blood pressure, diet, physical activity, and smoking), is associated with lower risk of cancer and mortality among all races and ethnicities. This abstract presents feasibility results from an innovative, community-based wellness event for Black women. The Partnering in Negating Statistics (P.I.N.S.) for Black Women Initiative was formed utilizing academic-community-government partnerships. Partners were engaged throughout the planning and implementation phases. The resulting initiative aimed to uplift Black women to achieve wellness through provision of education, access to resources (e.g., mammograms, pap smears, LS7 screening), and research. In August 2021, the wellness event occurred, during which, feasibility (defined Bowen et al.'s demand and acceptability) was assessed with a program evaluation. Descriptive statistics and thematic content analysis were performed on quantitative and qualitative data, respectively. Demand and acceptability were high. Attendees (N = 200 Black women) registered for and completed 19 mammograms, 14 pap smears, and 99 LS7 screenings. From evaluations (n = 52), attendees (20-74 years old) were well educated (92% with a college degree) and mostly un-partnered (68%). Largely, women heard about our event through family, friends, and community partners. Women were very to extremely satisfied with wellness content (92%) and the program overall (94%). Respondents found value in community engagement and reported need for an annual event. Requested improvements included a change of venue, different day

of the week, and more volunteers to staff the event. The P.I.N.S. for Black Women Initiative is a feasible avenue to engage Black women in cancer education and cancer-related services. This initiative provides a modifiable framework for community engagement which may increase representation of Black women in CCCs and lead to more equitable cancer outcomes.

P286 UNRELIEVED STRESS CONTRIBUTES TO HIGHER LEVELS OF CO-OCCURRING CANCER-RELATED COGNITIVE IMPAIRMENT (CRCI) AND ANXIETY IN OUTPATIENTS RECEIVING CHEMOTHERAPY

Kate Oppegaard, MS, RN, ACCNS-AG, OCN[®], University of California San Francisco; Christine Miaskowski, RN, PhD, FAAN, University of California San Francisco; Bruce Cooper, PhD, University of California, San Francisco; Steven Paul, PhD, University of California, San Francisco; Joosun Shin, MSN, RN, OCN[®], AGACNP-BC, University of California, San Francisco; Carolyn Harris, BSN, RN, BMTCN[®], OCN[®], University of California, San Francisco; Alejandra Calvo-Schimmel, RN, PhD, University of California San Francisco, Gerton, NC; Kord Kober, PhD, University of California, San Francisco

Research

The purpose of this project was to identify subgroups of patients with distinct co-occurring CRCI AND anxiety profiles and evaluate for differences in demographic, clinical, and stress characteristics among these subgroups. While most often studied independently, both CRCI and anxiety occur in a significant percentage of oncology patients and contribute to decrements in quality of life. Previous research suggests a bi-directional relationship between changes in cognition and anxiety. In addition, linkages between stress and anxiety are described in the literature. While cancer is known to be a stressful experience, little is known about which demographic and clinical characteristics and types of stress contribute to inter-individual variability in the co-occurrence of CRCI AND anxiety in outpatients receiving chemotherapy (CTX). Outpatients (n=1332) were recruited during their first or second cycle of CTX from seven sites. Attentional Function Index was used to measure CRCI. Spielberger State Anxiety Inventory was used to measure state anxiety. Patients completed these instruments a total of six times over two cycles of CTX. Global, cancer-related, and cumulative life stress were evaluated using valid and reliable instruments. Latent profile analysis was used to identify subgroups of patients with distinct CRCI AND anxiety profiles. Three

profiles were identified: high cognitive function AND low anxiety (57.3%), moderate cognitive function AND moderate anxiety (34.5%), and low cognitive function AND high anxiety (8.2%). Compared to patients with high cognitive function AND low anxiety, patients with low cognitive function AND high anxiety were significantly younger, less likely to be married/partnered, less likely to be employed, had a lower annual income, and were less likely to exercise on a regular basis. In addition, these patients had a worse comorbidity profile, poorer functional status, and were more likely to self-report ulcer/stomach disease, kidney disease, depression, and back pain. Significant differences in stress measures were found among the three latent classes in the expected pattern (i.e., high cognitive function AND low anxiety < moderate cognitive function AND moderate anxiety < low cognitive function AND high anxiety). While many factors may contribute to both CRCI and anxiety, clinicians can use this information to identify patients who may be at a higher risk of developing co-occurring CRCI and anxiety and initiate timely supportive interventions and/or referrals.

P287 A COMPARISON OF HEALTH COMORBIDITIES IN ADULT CANCER SURVIVORS IN KOREA AND THE U.S.

So-Hyun Park, PhD, ANP-BC, RN, Hunter Bellevue School of Nursing, City University of New York, New York, NY; Shiela M. Strauss, PhD, NYU Rory Meyers College of Nursing, New York, NY

Research

With increased cancer screening and treatment modalities, the number of adult cancer survivors and the survival time after cancer diagnosis continue to increase throughout the world. As adult cancer survivors live longer, it is critical to care for their health comorbidities to improve their life expectancy and quality of life. However, there is limited knowledge on comorbidities in adult cancer survivors and there is no standard cancer survivorship care. We must first determine the prevalence of comorbidities in adult cancer survivors to be able to establish globally acceptable guidelines on their standard of care. The U.S. and Korea are two nations that have an increasing number of adult cancer survivors but lack standardized survivorship care. Using nationally representative data, the purpose of this project was to assess and compare the prevalence of significant health comorbidities in adult cancer survivors in Korea and the U.S. Data from the U.S. National Health and Nutrition Examination Sur-

vey 2017-2018 and Korea National Health and Nutrition Examination Surveys 2017-2018 were used for the analysis. Adults who had a history of diagnosis with at least one cancer were identified as adult cancer survivors. Adult cancer survivors were compared regarding various comorbidities. SPSS Complex Samples software was used to determine comorbidity prevalence in the two populations. A greater proportion of U.S. adult cancer survivors compared with Korean adult cancer survivors reported most of the comorbidities examined. For example, this was the case for high cholesterol (51.9% vs. 31.8%); asthma (15.6% vs. 2.4%); high blood pressure (48.7% vs. 29.8%), especially for females (47.9% vs. 26.4%); heart attack (7.7% vs. 1.3%), especially for females (7.0% vs. 0.4%); and arthritis (50.3% vs. 19.9%), especially for males (48.3% vs. 8.9%). The proportion reporting osteoporosis was similar between the two populations (15.1% vs. 14.3%), but was more prevalent in females (21.8% vs. 21.0%) than in males (6.8% vs. 1.1%) in both populations. A greater proportion of U.S. adult cancer survivors experience some critical health comorbidities compared to adult cancer survivors in Korea, and gender disparities in some of these conditions between the two populations were observed. Further research is needed to examine the etiology of such country and gender differences in order to best manage health comorbidities in adult cancer survivors.

P288 **HEARING THE VOICES OF BEREAVED** **CAREGIVERS OF OLDER ADULTS WITH** **ACUTE MYELOID LEUKEMIA**

Elissa Poor, RN, BSN, OCN®, The University of North Carolina at Chapel Hill School of Nursing, Chapel Hill, NC; Ya-Ning Chan, MSN, RN, University of North Carolina at Chapel Hill, Chapel Hill, NC; Katie Iadonisi, RN, BSN, OCN®, The University of North Carolina at Chapel Hill School of Nursing, Chapel Hill, NC; Stephanie Betancur, BSN, RN, The University of North Carolina at Chapel Hill School of Nursing, Chapel Hill, NC; Kelly Tan, PhD, RN, Duke University Hospital, Durham, NC; Ashley Leak Bryant, PhD, RN-BC, OCN®, FAAN, UNC, Chapel Hill, NC

Research

Older adults with acute myeloid leukemia (AML) are living longer due to more effective novel regimens utilizing hypomethylating agents and venetoclax (HMA + ven), but these survival benefits may escalate patient and caregiver needs for palliative care. The perspectives, needs, and challenges of caregivers of individuals receiving HMA + ven are not well

known, especially at end-of-life into bereavement. Oncology nurses can benefit from research that authentically characterizes caregivers' experiences. The purpose of our study is to share findings detailing the powerful and instructive personal experiences of bereaved caregivers (BCs) of older adults with AML receiving HMA + ven therapy. We recruited 20 older adults with AML receiving HMA + ven and their caregivers between September 2020 and September 2021. During this time, 3 patients died and were survived by their caregivers, 2 of whom consented to be interviewed 3-6 months into their bereavement. Both BCs interviewed were in their 60s; one had lost their parent and the other their spouse. An oncology nurse conducted semi-structured telephone interviews of BCs; interviews were digitally recorded and transcribed verbatim. The research team reviewed transcripts, identified themes, and collaboratively categorized key messages into distinct and overlapping themes across both caregivers. We identified differences and similarities in 6 themes about caregivers' needs in information-seeking; reliance on meaningful social support; the impact of the COVID-19 pandemic; adapting to sudden and dramatic changes in patients' health; responding to patients' changing needs as they neared end-of-life; and differences in goals of care and attitudes toward hospice. Both caregivers highlighted the importance of closure in their relationships with providers. They also both expressed that participating in the interviews helped them process and give purpose to their grief. Our findings highlight the experiences of BCs of older adults with AML and how interaction with oncology nurses can positively impact caregiver experiences. This research is innovative because it simultaneously provides a healing space for BCs while also informing nurses of rare BC perspectives that may enrich their clinical practice. Insights gained from these interviews can also better inform future nursing research aimed at providing evidence-based psychosocial support to caregivers of elderly patients with AML throughout their treatment, at end of life, and into bereavement.

P289 **PALPITATIONS AND CO-OCCURRING** **MENOPAUSAL SYMPTOMS IN WOMEN** **PRIOR TO BREAST CANCER SURGERY**

Ying Sheng, PhD, MSN, RN, Indiana University, Indianapolis, IN; Janet Carpenter, PhD, RN, FAAN, Indiana University, Indianapolis, IN; Steven Paul, PhD, University of California, San Francisco, San Francisco,

CA; Christine Miaskowski, RN, PhD, FAAN, University of California, San Francisco, San Francisco, CA

Research

Palpitations (e.g., heart racing or pounding) are associated with greater insomnia, depression, and stress. Palpitations in women with breast cancer may be related to the cancer and/or its treatment. However, little is known about palpitations in women with breast cancer. This study aimed to evaluate for differences in demographic and clinical characteristics and menopausal symptom severity and distress between women with breast cancer who did and did not report palpitations prior to surgery. This analysis used data from a longitudinal study of neuropathic pain and lymphedema in women who underwent breast cancer surgery. Prior to surgery, 398 women completed questionnaires on demographic and clinical characteristics, functional status (i.e., Karnofsky Performance Status scale), and comorbidity burden (i.e., Self-Administered Comorbidity Questionnaire). Menopausal Symptoms Scale was used to evaluate for the occurrence of palpitations (yes/no) and 45 additional menopausal symptoms. Parametric and non-parametric tests were used to evaluate for differences in demographic and clinical characteristics and the severity and distress of menopausal symptoms between patients with and without palpitations. Of the 398 patients, 15.1% had and 84.9% did not have palpitations prior to breast cancer surgery. Patients with palpitations had lower annual household income ($p=.001$), lower functional status (89.7 ± 11.1 versus 93.9 ± 10 , $p=.004$), higher comorbidity burden (5.3 ± 3.2 versus 4.1 ± 2.7 , $p=.004$), were more likely to report back pain (43.3% versus 25.4%, $p=.008$), and had a higher total number of menopausal symptoms (excluding palpitations) (21.5 ± 7.8 versus 10.4 ± 7.8 , $p<.001$), compared to those without palpitations. Patients with palpitations reported higher severity scores for difficulty concentrating (4.3 ± 2.3 versus 3.2 ± 1.9 , $p=.001$), dizziness (4.8 ± 2.6 versus 2.6 ± 1.4 , $p=.004$), swollen hands/feet (5.3 ± 2.4 versus 3.1 ± 1.7 , $p=.001$), and nighttime waking (5.5 ± 2.8 versus 4.2 ± 2.4 , $p=.001$). In addition, they reported higher distress scores for anxiety (5.7 ± 2.7 versus 4.2 ± 2.7 , $p=.001$), hot flashes (5.0 ± 3.3 versus 3.3 ± 2.7 , $p=.009$), swollen hands/feet (5.7 ± 2.7 versus 3.1 ± 2.3 , $p=.002$), and nighttime waking (5.4 ± 3.1 versus 3.7 ± 3.0 , $p=.001$). While the etiology of these palpitations warrant investigation, these findings suggest that 15% of women prior to surgery experience this symptom. Palpitations appear to co-occur with a number of menopausal symptoms. Future research is warranted on the impact of palpitations on other aspects of

women's lives including quality of life and coping. In addition, the mechanisms that underlie palpitations warrant investigation.

P290

DISTINCT SHORTNESS OF BREATH PROFILES IN PATIENTS UNDERGOING CHEMOTHERAPY

Joosun Shin, MSN, RN, OCN®, AGACNP-BC, University of California, San Francisco; Kord Kober, PhD, University of California, San Francisco; Bruce Cooper, PhD, University of California, San Francisco; Steven Paul, PhD, University of California, San Francisco; Carolyn Harris, BSN, RN, BMTCN®, OCN®, University of California, San Francisco; Kate Oppegaard, MS, RN, ACCNS-AG, OCN®, University of California San Francisco; Alejandra Shimmel, RN, PhD, University of California, San Francisco; Christine Miaskowski, RN, PhD, FAAN, University of California San Francisco

Research

Shortness of breath (SOB) is a distressing symptom that occurs in approximately 10 to 70% of oncology patients. Little is known about inter-individual variability in the occurrence of SOB and associated characteristics among patients receiving chemotherapy (CTX). The purpose of this project was to identify subgroups of patients with distinct SOB profiles and evaluate for differences in demographic and clinical characteristics and common co-occurring symptoms among the subgroups. Outpatients ($n=1329$) completed questionnaires six times over two CTX cycles. The occurrence of SOB was assessed using the Memorial Symptom Assessment Scale. After removing the patients who did not report SOB, latent profile analysis was used to identify subgroups of patients with distinct SOB profiles. Spielberger State-Trait Anxiety Inventory, Lee Fatigue Scale, Center for Epidemiological Studies-Depression Scale, General Sleep Disturbance Scale, Attentional Function Index, and Brief Pain Inventory assessed co-occurring symptoms. Four distinct SOB profiles were identified (None [70.5%], Decreasing [8.2%], Increasing [7.8%], All high [13.5%]). Compared to None class, All-High class was more likely to be older and female, more likely to report a current or previous history of smoking, live alone, be unemployed, and report a lower annual household income. In terms of clinical characteristics, compared to None class, All-High class was more likely to have lung cancer, to have had a higher number of cancer treatments, a higher number of comorbid conditions, a higher comorbidity burden, a poorer level of function, and were more likely to self-report depression, osteoarthritis, back pain, and rheumatoid arthritis.

Compared to the other three classes, a higher percentage of patients in the All-High class self-reported a diagnosis of lung disease. Compared to None class, All-high class had higher levels of depressive symptoms, trait and state anxiety, morning and evening fatigue, worst pain, and pain interference, as well as lower levels of attentional function and morning energy. This study is the first to identify subgroups of patients with distinct SOB profiles in patients receiving chemotherapy. Given that almost 14% of the patients reported a consistently high level of SOB and increased severity of co-occurring symptoms, clinicians need to assess SOB regularly and provide appropriate interventions.

P291 **IMPACT OF HEMOGLOBIN ON ONCOLOGY** **PATIENT FALLS**

Kathleen Shuey, MS, RN, ACNS BC, AOCN[®], Baylor University Medical Center, Dallas, TX; Teri Ellis, MSN, RN, NE-BC, Baylor University Medical Center, Dallas, TX; Alaina Tellson, PhD, RN, NP-BC, NE-BC, Baylor Scott & White Health, Dallas, TX

Research

The Agency for Healthcare Research and Quality indicates that approximately 700,000 to 1 million falls occur in US hospitals annually. On average, there are 3 to 5 falls per 1000 patient days. A review of the literature identified a multitude of studies addressing risk factors and prevention tactics. In oncology, disease, treatment, and treatment side effects can place a patient at a greater risk of fall. Treatment can lead to a decreased hemoglobin. Patients may not realize the impact that treatment or cancer has had predisposing the patient to increased risk of a fall. Additionally, not all patients who have a low hemoglobin on the oncology units fall. A literature review did not identify studies in the oncology patient population that examined the impact of hemoglobin on fall rates. The purpose of the proposed study is to determine clinical factors that impact hospitalized oncology patients with a low hemoglobin that fall versus hospitalized oncology patients with a low hemoglobin that do not fall. A retrospective chart review will be performed. The study population will consist of a convenience sample of oncology patients hospitalized on three inpatient oncology units from July 2019 through June 2021. All patients that fall during the identified time frame will be included in the sample. A group of patients matched by age (± 5 years), diagnosis, and unit location that did not fall during the same time frame will serve as a comparison group. The non-fall group will be matched 2:1 to the fall group. Hemoglobin and fall

risk will be evaluated on admission, 24-48 hours prior to fall and closest to the time of fall. Additional data to be evaluated includes cancer diagnosis, treatment, secondary diagnoses, length of stay, functional mobility, and medications administered during the hospitalization. Sample characteristics will be described using descriptive statistics. Evaluation of data will include us of frequencies, percentages, means, standard deviations, chi-square test, two-sample t-test and logistic regression model. In a population that consists largely of hematology patients, most are admitted with or develop a low hemoglobin. Not all patients who have a low hemoglobin fall. This study may identify additional risk factors that would identify which patients with a low hemoglobin have an increased risk of falls.

P292 **SCALP COOLING THERAPY TO PREVENT** **CHEMOTHERAPY-INDUCED ALOPECIA:** **EXAMINING ONCOLOGY PATIENT** **PERCEPTIONS AND ADHERENCE TO HOME** **HAIR CARE RECOMMENDATIONS**

Jamie Sitarz, BSN, RN, OCN[®], UCHealth, Highlands Ranch, CO; Cara Spencer, PhD, RN, FNP-BC, UCHealth, Aurora, CO

Research

Chemotherapy-induced alopecia (CIA) can be one of the most distressing side effects experienced by cancer patients undergoing systemic therapy. Alopecia can range from mild hair thinning to complete hair loss and can be persistent after the completion of therapy. Although most CIA is temporary, this side effect can cause significant anxiety and may lead to refusal of curative treatment in up to 8% of cases. Scalp cooling is a therapeutic option to minimize CIA that lengthens their time spent in the infusion center, can cause discomfort, and requires hair care modifications at home. Presently, there is a dearth of literature and evidence-based studies regarding the required home hair care modifications associated with scalp cooling therapy. The purpose of this study was to examine patient perceptions and adherence to home hair care recommendations (HCR) throughout the course of their treatment while utilizing scalp cooling therapy. In addition, the goals were to learn which HCR were the most onerous and how they impacted their daily lives. This cross-sectional observational and descriptive study used repeated measures survey data. Participants completed electronic surveys with multiple choice and short answer questions during each treatment, corresponding with their current treatment phase; initial, mid-treatment or final. There were 29

participants that completed the final survey out of 43 that participated in the study. Survey data was analyzed utilizing descriptive statistics. Final survey results revealed that most participants found the HCR to be easy or manageable and that they had a negligible impact on their daily lives. Participants revealed that the most adhered to HCR was “avoiding hair chemicals” and that “avoiding hair washing during periods of heavy shedding” was the least adhered to. Similarly, participants rated “avoiding hair chemicals” as the easiest HCR and “avoiding hair washing during periods of heavy shedding” as the most difficult. Lastly, participants reported that scalp cooling therapy was worth the effort, time, discomfort, and modifications to their home hair care and would recommend it to others. Armed with the findings from this study, oncology nurses must set appropriate expectations about the HCR, provide education related to the most challenging behavior modifications and encourage self-care throughout treatment to assure optimal hair retention outcomes.

P293 **SUPPORTIVE ONCOLOGY CARE AT HOME INTERVENTION FOR PATIENTS WITH PANCREATIC CANCER**

Melissa Smith, MSN AGPCNP-BC, OCN[®], Medically Home, Boston, MA; Ryan Nipp, MD, MPH, Mass General Brigham Cancer Center, Boston, MA; Eliza Shulman, DO, MPH, Medically Home, Boston, MA; Areej El-Jawahri, MD, Mass General Brigham Cancer Center, Boston, MA; Patricia Brown, Esq, Medically Home, Boston, MA; Marcy Bergeron-Noa, DNP, Medically Home, Boston, MA

Research

Patients with pancreatic cancer receiving chemotherapy often experience substantial symptoms and high healthcare utilization. We sought to determine the feasibility of delivering a Supportive Oncology Care at Home intervention designed to address the needs of these patients. We prospectively enrolled patients with pancreatic cancer, participating in a parent trial of neoadjuvant FOLFIRINOX, residing within 50 miles of the hospital, and in-state. Patients received the intervention during neoadjuvant treatment (up to 4 months). The intervention entailed: 1) a technology kit for daily remote monitoring of symptoms, vital signs, and weekly weights; 2) the care model including scheduled IV hydration, real-time RN and NP symptom assessment and management that was virtual or in-home; and 3) structured communication with the primary oncology team. The intervention was defined

as feasible if $\geq 60\%$ of patients enrolled and $\geq 60\%$ completed the daily assessments within the first two weeks of enrollment. We tracked all communications. We conducted exit interviews with patients, caregivers, and oncology clinicians to assess the acceptability of the intervention. From 1/2019-9/2020, we enrolled 80.8% (21/26) of eligible patients. One patient became ineligible post consent due to moving out-of-state, resulting in 20 participants (median age = 67 years; 60.0% female). Within the first two weeks 65.0% completed all daily assessments, with participants reporting 96.1% of daily symptoms, 96.1% of daily vital signs, and 92.5% of weekly body weights. Each generated a weekly average of 2.22 phone calls, 2.96 emails, and 0.15 home visits. In exit interviews, $>80\%$ of patients, caregivers, and clinicians found the intervention to be helpful and convenient, and reported high satisfaction with the communication among patients, clinicians, and the hospital in the home team. Patients receiving the intervention had lower rates of treatment delays (55.0% v 75.0%), urgent clinic visits (10.0% v 25.0%), ER visits or hospitalizations (45.0% v 62.5%), and a lower proportion of days spent in urgent clinic, ER, or hospital (2.7% v 7.8%), compared with those not receiving the intervention who were in the same parent trial (n=24). These findings demonstrate the feasibility and acceptability of a Supportive Oncology Care at Home intervention. Future work will investigate the efficacy of this intervention for decreasing healthcare use and improving outcomes for all patients dealing with cancer.

P294 **EMERGENCY DEPARTMENT VISITS AND HOSPITAL ADMISSIONS FOR ADULT CANCER PATIENTS POST OUTPATIENT CHEMOTHERAPY: DOES THE ONCOLOGY NURSE NAVIGATOR MAKE A DIFFERENCE?**

Sunny Stirling, PhD, MBA, RN, OCN[®], CMSRN, RN-BC, Sharp HealthCare, San Diego, CA, and University of San Diego, San Diego, CA; Caroline Etland, PhD, RN, CNS, AOCN[®], ACHPN, University of San Diego, San Diego, CA; Cynthia Connelly, PhD, RN, FAAN, University of San Diego, San Diego, CA; Laurie Ecoff, PhD, RN, NEA-BC, CNL, University of San Diego, San Diego, CA

Research

The purpose of this project was to examine the contribution of the Oncology Nurse Navigator (ONN) in ED visits and hospitalizations for adult cancer patients post outpatient chemotherapy. Aim 1: Describe patient sociodemographic, care site characteristics, the ONN's involvement, ED visits and/or hospital admissions with

any of ten chemotherapy related conditions. Aim 2: 2a: Examine relationships among variables. 2b: Describe the difference in ED visits and hospital admissions between the ONN involved and non-ONN involved groups. Aim 3: Identify factors that explain the amount of variance in ED visits and hospitalizations. Cancer is the second leading cause of death in the U.S., and worldwide. The Centers for Medicare and Medicaid Services introduced the Chemotherapy Measure which tracks Emergency Department visits and hospitalization within 30 days of any outpatient chemotherapy treatment. The ONN has offered some benefit in cancer care, but its role in ED visits and hospital admissions is unknown for adult patients with cancer post outpatient chemotherapy. Descriptive correlational design using retrospective EHR data collected from January 1, 2018 to December 31, 2019. Descriptive and inferential statistical approaches were used to analyze the data. Total 1,370 patient cases with 12,996 visits were examined. Approximately 35% of patients who had outpatient chemotherapy had an ED visit and/or a hospital admission. The most common conditions noted were anemia, dehydration, and pain. Medicare insurance, chemotherapy location, dehydration, diarrhea, emesis, and neutropenia were significantly related number of ED visits. Hospital length of stay, anemia, dehydration, fever, nausea, neutropenia, pain, pneumonia, and sepsis were significantly related to number of hospitalizations. There was no significant difference in number of ED visits and hospitalization between ONN vs. non-ONN groups. The multiple regression model showed Medicare insurance and chemotherapy location significantly contributed to the predictive model for ED visits. Nausea, pain, and pneumonia significantly contributed to the predictive model for number of hospital admissions. The chemotherapy measure metrics, such as ED visits and hospital admissions, were not appropriate clinical outcomes to measure the ONN's efficacy. Navigating cancer treatment is the primary role function of the ONN, rather than daily symptom management and intervention. Additional research is necessary to understand the fiscal and operational outcomes of the ONN, including using a longitudinal design to measure over the cancer continuum.

P295 RISK OF MAJOR ADVERSE CARDIOVASCULAR EVENTS AFTER INITIATION OF ANDROGEN DEPRIVATION THERAPY IS HIGHER FOR OLDER PATIENTS

Julia Vandross, NP-BC, BSN, MSN, Providence Saint John's Health Center, Santa Monica, CA; Stuart

Atkinson, MB ChB, Tolmar Pharmaceuticals, Inc., Buffalo Grove, IL; Deborah Boldt-Houle, PhD, Tolmar Pharmaceuticals, Inc., Buffalo Grove, IL

Research

Recent literature has suggested an association between androgen deprivation therapy (ADT) and increased cardiovascular (CV) risk in prostate cancer (PCa) patients. However, it is not yet known whether CV risk is conferred by ADT itself or other comorbidities, and these data would be valuable for clinicians treating patients with PCa on ADT. Nurses play an important role in the management of CV health. Advanced practice nurses have been shown to achieve results equal to or better than general practitioners for the management of CV risk factors, and a nurse-led intervention for CV risk modification was effective. This study evaluates the relationship between risk of major adverse CV events (MACE) and age in patients with PCa on ADT using real-world data. Analyses of US electronic medical records (2010 to 2020) of PCa patients (n=44,339) receiving LHRH injections (agonists/antagonists) were conducted to evaluate the rate of CV event-free survival since ADT initiation in the following age subgroups: <60, 60 to <70, 70 to <80, and ≥80 years old. The database contained 178,388 LHRH agonist and antagonist injection entries and 965 documented MACE events. Exclusion criteria included a lack of an ADT initiation date and CV event(s) within 6 months prior to ADT initiation. MACE was defined as myocardial infarction, stroke, and death from any cause. 6%, 24%, 39%, and 31% of patients were <60, 60 to <70, 70 to <80, and ≥80 years old, respectively. The likelihood of MACE-free survival fell from 99-100% at one year following ADT initiation, to 93-99% at six years after ADT initiation. Risk of MACE was higher in older patients compared to younger patients in the first seven years after starting ADT. The risk of MACE was higher for older patients in the first seven years after ADT initiation. A potential explanation for this finding is the likely higher prevalence of co-morbidities that contribute to cardiovascular disease in elderly patients, such as diabetes, obesity, and frailty. Nurses and clinicians should be aware that age is a predisposing risk factor for CV disease in patients with PCa undergoing ADT. Future studies evaluating the role of co-morbidities on CV risk for PCa patients during ADT may be helpful to identify other CV predictors.

P296 PERCEPTIONS OF HEAD AND NECK CANCER PATIENTS DURING THE COVID-19 PANDEMIC

Hsiao-Lan Wang, PhD, RN, CMSRN, ACSM EP-C, FAAN, University of South Florida, Tampa, FL; Laura Szalacha,

EdD, University of South Florida, Tampa, FL; Jessamine Cadenas, BA, University of South Florida College of Nursing, Tampa, FL; Barbara Smith, PhD, RN, FACS, FAAN, University of South Florida, Tampa, FL

Research

The coronavirus (COVID-19) pandemic disproportionately affects survivorship outcomes in head and neck cancer (HNC) patients. Perceived threat has been applied to understand vaccination behavior. The purpose of this study was to describe demographic and clinical factors related to the perceived threat of COVID-19 among those undergoing/after HNC treatment. HNC patients who were undergoing or after radiation or chemoradiation were recruited for this cross-sectional study. Participants completed a phone survey that included the Perceived Threat Scale of COVID-19, the Perceived Stress Scale, demographics, COVID-19 screening items, State of Florida COVID-19 screening positive data. Descriptive statistics, Chi Square test, t-test, and multiple regression were performed. Participants (N=30) mean age was 62.5 years (SD=11.1). The most common tumor site was the mouth (37%) and 60% had stage III/IV cancer. The majority underwent chemo-radiation (57%) and had completed treatment (63%). In a multiple regression model, only perceived stress ($\beta=1.20$, $SE=0.478$, $t=2.51$, $p=0.019$) and female sex were significant predictors of perceived threat of COVID-19 ($\beta=6.81$, $SE=2.79$, $t=2.44$, $p=0.022$). Health messages include threat of COVID-19 should be carefully designed. HNC cancer patients, especially females, who perceived more threat from COVID-19, are those who encountered more stressful emotion. Effective and transparent communication from scientific organizations, public health experts, and media outlets on the safety and efficacy of COVID-19 vaccines should be the focus to promote vaccination behavior.

P297 EVIDENCE-BASED PROTOCOLS FOR INTEGRATING HOMEOPATHY INTO BREAST CANCER TREATMENT PLANS: CLINICAL UPDATE

Heidi Weinhold, ND, Canonsburg, PA

Research

The objective of this presentation is to present a clinical update on the available evidence and benefits of integrating homeopathy into breast cancer treatment plans. Nurses are on the front lines of patient care. Data sources include research studies, review articles, and clinical practice guidelines. Oncology nurses need

to be aware of the evidence when recommending homeopathic interventions to their patients. Cosmetic surgeons have been recommending homeopathic Arnica to their patients with excellent results to help decrease bruising and swelling associated with elective procedures. The sesquiterpene lactones (primarily helanalin) are responsible for the plant's anti-inflammatory, anti-ecchymotic, and analgesic properties. Recent evidence suggests that incorporating homeopathy into peri-surgical protocols for both Mastectomy and Breast Reconstruction surgery can decrease seroma formation, decrease drain removal time by 18%, and decrease bruising and pain. Additionally, the patient opioid intake in the Arnica group was lower when compared to the group that did not receive homeopathy (Maisel Lotan et al., 2020). Incorporating homeopathy as an adjunct therapy in patients undergoing mastectomy and breast reconstruction can help speed post-operative recovery time, and reduce delays in treatment. Kupstas and colleagues (2019) found that if women delay the start of chemotherapy for a period longer than 120 days post-surgery, it can reduce the patient's survival rate by 29%. Ninety-five percent of patients experience some degree of radiation burns during treatment. There continues to be insufficient support in research and literature to recommend a wide variety of topical agents including Aloe to manage radiation induced skin reactions. A large randomized clinical trial involving Homeopathic Calendula cream, applied twice daily to irradiated areas, reported lower levels of pain, a reduced prevalence of grade 2 dermatitis, and fewer treatment interruptions. Despite the evidence for use, many medical centers have not yet integrated Calendula Cream as part of their medical protocol for radiation treatment. Nurses are the harbingers of change and research supports integrating homeopathic therapies into conventional clinical settings to optimize patient care. Homeopathic medicine has a low risk of side effects due to the use of micro-doses. Incorporating Homeopathy is a potentially cost-effective, low risk adjunct treatment and may be considered in patients undergoing mastectomy, breast reconstruction and/or radiation.

P298 CANCER SURVIVORSHIP CLINICIANS OPINIONS ABOUT SURVIVOR CARE NEEDS

Meagan Whisenant, PhD, APRN, The University of Texas Health Science Center at Houston Cizik School of Nursing, Houston, TX; Loretta A. Williams, PhD, APRN, AOCN®, OCN®, The University of Texas MD Anderson

Cancer Center, Houston, TX; Guadalupe Palos, DrPH, LMSW, RN, The University of Texas MD Anderson Cancer Center, Houston, TX; Maria Rodriguez, MD, The University of Texas M D Anderson Cancer Center, Houston, TX

Research

Cancer is associated with late effects that can persist for many years. Evidence suggests that systematically monitoring the cancer experience using patient-reported outcome (PRO) measures can improve outcomes. To date, no validated PRO measure addressing the needs and concerns of long term cancer survivors exists. The purpose of this study was to collect feedback from clinicians about the needs and concerns of cancer survivors as an initial step in developing a PRO measure for use in their care. 30 clinicians and physicians completed an investigator-derived, open-ended survey about the major needs and concerns of long term cancer survivors. Content analysis was used to describe themes of survivor care needs. Survivorship clinicians were physicians (10%) and advanced practice providers (90%) practicing in cancer survivorship specific clinics for a mean of 9.1 years (range < 1 to 30 years). Survivorship clinicians provided care for survivors of thoracic (24%), breast (21%), head and neck (17%), genitourinary (10%), sarcoma (7%), lymphoma (7%), and other (14%) cancers. Clinicians identified needs including the management of health maintenance (83%), psychosocial concerns (73%), long-term effects of cancer treatment (67%), financial issues (33%), sexual health (20%), changes in appearance (17%), and surveillance for cancer recurrence (20%). Cancer survivors have unique concerns to consider in the development of a PRO measure for use in their long-term care. Clinician and patient input will be vital to identifying these needs. Further research is required to combine cancer survivors and clinician-identified needs.

P299

FAMILY CAREGIVERS OF THOSE WITH CANCER: QUALITY OF LIFE AND BURDEN OUTCOMES FROM A SEQUENTIAL MULTIPLE ASSIGNMENT RANDOMIZED TRIAL

Gwen Wyatt, RN, PhD, FAPOS, FAAN, Michigan State University, College of Nursing, East Lansing, MI; Alla Sikorskii, PhD, Michigan State University, East Lansing, MI; Rebecca H Lehto, PhD, RN, FAAN, Michigan State University, East Lansing, MI; Pratim Niyogi, Michigan State University Department of Statistics and Probability, East Lansing, MI; Sarah Brewer, MPH, Michigan State University Department of Epidemiology and Biostatistics, East Lansing, MI; Kanjana Thana,

PhD, RN, Michigan State University College of Nursing, East Lansing, MI; Kanjana Thana, PhD, RN, Chiang Mai University Faculty of Nursing, Chiang Mai

Research

Approximately three million friend or family caregivers provide unpaid care for cancer patients at home. Caregiver burden often goes unrecognized by healthcare professionals, and persistent high-level burden over time may put caregivers at risk for long-term health problems and compromised health-related quality of life (HRQOL). The purpose of this project was to conduct a secondary analysis focused on HRQOL among caregivers engaged in a 12-week complementary therapy sequential multiple assignment randomized trial (SMART) of reflexology and/or meditative practices (MP), to manage cancer patients' symptoms. In this SMART, patient-caregiver dyads were initially randomized to caregiver-delivered reflexology for the patient (N=150), MP with the patient (N=150), or control (N=47). After 4 weeks, dyads with patients not improving on fatigue (non-responders, n=69 to reflexology and n=57 to MP) were re-randomized to continue the same therapy or add the other therapy for an additional 4 weeks. Week-12 caregiver HRQOL measured using the Patient Reported Outcomes Measurement Information System (PROMIS) Profile-29 and the Caregiver Reaction Assessment Tool (CRAT) for caregiver burden scores were analyzed using general linear models. In the comparison of 4 adaptive intervention sequences: reflexology for 8 weeks, reflexology for 4 weeks followed by MP for 4 weeks if no response to reflexology, MP for 8 weeks, MP for 4 weeks followed by reflexology for 4 weeks if no response to MP, there were no differences in PROMIS-29 scores. However, CRAT domains of impact on schedule, family support, and finances worsened when adding reflexology after the first 4 weeks of MP. The CRAT domain of health was worsened by adding either intervention compared to continuing the same one. Caregivers who participated in a more passive mind-body therapy such as meditative practices, rather than a body-based therapy like reflexology may be more likely to attrite from the study, yet those who remain in the study, may experience lower caregiver burden in some areas. Cancer caregivers who deliver reflexology may need to consider their schedule closely when agreeing to deliver a body-based therapy that requires time and active participation. For the first time, caregivers of non-responders to an intervention for symptom management have been examined and provided an adaptive option.

P300

DIFFERENCES IN THE SYMPTOM EXPERIENCE OF CANCER SURVIVORS WITH AND WITHOUT CHEMOTHERAPY-INDUCED PERIPHERAL NEUROPATHY

Ling Xu, RN, BSN, University of California, San Francisco, San Francisco, CA; Kord Kober, PhD, University of California, San Francisco, San Francisco, CA; Bruce Cooper, PhD, University of California, San Francisco, San Francisco, CA; Steven Paul, PhD, University of California, San Francisco, San Francisco, CA; Yvette Conley, PhD, FAAN, University of Pittsburgh, Pittsburgh, PA; Jon Levine, MD, PhD, University of California, San Francisco, San Francisco, CA; Christine Miaskowski, RN, PhD, FAAN, University of California, San Francisco, San Francisco, CA

Research

Chemotherapy-induced peripheral neuropathy (CIPN) occurs in 10% to 60% of cancer survivors. However, little is known about the symptom experience (i.e., occurrence, severity, and distress associated with other common symptoms) of cancer survivors with or without CIPN. Study purposes were to evaluate for differences in occurrence rates, as well as severity and distress ratings for 32 common symptoms in a sample of cancer survivors with (n=426) and without (n=196) CIPN. Survivors were recruited from throughout the San Francisco Bay area. All of the survivors completed detailed questionnaires and underwent sensory and balance examinations. Results of the self-report measures, clinical history, and examination findings were used to categorize the survivors as having or not having CIPN. To evaluate their symptom experience, survivors completed the 32 item Memorial Symptom Assessment Scale (MSAS). Survivors indicated the occurrence of each symptom (yes/no). If they experienced the symptom, they rated its severity and distress using 0 to 10 numeric rating scales. Differences between the survivors with and without CIPN in occurrence, severity, and distress ratings were evaluated using parametric and non-parametric tests. A significant difference in total number of MSAS symptoms was found between the survivors with (10.1 ±5.2) and without (7.0 ±4.5, p<.001) CIPN. Compared to the those without CIPN, survivors with CIPN reported higher occurrence rates for: difficulty concentrating, pain, lack of energy, feeling nervous, feeling drowsy, difficulty sleeping, feeling bloated, diarrhea, feeling sad, itching, swelling of arms or legs, and “I don’t look like myself” (all p<.05). For those who experienced the symptoms, survivors with CIPN reported high severity scores for difficulty

concentrating and pain and higher distress scores for difficulty concentrating, difficulty sleeping, feeling irritable, and swelling of arms or legs (all p<.05). Symptom severity and distress scores for the survivors with CIPN were in the moderate range. These findings suggest that survivors with and without CIPN experience a significant symptom burden. However, a significantly higher percentage of survivors with CIPN experience a number of symptoms that are more severe and distressing. Clinicians need to use a comprehensive symptom assessment scale to determine the symptom burden of cancer survivors and initiate and evaluate evidenced-based symptom management interventions.

P301

THE ROLE OF INNER STRENGTH IN QUALITY OF LIFE AMONG COLORECTAL CANCER SURVIVORS WITH STOMA OR NOT

Hannah Yu, BS, RN, Chung-Ang University, Seoul; Gaeyoung Kim, MPH, RN, Chung-Ang University, Seoul; Eunjung Ryu, PhD, Chung-Ang University, Seoul

Research

This study aimed to investigate the adaptation and quality of life, to assess the relationships among inner strength, social group membership and quality of life, to identify influencing factors of quality of life in colorectal cancer survivors who finished cancer treatment. This study is designed as a descriptive survey. Data was collected from June 1st to 30th in 2021. The inclusion criteria is the colorectal cancer survivors who are active in an online community at least 3 months passed after cancer treatment. Total 170 colorectal cancer survivors were participated in this study and the survey was done by online. Among 170 participants of this study, non-stoma group was 139 (81.8%) and stoma group was 31 (18.2%). The quality of life of non-stoma group was 17.44 (±5.01) and stoma group was 15.29 (±5.67). There was a significant difference between non-stoma and stoma group in ‘Connectedness’ (p=.046) and quality of life (p=.036). The results showed that inner strength was positively correlated with the social group membership and the quality of life in colorectal cancer survivors. In the hierarchical regression analysis, the strongest affecting factor of quality of life was the inner strength, adjusted for age and sex. The quality of life was higher when the age is younger, women than men, and higher of the inner strength. The model accounted for 31.5 % of the variance in quality of life. The findings of the present study suggest that the inner strength can improve quality of life in colorectal cancer survivors

with stoma. Furthermore, the key roles of connectedness in improving inner strength and caring for stoma group have been reported. Further study is required to be deeply understand the experience of colorectal survivors' adaptation and transition to their life after cancer treatment and develop arbitration plan for improving the colorectal cancer survivors' quality of life

P302 **COUPLES' EXPERIENCE OF UNCERTAINTY IN FACING GYNECOLOGICAL CANCER**

Yingzi Zhang, PhD, RN, University of Rochester, Rochester, NY; Sally Norton, PhD, RN, FNAP, FPCN, FAAN, University of Rochester, Rochester, NY; Marie Flannery, PhD, RN, AOCN®, University of Rochester School of Nursing, Rochester, NY; Rachel Carter, MS, University of Rochester, Rochester, NY; Charles Kamen, PhD, MPH, University of Rochester, Rochester, NY

Research

Uncertainty is common and distressing for patients and their partners, which causes clinically significant levels of depression and anxiety. Research about couples' experience of uncertainty when experiencing gynecological cancers is limited. This knowledge is essential for developing an intervention to alleviate negative influences of uncertainty, such as diminished quality of life and poor adjustment. This study was to characterize needs and preferences for managing uncertainty among patients with gynecological cancer and their partners. We used a focused qualitative descriptive design and recruited three couples facing gynecological cancer. Key inclusion criteria: ≥ 21 years old, self-identify as being in a romantic relationship, patient's diagnosis of gynecological cancer ≤ 3 months, and has a life expectancy of > 6 months. Zoom joint

and individual semi-structured interviews with each couple for a total of 9 interviews were conducted. The couples were asked to narrate their experience of uncertainty since the cancer diagnosis. Interviews were audio-recorded, de-identified, transcribed verbatim, verified, and double coded. Data were analyzed using a content analysis approach guided by Han's taxonomy of uncertainty in ATLAS.ti (version 9.0). The issues of uncertainty, including scientific, practical and psychosocial uncertainty, were often interrelated. The most commonly reported issues of uncertainty were psychosocial uncertainty which related to the influence of cancer on people's personal life. Individuals expressed different personal judgement of sources of uncertainty, with ambiguity (i.e. lack of evidence to estimate the risk) in patients and probability (i.e. the likelihood of a future event) in partners as the most commonly reported. Needs included requiring additional information, such as communicating with children about cancer, emotional and practical support, reassurance from others, and stress reduction. Their preferences for managing uncertainty were diverse and categorized into the emotional-oriented coping, action-oriented coping, positive appraisal, and coping as a couple. The findings provide insight into the breadth of uncertainty experience in couples experiencing gynecological cancer. There is a need for strategies to target irreducible uncertainty derived from probability and ambiguity to relieve associated distress and facilitate the adjustment. This study is the first one that demonstrated the richness of people's uncertainty experience in gynecological cancer, which will widen the scope of the couple intervention to target irreducible uncertainty as well as reducible uncertainty.