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table of CONTENTS

1. Plenary Session Abstracts  
   PAGE 5
2. Oral Abstracts  
   PAGE 15
3. Poster Abstracts  
   PAGE 105
plenary session

ABSTRACTS
THE GLOBALIZATION OF CANCER
Otis W. Brawley, MD, USA

Cancer is a growing problem world-wide. For several decades, more humans have been dying annually from cancer than from HIV/AIDS, Tuberculosis and Malaria combined. This year cancer will become the leading cause of death, world-wide. Much of this increase in the number of cancer deaths is due to improvements in treatment of other diseases, leading to an increase in the number of persons over age 65 years. Cancer is a disease of the elderly and today more humans are alive over the age of 65 years than have lived to that age in the history of the world.

It is estimated that, in 2005, there were 11 million new cases of cancer diagnosed, 7 million cancer deaths and 25 million people living with cancer, worldwide. It is estimated that there will be 27 million diagnosed, 17 million cancer deaths and 75 million people living with cancer in 2030. In 2005, Lung cancer comprised 12.5% of diagnosed cancers, breast cancer was 10.5%, colorectal cancer 9.4%, gastric cancer 9.4%, prostate cancer 6.1%, liver cancer 5.9% and cervix 4.6%.

Geographic variation in cancer incidence is related to differences in: 1) tobacco consumption; 2) the prevalence of infectious agents [hepatitis B & C, human papillomaviruses, Helicobacter pylori]; 3) socioeconomic and lifestyle differences; and, d). diet and nutrition. The major preventable cause of cancer in the world is tobacco consumption and the second greatest threat is the increase in the number of persons who are overweight and obese. Cancer reduction strategies include: tobacco control, healthy lifestyle including attention to diet and exercise, and when appropriate certain vaccinations and proven early detection tests. Attention to pain control and quality of life of the cancer patient is a pressing issue worldwide. Partnerships between physicians and nurses in cancer care are fundamental to executing strategies to reduce cancer incidence, morbidity and mortality.

MOVING EVIDENCE INTO PRACTICE
Lesley Degner, Canada

This presentation will describe an innovative organizational intervention, the Nursing Knowledge Translation Centre, designed to facilitate the uptake of knowledge in practice. Estimates suggest that 30–45% of patients are not receiving care according to the best available scientific evidence and that 20–25% of the care provided is not needed or potentially harmful. Practitioners tend to be reluctant to change their tried and true ways of responding to new information and to make changes quickly. This may be because in response to the varied and complex demands of clinical care, practitioners use adaptable patterns of thinking that are much more intricate, elaborate and flexible than any codified knowledge such as research findings or guidelines can ever be. These patterns of thinking, termed mindlines by Gabbay and le May, are also more complex than heuristics or rules of thumb, because they include a wide range of contingent psychosocial, managerial, financial, professional, ethical and other ramifications that can affect clinical decisions. Built up over a professional lifetime, and collectively reinforced between respected colleagues, mindlines can often be resistant to change even when convincing evidence indicates current interventions are actually harmful to patients.

The Nursing Knowledge Translation Centre has been designed to help nurses re-examine their mindlines, and to adjust these in response to newly emerging evidence. The managerial and architectural features of the Centre will also be addressed in this presentation.


MOVING EVIDENCE INTO PRACTICE
Kinta Beaver, UK

This session will use an example from the investigators research field to describe the complexities of evaluating and implementing a nurse-led intervention in clinical practice. The Promoting Action on Research Implementation in Health Services (PARIHS) framework was developed to reflect the complex layers in changing practice (Rycroft-Malone 2004) and this model will be used to underpin the practical example presented. The PARIHS framework postulates that successful implementation of evidence is a function of the dynamic relationship among evidence, context and facilitation (Kitson et al. 1998, McCormack et al. 2002). Evidence within the framework includes research, but also incorporates clinical experience and patient preferences (e.g. previous experience). Context refers to the proposed setting in which a change is to be carried out. Facilitation relates to the fact that providing research findings, on its own, is unlikely to engender changes to practice and there are other factors that can have a facilitating or inhibiting influence. This presentation will chart the history of work on developing a nurse-led telephone follow-up intervention for women with breast cancer. The development work and the eventual evaluation of the telephone approach will be described in relation to the organizational factors that influenced the entire research process. Despite growing evidence that routine hospital follow-up appointments for women treated for breast cancer have little value for either health professionals or patients, this historical practice has persisted. Hence, evidence alone is not sufficient to ensure that new strategies for follow-up are adopted and implemented. Evidence of a positive impact on patient outcomes has to be balanced against economic and organisational factors that present potential barriers to implementation.

One of the most significant psychological factors affecting people in the face of terminal illness is the compromising of their perceived personal dignity. Therefore, nurses caring for oncology patients with advanced disease ought to be concerned with the issue of patient dignity and how best to support it in the provision of end of life care. Drawing on programmatic research examining the issue of dignity in the terminally ill, this plenary address will examine the construct of dignity as understood from the perspective of terminally ill patients, identify the factors that both bolster and erode patient dignity, and discuss a range of patient-centered therapeutic interventions that should be included as part of the patient’s overall plan of comfort care.

It was 1963 Catholic little sisters quietly began hospice care in Korea.

The concept of hospice was introduced in 1969 by the national workshop on the death & dying and started the first hospice home care service in 1987 at Yonsei University college of Nursing. In 2002, government driven hospice palliative project began to develop Korean model, standard education and the hospice law legislation, national health insurance coverage are in progress. Advanced practice nurse the hospice-palliative specialty program started in 2003 and 176 nurses completed there master degree in 2008.

Several issues and challenges are addressed including ethical issues of the withholding futile treatment.

An example of a program on spirituality research for the knowledge based practice which is the must for the holistic care at the end of the life care.

The use of complementary and alternative therapies (CAM) by Americans is well established. CAM is a group of diverse medical and health care systems practices and products that are not generally considered part of conventional medicine. Complementary medicine is used with conventional medicine and alternative medicine is used in place of conventional medicine. Approximately 38% of adults are using some form of CAM. CAM use is greater among women, and those with higher levels of education and incomes. Among the most common CAM therapies used by Americans are natural products, deep breathing, meditation, chiropractic and osteopathic therapy, massage and yoga. The top three natural products used are fish oil, glucosamine and Echinacea. The diseases/conditions for which CAM is most frequently used among adults include back pain, neck pain and joint pain (NCCAM, 2008).
practice and philosophies in the workplace toward the role of family during active treatment can serve as antecedents to how families are perceived, and how families might view themselves as they transition into survivorship phases.

**MEASURABLE BEHAVIORAL LEARNING OBJECTIVES:**

1. To understand survivorship within the context of long-term partnerships between the health care system or professionals, the cancer survivor, and the family caregiver survivor.
2. To apply partnership principles in cancer survivorship.
3. To identify current service orientations or approaches in active cancer treatment that defy notions of partnerships in survivorship care - Individualism versus Holism; Sickness versus Wellness, Fragmentation versus Continuity, Paternalism versus Autonomy
4. To be aware of evidence that support the role of ‘family as partner’ in cancer survivorship

**Key concepts for knowledge translation:**
- Survivorship, partnership, wellness care, family
- Conceptual model for moving research into practice
- A model(s) that incorporate(s) nurse, cancer survivor, and family as partners in promoting wellness in cancer survivorship

**ADDRESSING THE NEEDS OF CANCER SURVIVORS**

*Professor Jessica Corner, England*

The good news that people are living longer following a cancer diagnosis brings with it consequences. There are growing numbers of people who live for many years following primary cancer treatment, yet little information exits as to the health and well-being of individuals with cancer over the long term. The England Department of Health published a new strategy for cancer in 2007 which recognised the importance of addressing the needs of cancer survivors and launched a National Cancer Survivorship Initiative. A Vision for the Initiative has just been published which sets out the objective of achieving 5 shifts in care and support for people living with and beyond cancer whereby greater focus on recovery, health and well-being after cancer treatment is achieved. The presentation will describe the background to this ground breaking policy initiative for cancer care in England and some of the actions being taken to develop new models of care and support for cancer survivors currently underway as part of the National Cancer Survivorship Initiative.

**SCREENING, PREVENTION AND GENETICS**

**STARTING A CANCER SCREENING FOCUSED RESEARCH PROGRAM WITH AN UNDERSERVED POPULATION**

*Frances Lee-Lin PhD, RN, OCN, CNS, USA*

Despite the widespread availability of cancer screening, disparities in cancer screening rates persist among Asian Americans. Breast cancer is the most commonly diagnosed cancer among Asian American women in the United States (US). Asian American women still have higher incidence and death rates for cervical cancer than US Caucasian women despite an overall decline in cervical cancer deaths in the US. Colorectal cancer screening rates among Asian Americans in the US are lower than the Caucasian population. This presentation describes how a cancer screening focused research program was launched for Asian Americans, especially for Chinese Americans, the largest Asian populations in the US.

First study examined the perceptions and beliefs about breast and cervical cancer, mammography, and Pap smear practices among Chinese American women. Three questionnaires were combined, modified, translated, and pretested for the study. A study sample of 100 Chinese American Women, ages 40 and older, was recruited from Portland, Oregon. Only 48.5% of the participants reported a mammogram within the last year and 68% of respondents reported that their last Pap was within the past 3 years.

The ongoing second study is aiming to improve mammography screening among Chinese American women through a targeted educational program and individualized counseling. In the first phase, focus groups data were gathered to explore participant’s awareness and beliefs about breast cancer risk and screening for breast cancer. We also explored how information was shared within the community and the targeted educational program was revised based on participant’s feedback. Another ongoing study focuses on improving colorectal screening among Chinese, Korean, and Vietnamese Americans using a specific culture-based educational intervention within a community center environment. The preliminary data indicated great fecal occult blood test (FOBT) return rates in the community environment even before the educational intervention.

**GENETIC COUNSELLING TEAM: PRACTICING NURSE IN EARLY DETECTION IN THE FAMILIES WITH RETINOBLASTOMA**

*Leila Leontina Couto, Brazil*

Retinoblastoma is the most common neoplasm of the eye in children. It represents about 3% of all childhood malignancies. The Brazilian Oncology Pediatric Section (INCA/MS) provides genetic counseling to patients with retinoblastoma. The nurse from the genetic counseling team makes the first contact with the families. She explains the risk of retinoblastoma in families, the illness and others cancer risk factors. The nurse forward to a genetic counselor and participate the follow-up of the families. It represents about 3% of all childhood malignancies. The Brazilian Oncology Pediatric Section (INCA/MS) provides genetic counseling to patients with retinoblastoma. The nurse from the genetic counseling team makes the first contact with the families. She explains the risk of retinoblastoma in families, the illness and others cancer risk factors. The nurse forward to a genetic counselor and participate the follow-up of the families. It assists 140 children with retinoblastoma since 2002. All the probands and their families were submitted to genetic counseling, following an algorithm that included molecular testing of RB1 gene and ophthalmological examination of all first degree relatives.

Hereditary cases of retinoblastoma were identified through the finding of a germinal mutation in RB1 gene in peripheral lymphocytes. The combination of genetic counseling time, molecular biology and the ophthalmologic investigation provided a good follow-up and security advices for the probandos and their families.
NATIONAL TUMOR BANK: A MODEL BASED ON IMOGENE KING’S NURSING THEORY OF GOAL ATTAINMENT.
Flávia Vieira Guerra Alves,
Leila Leontina Couto, Brazil

Introduction
The Brazilian National Tumor and DNA bank (NTB) is a public non-profit bank at the Brazilian NCI (INCA). NTB has started its activities on May 2006, with the objective of setting up collections for cancer research of the more relevant tumors affecting the Brazilian population. Assistant and research nurses in charge of applying the epidemiological questionnaire were trained by epidemiologists to assure the quality of data collected. Patients that consented for tissue banking collections are asked by the nurse to answer the online NTB epidemiological questionnaire. INCA’s epidemiologists regularly evaluate data and entry consistence. This tool was tested and validated to inquiry about the most cancer relevant variables for cancer risk assessment.

Objective
The object of this study was to evaluate the competences and contributions of BNT nurses using the Imogene King’s theory of Goal Attainment and Interacting Systems as referential theory.

Methodology
The research was bibliographic and exploratory. Twenty three articles were analyzed according Imogene King’s theory of Goal Attainment and Interacting Systems.

Conclusion
Essentially, the interviewer must have the ability to communicate and to give conditions to the participant to build their own knowledge about the entire process of consent, collection and use of tissue samples. According to this conceptual model of interpersonal system, we found that the nurse is the professional that more directly and intimately interacts with participants, facilitating definitions, transmitting information, answering questions simulating the dialogue, contributing to the emotional balance, and minimizing the stress. Nurses have the ability to incentivize the patient’s autonomy for the decision of accepting or not to be a donor. Nurses today have an obligation to provide to the public information about the management of disease.

TUMOR BANK NURSES: A NEW FIELD TO EXPLORE IN ONCOLOGY NURSING
Leila Leontina Couto, Brazil; Maria Tensão dos Santos Guedes

The Brazilian National Tumor and DNA bank (BNT) is a public non-profit bank at the Brazilian NCI (INCA). BNT has started its activities on May 2006, with the objective of setting up collections for cancer research of the more relevant tumors affecting the Brazilian population. Assistant and research nurses in charge of applying the epidemiological questionnaire were trained by epidemiologists to assure the quality of data collected. Patients that consented for tissue banking collections are asked by the nurse to answer the online NTB epidemiological questionnaire. INCA’s nurses and epidemiologists regularly evaluate data and entry consistence. This tool was tested and validated to inquiry about the most cancer relevant variables for cancer risk assessment.

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MODELS OF CARE DELIVERY AND ORGANIZATIONAL CHANGE
Ahmad Al-Khtieb, RN, PhD,
Mohammed Abu-Humaid RN, UK

Patient with Cancer most often have complex care needs in all professional disciplines, are having an impact on the delivery of cancer care and oncology nurses have a major role to play in the delivery of comprehensive cancer care.

The role of nursing staff within a total care delivery model (primary care Model) at King Hussein Cancer center for patient was supported by the organization itself and determined by a variety of factors such as economic issues, Leadership beliefs, and the ability to recruit and retain staff. Ideally, evidence of the effect of care model on quality and patient safety would also be a major factor in decision making and help on the changes impact in the organization.

A nursing model pertains solely to the practice domain of nursing, whereas a Model of care describes the delivery of health care within the boarder context of the health system. The model of care to be considered should be evidence based, and/or grounded in theoretical propositions, based upon assessment of patient and health provider needs, corporate evaluation of health related and intervention outcomes, and be considered of the safety and wellbeing of patient and nurses.

To make the organizational change work, you need to have everyone in the system on an equal basis and eliminate the distortions related to the coverage crisis that undermine effective reform. Organizational changes can affect both access to care and quality of care. When employers make an investment in work place training it will lead to competency development, and recognizing personal and organizational change. The changes which occurred at the KHCC during its formation and leading up to its Joint Commission International (JCI) accreditation can be understood within the conceptual frame of the transformational leadership model. Changes in the institution were achieved through increased motivation and positive attitudes toward the use of a primary care delivery model as a tool for continuous improvement processes for patient quality of care.

MODELS OF CARE DELIVERY AND ORGANIZATIONAL CHANGE
Greta Cummings, RN, PhD, Canada

Models of care are important complex structures that broadly describe how health services are delivered to a population of patients. Model components include the healthcare team comprised of several disciplines, role expectations and competencies of individual healthcare professionals, healthcare delivery structures (clinics, beds, schedules, etc), communication systems among providers...
and patients, standards of care for the specific patient population, and the use of knowledge and evidence to achieve best practices and identified outcomes.

Models of care are continually evolving based on changing patient needs, professional scopes of practice, technology, new knowledge, and at times, ideologies and fads. However, some current models can also lag behind in meeting patient needs as a result of traditionalism, inertia in the face of change, power struggles, conflicting ideologies and political pressure. Drivers for changing models of care include fiscal imperatives, a renewed emphasis on patient focused care, and new knowledge. Hence, efforts to change models of care are often met with mixed results.

This session reviews the challenges and opportunities encountered when trying to change models of care. This includes the role and practices of leadership in managing organization change and how the challenges can be managed directly in order to increase the chances of success.

ROBERT TIFFANY LECTURESHP

ONCOSEXOLOGY: THE GROWING PAINS OF A NEW SUB-SPECIALITY IN CANCER REHABILITATION?  
Dr. Isabel D. White, London.

The relative importance of quality of life issues in oncology continue to increase along with improved survival rates. There are estimated to be more than 10 million cancer survivors in the United States today (US National Cancer Institute, 2007). This figure compares with recent British estimates of 2 million cancer survivors and the prediction that this number will increase at a rate of 3.2% per annum (Maddams, Moller & Devane, 2008). However, the success of multi-modality cancer treatment often comes at a price in relation to the number of people who experience late effects years after their treatment is completed (Rowland et al, 2006).

The sexual consequences of cancer represent a complex interplay of the physical, psychological and relationship impacts of illness and treatment on sexuality and sexual expression. Sexual well-being has been identified as a core element of quality of life for people affected by cancer, particularly those receiving treatment for malignancies of the breast or pelvic organs. Sexual difficulties are one of the more common consequences of treatment for pelvic malignancies, affecting between 50–80% after radiotherapy for cervical cancer (Flay & Matthews, 1995, Vistad, Fossa & Dahl, 2006) up to 70% of men after prostate cancer treatment (Incrocci, 2006, 2007) and 15–100% of patients diagnosed with colorectal cancer (Monga, 2002). However, despite these research estimates we still lack robust data on the prevalence and natural history of the full range of sexual difficulties associated with cancer treatment. Furthermore, although considerable progress has been made in the pharmacological management of treatment-induced erectile dysfunction, we still lack satisfactory evidence for the management of desire and ejaculatory disorders in men and research into female sexual difficulties continues to lag behind male research by decades (Miles et al, 2007).

Sexual dysfunction in people affected by cancer can be transient or permanent and may be a consequence of biological, psychological and interpersonal factors, or a combination thereof.

Anatomical changes (vaginal stenosis, rectal excision), physiological changes (hormone manipulation) and the consequences of surgery such as radical prostatectomy may prevent normal sexual functioning even when sexual desire remains intact. Side effects of treatment such as nausea, vomiting, fatigue, diarrhoea or hair loss can result in adverse effects on sexuality together with disturbances of body image. Negative emotional states such as anxiety or depression that commonly accompany a cancer diagnosis may also disrupt sexual expression.

Hence this lecture addresses two key themes: the first outlines the treatment consequences for many living with and beyond cancer and considers how cancer nurses can contribute to helping people reach their recovery and rehabilitation potential.

The second theme explores the assessment and care of individuals and couples whose sexual lives have been adversely affected by cancer treatment. Following a brief overview of the range of sexual difficulties that can arise from cancer treatment, this paper will emphasise the urgent need to improve the routine assessment of sexual difficulties in clinical practice. Challenges faced by clinicians in addressing treatment-related sexual difficulties within the limitations of acute oncology services will be outlined and the paper will conclude by proposing an integrated model of sexual rehabilitation after cancer therapy.

This lecture hopes to inspire nurses to consider patients’ lives beyond the end of treatment. This is something the majority of cancer nurses working in acute oncology may have limited experience of in day to day practice. Nurses and colleagues from the wider treatment team need to be equally committed to caring for problems created by cancer or its treatment as they are to promoting long-term survival.

There is still much progress to be made if we are to contribute meaningfully to the process of rebuilding the psychological, social and thus sexual dimensions of people’s lives as effectively as we currently address the physical aspects of their recovery or rehabilitation after cancer.

FACTORS INFLUENCING CANCER LEGISLATION (PANEL DISCUSSION)

ISSUES IMPACTING CANCER LEGISLATION (PANEL DISCUSSION)

Winnie Kw So, Hongkong

Cancer is the major cause of death worldwide and in the local community. Due to the aging population and changes in lifestyle of the citizen, it is expected that the incidence of cancer will continue to increase. In fact, according to the World Health Organization, about 30% of cancer death can be prevented. Fight against cancer is relied on the support from the government, together with collaborations with the policymakers, the healthcare professionals and the public. This presentation will provide an overview of the cancer population at the local community. It will then examine the process of legislation and the cancer legislative items recently discussed in the legislative council. The movement of the implementations of cancer legislation in the local community will be explored. Lastly, the presentation will discuss barriers to pass legislation and strategies of implementing legislation from the perspectives of a citizen as well as a healthcare professional.
WORKFORCE/WORKFORCE ISSUES AND STRATEGIES FOR SUCCESS

Dean Clarke, Canada

The presentation abstract

In this presentation key aspects of the nurse workforces in the United States and Canada will be reviewed, as well as the major challenges facing these two countries, both in general and in terms of specialist and advanced practice clinicians, including demographic trends, technological change, economic crises and workforce shortages destined to worsen in the coming years. Policy implications and strategies will also be discussed.

WORKFORCE/WORKPLACE ISSUES IN ONCOLOGY NURSING AND STRATEGIES FOR SUCCESS: PHILIPPINE PERSPECTIVE

Dr. Eden Esmas-Cacanindin, RN, Ed.D., Philippines

This presentation on workforce/workplace issues in Oncology Nursing in the Philippines was based on literature review and findings in a small scale study. The data during this study was collected during the 17th Anniversary Celebration of the Philippine Oncologic Nurses’ Association last January 29, 2010. There were 100 participants during this national convention. However, not all of them were oncology nurses or practitioners. Fifty questionnaires were distributed randomly to all oncology nurses with 62 percent return.

Findings in this study show the following: 1) That there is a shortage in the number of experienced nurses working in the oncology units. Most of the respondents belong to the 21-24 age group. Their years of experience as a professional nurse ranges from less than one to 2 years. This is due to the increasing number of "seasoned" nurses who look for employment abroad—seeking for greener pasture. 2) The most common skill mix found in the oncology units include the physicians, nurses, unit managers (who happen to be nurses), nursing aide and spiritual leader. Social worker, counselor and support group are found in the tertiary hospitals in the metropolis. The nurse assumes other roles like counselor, teacher, spiritual advocate, nursing aide at times, and ward clerk. The nurses identified the top three issues in the workplace: 1) Salary, 2) Availability of training, and 3) administrative issues such as hazard pay, staffing. Other identified issues are that of safety.

Salary has been a perennial issue among the health care workers in the Philippines. This is one of the reasons why most of the nurses look for employment abroad. Although the Philippine government has improved the salary scale of nurses especially in the government hospitals, the salary is still not at par with that of the salary abroad. Individual institution, however, compensates for the meager income by giving health benefits like free medicine, free hospitalization, additional leave and the like.

To address the issue on training, Nursing Education takes an active role. The bachelor of Nursing Curriculum is competency based—so that the various competencies that are needed in caring for those who are in their end stage of life are spelled out. The new graduate nurse is equipped with beginning knowledge, skill and attitude care for a client with terminal illness. Furthermore, to compensate for limited training programs offered in some the hospitals, most of the respondents claimed that nurses are given sponsorship to post graduate programs and allowed to attend continuing education programs offered outside their work setting.

As to the staffing issues, strategies are done in order to analyze the work load of nurses. Research studies are conducted, specifically the time and motion studies to determine the value added and the non-value added activities of the nurse. Proportion of the professional and the non-professional skill mix are based on this research studies. The Department of Health, through the initiative of the Association of Nursing Service Administrators of the Philippines, recently came up with a standard nurse-patient ratio and professional and non-professional staffing mix based on several factors. An oncology center needs to be financially viable to cater to the needs of its clientele. In the area of marketing, the common marketing strategies utilized by health institutions to improve the financial viability of the oncology centers are media advertisement, personal contacts and creation of image for the cancer care programs.

To attract oncology nurses to stay, respondents say that administrators in the center value their employees by giving awards, like outstanding oncology nurse award, a tap on the shoulder affirming a "good work done" and by showing flexibility in their schedule.

Conclusion

Like any other countries in the world, the Philippines is beset with issues and concerns in the workplace and workforce. There is a great deal of awareness by the health sectors and those in the nursing academe regarding these issues, although not much is written, however, actions are being taken by individual health agencies, nursing education, nursing organization, especially the Philippine Oncology Nurses’ Association, The Philippine Cancer Society and the Department of Health in order to address these Concerns.

GLOBAL PERSPECTIVES IN EDUCATION (PANEL DISCUSSION)

GLOBAL PERSPECTIVES ON EDUCATION

UNITED STATES

Brenda Nevijon, MSN, RN, FAAN, USA

In the United States, oncology nurses comprise only a portion of nurses who interact and provide care to people diagnosed with cancer. Thus, the formal and continuing educational needs of nurses are complex. The following framework will be used to explain educational needs and resources: pre-licensure students, generalist nurses who care for people with cancer, nurses who specialize in cancer care, advanced practice nurses who are generalists, and oncology advanced practice nurses. This education includes teaching patients and families about cancer and its treatments. The presentation will also address how the public’s access to detailed health information has influenced patient teaching. Resources that patients and families can use will be described.
GLOBAL PERSPECTIVES ON EDUCATION
Petra Fordelmann, South Africa

The paper will reflect the current Perspectives on Cancer Nursing Education in Africa.

It aims to summarize the current situation regarding Oncology Nurse Education in Africa, focusing on the challenges faced throughout Africa in successfully introducing formal courses including the language barriers, the lack of understanding of cancer, the lack of trained Oncology and Palliative care staff, the lack of cancer care facilities and ultimately the lack of financial resources.

It will also describe the cancer care resources available in Africa, the progress made in communication and cancer care amongst the Oncology Professionals in Africa.

The focus should be on a complete restructuring of training of all aspects of nursing, and specifically Cancer Nursing in Africa, specifically focusing on the governing bodies for nursing throughout Africa.

The objective of this paper is to encourage appreciation for the situation in Africa and to stimulate thought amongst nurses globally, taking into consideration the specific constraints that exist in our continent.

GLOBAL PERSPECTIVES ON EDUCATION

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DEVELOPMENT OF EDUCATION PROGRAM FOR PEOPLE WITH BREAST CANCER IN JAPAN
Hiroko Komatsu, RN, PhD, Japan

Background and Purpose
Given the rapid aging of the population in Japan, the prevalence of cancer as well as cancer mortality will continue to rise in coming years. As the mortality from cancer increases to 2020, cancer will come to account for half of all mortality in Japan. This trend is drawing public attention. Reforming cancer treatment strategies has become an issue of national priority in the health care field. Public expectation and demand for improved cancer treatment policy have reached a peak. The issue of “cancer refugees” has drawn public attention. Japanese cancer patients do not always have clear guidance and support when they seek cancer treatment options that suit them. There is a disparity in the quality of medical treatment depending on the region and institution; this is especially true for cancer. Finally, a “cancer control act,” legislation which aims to promote measures to prevent and treat cancer was enacted in 2006. This cancer control act contains landmark provisions that ensure participation of community members in the “cancer control council”: the council develops policy and fundamental plans for cancer control initiatives. This can be viewed as a paradigm shift. Building a partnership between community members and healthcare professionals is regarded as essential in solving cancer-associated health problems. Under the collaboration between St. Luke’s College of Nursing and the St. Luke’s International Hospital, we conducted on the development of psychoeducational programs for women with breast cancer, and evaluating their effectiveness. We have also developed and applied into practice a peer-support educational program for women diagnosed with breast cancer for the purpose of encouraging women completing the program to assume their role as peer supporters and build a partnership with health care professionals, enabling peers to offer experiential empathy and wisdom. In this symposium, I report on the process of the development of these educational programs that we have worked on to date, as well as on their results.

Methods
We developed an outpatient self-modification program by combining a support group for reducing depression and anxiety, and cognitive behavioral therapy to improve quality of life (QOL) to continue treatment in outpatients with breast cancer. We examined the effectiveness of the self-modification program in a quasi-experimental study design. Following a series of discussions with core members of the support group, we proposed a new peer-support educational program, which was later re-organized into an e-learning-based educational module.

Results
The effectiveness of the outpatient self-modification program was examined in terms of the QOL of patients with breast cancer. The results showed that there were significant differences in scores on the physical functioning (PF) and mental health (MH) subscales between the intervention and control groups. I mentioned that women with breast cancer who undergo post-operative adjuvant chemotherapy, having video-based rehearsals to prepare themselves for outpatient chemotherapy, and keeping journals on measures against adverse effects, were promoted their effective coping with such therapy reactions and help them maintain their mental health. At the same time, sharing their distress among breast cancer patients and exchanging useful information while receiving outpatient care also contributed to the promotion of QOL. Our peer-support educational program focused on gaining proper knowledge on breast cancer, understanding roles as volunteer workers, and promoting effective communication with cancer patients, among other aims. Women with breast cancer who completed this educational program have since been actively involved in the implementation of the peer-support program known as “smile community” at the St. Luke’s...
International Hospital, with high satisfaction among breast cancer patients.

**Conclusion**
Peer-support educational programs are an effective educational approach to enable patients with breast cancer to share their experiential empathy and wisdom with cancer patients.

**GLOBAL PERSPECTIVE ON EDUCATION**
**THE ISRAELI EXPERIENCE**
Sarah Ben Ami R.N; M.A, Israel

Education is a comprehensive issue that includes national, regional and international aspects. Oncology nurses in Israel are required to be a R.N with academic education and certified in the post basic course in oncology nursing (700 hours)

Advanced oncology nurses continue formal (master degree) and non formal education through in service programs and professionals organizations.

The Israeli Oncology Nursing Society (IONS) was founded in 1986. Our mission is to promote the oncology nurse’s knowledge regarding the patient’s Bio Psycho Social needs along the disease trajectory. 500 oncology nurses are active members of the society. The IONS is involved in the development of all the levels of cancer nursing education from nursing school to advanced practice.

IONS educational activities consist of: a national conference based on member’s presentations of clinical, educational and research activities.

Workshops, seminars and courses based on nurses needs as well as selected topics that have been highlighted in our strategic plan as: aspects in hematology and BMT, Breast Cancer, bone health, Gyneco oncology and urinary malignancies.

Special interest groups have developed in order to answer the needs of small groups of specialized nurses like: radiation therapy, breast care, hematology and others. The groups meet several times a year, and share their specific knowledge among other nurses by organizing seminars around the country.

The society journal: "Seud Oncology" is published 3 times a year in Hebrew; it offers a forum for publishing research, clinical guidelines and the society news.

The society web site (www.ions.org.il) is also a useful educational tool for cancer patients, nurses in general and oncology nurses.

**Cooperation and collaboration**
IONS works in close relationship with national and international organizations, like: the Israeli Cancer Association, the Ministry of Health and other nursing organizations.

International projects have been initiated with the ISNCC, ONS, MECC and others.

In the regional arena the society works closely with MECC (Middle East Cancer Consortium) which represent 5 countries in the Middle East. One of the foremost projects was hosting the ONS leadership institute in the Dead Sea in Israel. 44 oncology nurses from the Middle East countries participated. This meeting enabled the participants to meet and exchange knowledge on professional and personal levels.

For the future, there are many educational challenges to promote the excellence of professional oncology nursing in Israel like multinational research projects on clinical and multicultural topics, as well as advanced academic education.
oral ABSTRACTS

DISCLAIMER

The abstracts included in this Program & Abstract Book have been presented as they were submitted by the authors. The 16th ICCN Scientific Planning Committee has not altered the submissions for inclusion. Author's credentials have been included where submitted.
O-01 COGNITIVE DYSFUNCTION: WHAT IS IT AND WHAT CAN ONCOLOGY NURSES DO ABOUT IT?
Rachel E. Behrendt, DNP, APN-C, AOCNS.
Robert Wood Johnson University Hospital, New Brunswick, NJ, USA.

Cognitive dysfunction in patients who are receiving or have received treatment for cancer is increasingly recognized as a problem. Cognitive dysfunction has been defined as, The inability to understand experiences or related current events to past events; the inability to adequately process information because of impairment of a variety of functions such as memory, mood, concentration, attention, word association, and comprehension (Cohen & Armstrong, 2004). These symptoms are distressing to patients and their families; have significant impact on quality of life, employment, interpersonal relationships, and adherence to treatment regimens or follow up care.

Current research indicates that use of growth factors to prevent dose-limiting bone marrow suppression has enabled use of more dose-dense and dose-intense regimens with the aim of cure or disease stabilization. While this advancement in care has led to increasing survivorship it has also translated into increasing numbers of patients who are disabled by the treatment effects. Cognitive dysfunction is one such disability. In studies, up to 85% of cancer patients experienced some level of dysfunction with between 20–25% experiencing lifelong impairment (Von Ah, 2009; Jenkins, 2005, van Dam, 1998).

Cognitive dysfunction has been studied across many cancers and appears to be related to several interconnected mechanisms of action independent of the cancer type. Cognitively, the areas most affected are executive functions and memory. As distressing as these symptoms are for patients, many care providers are unaware of the level of impairment patients experience or the long-term nature of the dysfunction and few assess for or educate patients about these symptoms. With an increasing emphasis on survivorship effectively educating, assessing, and treating patients for the symptoms they may experience requires a sound understanding of the research, pathophysiology, and evidence-based interventions. This presentation will give practitioners the tools to perform pre-treatment cognitive assessments, interventions that are easily incorporated into patient evaluations and adaptive tips that can be taught to patients.

O-02 ENHANCING KNOWLEDGE FOR SURVIVORSHIP: LATE EFFECTS OF RADIOThERAPY TO THE PELVIS
Pauline M. Rose, RN MN.
Princess Alexandra Hospital, Brisbane, Australia.

Radiotherapy is a local, primary treatment for many solid tumours, and an adjuvant or neoadjuvant treatment for others. The two major types of radiotherapy delivery are external beam radiotherapy and brachytherapy. Side effects of the radiotherapy may be both acute, that is: in the first few days to weeks following commencement of treatment, and late effects. Late effects can occur from weeks to years after completion of the radiation treatment and are related to the type of cell or tissue involved. Late gastrointestinal toxicity is not entirely related to the dose of radiotherapy delivered, and depends on a complex interaction of physical, patient related, treatment, and genetic factors. Concurrent chemoradiation may also influence late toxicity. Many clinical staff, including nurses in the acute radiotherapy and other practice settings, may have limited experience in managing patients with chronic effects of pelvic radiotherapy. Incontinence is a particular problem that may impact on quality of life for these patients over many years. This paper will review the common types of tissue late effects in the pelvis which may lead to incontinence or other symptoms as a result of radiotherapy in this area.

O-03 THE DEVELOPMENT OF A HEALTH AND LIFESTYLE COACHING PROGRAMME FOLLOWING RADICAL BREAST, GYNAECOLOGICAL AND PROSTATE CANCER TREATMENT
Sarah S. Rudwaleit, BSc (Hons) Nursing Science1, Karen Roberts, PhD2.
1North of England Cancer Network, Team Valley Gateshead, United Kingdom. 2Queen Elizabeth Hospital, Gateshead Hospitals NHS Foundation Trust, Gateshead, United Kingdom.

This pilot will focus on the ways in which people cope following a cancer diagnosis and will develop and evaluate a programme to support self-management following cancer treatment.

Aims
1. To understand more fully survivorship needs of people following a cancer diagnosis, and in particular, it’s relationship to gender, age, health status and a social model of illness.
2. To develop a supportive care programme for people to help them adapt and cope with life after treatment – using a coaching / cognitive behavioural therapy approach.
3. To evaluate the pilot implementation of this programme on the adaptation and well-being of cancer survivors.
4. To assess the acceptability of early discharge from secondary care cancer follow-up from users perspective and replacement with a self-care management model.

Objectives
To determine whether a health and lifestyle coaching programme can:
1. Reduce anxiety in the post-treatment phase
2. By focusing on health not illness, motivate people to change and improve their health in the future e.g. stop smoking, lose weight etc.
3. Help patients become ‘people’ again, and facilitate this transition from cancer patient to whom they were prior to their illness
The programme based on a Cognitive Behaviour Therapy model will be held within a community non health setting and last for 8 weeks.
10 people who have completed radical cancer treatment for breast, gynaecological or prostate cancer within the last three to six months will be recruited by a key worker (clinical nurse specialist or oncologist).

Evaluation Methodology
Evaluation will be carried out as determined by the NCRI, and this will include:
A baseline assessment against current service provision.
A robust cost analysis / benefit of the tested approach to care. Professional and user views on the tested approach will be carried out.
It will be implemented and evaluated using outcome measures such as the CORE (Clinical Outcomes in Routine Evaluation) System (CORE 2007), and EORTC QLQ-C30 (Aaronson et al 2001).
The concept of self – care will empower individuals who attend the coaching programme to have more control over their adaptation and survivorship. The motivational nature of coaching will capitalize on the health education opportunity presented by illness. It will improve the skills of cancer survivors in navigating access to information, and signpost them to appropriate health and social care support. The programme will enhance patient’s experience of cancer survivorship and prepare them for the future.

O-04 THE AMERICAN Lymphedema Framework Project (ALFP) National Stakeholders Open Space Meeting: Planning and Results
Jane M. Armer, PhD, RN1, Janice Cormier, MD, MPH2, Joseph Feldman, MD3, Robin P. Shook, MS4, Bob R. Stewart, EdD5.
1University of Missouri, Columbia, MO, USA, 2 MD Anderson Cancer Center, Houston, TX, USA, 3 Northwestern University, Evanston, IL, USA.

Introduction
The ALFP is a national initiative introduced in 2008 to improve the management of lymphedema (LE) and related disorders in the US. A National Stakeholders Conference was held in March 2009 to share perspectives on the current state of LE, establish priority issues, and recommend actions to move the field forward.

Methods
The concept of an Open Space meeting was introduced at a Steering Committee meeting in October 2008. Committee members subsequently submitted names of individuals and organizations to be invited. Conference goals were established and grant support was solicited. Invitations to 275 potential constituents were sent prior to the meeting.
Results
Seventy–one LE stakeholders participated in the day–long conference, consisting of: patients/advocates (15%), therapists (26%), physicians (9%), industry representatives (17%), researchers (16%), nurses (4%), and educators (3%). Initially facilitators guided participants to create multi–disciplinary working groups to identify issue in LE management. Then topic–based groups brainstormed about solutions, needs, and action plans to address the issues. Summary sheets were collected over the course of the day. Transcribed summary sheets of the proceedings were distributed electronically to participants 24 hours after the meeting.

The participants identified major issues to improve the management of lymphedema in the United States, then proposed solutions, needs, and action plans. The seven major issues were: document evidence based practice for lymphedema management; establish research efforts to refine diagnostic standards and provide evidence for effective treatments; establish criteria for health provider education; create awareness about LE and related lymphatic system disorders; provide information for patient education, support, and self–management; improve reimbursement for LE treatment; and establish credibility for the American Lymphedema Framework Project.

Conclusions:
Open Space meetings are an effective format to solicit input from multiple constituencies. The results and outcomes of the ALFP National Stakeholders Conference will enable the ALFP to achieve its mission to improve LE management in the US and also make a global contribution.

O-05 ADDRESSING INTIMACY & SEXUALITY - ON THE DEVELOPMENT OF A COMMUNICATION SKILLS PROGRAMME*
Lynne Dodson. UHBFT, Birmingham, United Kingdom.

Background
Approximately 35–50% of cancer survivors suffer a sexual dysfunction as a consequence of their treatment. Unfortunately, professionals rarely initiate discussions about sexuality and sexual rehabilitation is not provided in most oncology settings. Feedback from the Advanced Communication Skills Training Programme identified that participants continued to feel unskilled and lacking in confidence when addressing intimacy and sexuality issues. In response to this feedback, a new workshop has been developed to address gaps in knowledge base and to improve specific communication skills and confidence in dealing with the sensitive topic of intimacy and sexuality. This 1 day workshop is aimed at senior health professionals working in cancer care. It contains both didactic and experiential learning components and was developed based on the expertise of a Clinical Psychologist, Sex therapist and Lead Cancer Nurse and Trained Advanced Communication Skills Facilitator.

The content covered:
• Why Sexuality is an important topic
• How Sexual Functioning can be affected
• Case Study
• What is our role?
• When to bring topic up
• Sexual Communication Skills
• Practice Session

Teaching Aims
• To achieve a basic understanding of sexual dysfunction after cancer
• To consolidate knowledge and understanding of the principles of effective communication with patients and colleagues using evidence–based practice appropriate to an inter–professional and multi–cultural healthcare system
• To understand how core advanced communication skills can be adapted to address the topics of intimacy and sexuality
• To increase confidence and begin to develop a way of addressing sexual issues specific to the individual practitioner’s setting
• To be able to give patient’s permission to raise sexual issues
• To be able begin to provide limited information about sexual issues related to individual specialism

Teaching methods
Lectures/didactic sessions
Role play exercises
Guided reading

Results
Workshop participants report increased awareness of the issue of sexuality after cancer, increased confidence when addressing the topic, an improvement in sexual communication skills and confidence that the workshop will impact positively on their practice. Follow–up data will also be reported.

Conclusions
Introducing the topic of sexuality and intimacy as a separate but mandatory follow–on workshop to the standard Advanced Communication Skills Programme is recommended. Recommendations are also made for the development of future workshops aimed at those wishing to move beyond level 1 training in sexuality and intimacy.

O-06 WHAT HAPPENED: SEXUALITY AFTER CANCER
Anne Katz, RN PhD.
CancerCare Manitoba, Winnipeg, MB, Canada.

Up to 80% of cancer survivors experience alterations in sexual functioning as a result of the cancer and/or its treatments. This oral presentation will discuss how sexuality is affected by different kinds of cancer.

CONCURRENT SESSION A2
“QUALITY CARE AND CANCER IN THE ELDERLY”
(PEACHTREE BALLROOM D)
CHAIR: BAKARY SARR

O-07 AN EVIDENCE BASED STUDY ON THE MINIMUM VOLUME OF BLOOD WASTAGE FROM ARTERIAL LINES.
Wanda Rodriguez, RN, MA, CCRN, CPAN, Doreen McCarty, BSN, RN, CPAN, Stephanie Nolan, MS, RN, CPAN, Joyce Kane, MSN, RN, CCRN, Mary O’Sullivan, BSN, RN, CPAN, Denise Stone, BSN, RN, CPAN, Memorial Sloan-Kettering Cancer Center, New York, NY, USA.

Laboratory testing continues to be a preventable source of blood loss in critically ill oncology patients. Factors contributing to nosocomial blood loss include frequent testing, lack of standards, leading to inconsistent practices, and frequent use of arterial catheters. The Critical Care Evidence Based Practice Committee wanted to standardize the minimum blood volume wasted from arterial lines prior to specimen collection. We sought strategies to minimize waste volume from arterial lines. Fifty articles from evidence–based databases were reviewed to determine if current practices or standards exist regarding the minimum volume of blood wasted from arterial lines during specimen collection. There were a limited number of meta–analysis, randomized experimental design, quasi–experimental and non–experimental studies related to blood– conserving mechanisms. Expert opinions, outside institutional practices, and observation of current practice at our institution were also evaluated. The Stetler Model was used to rank the evidence. Literature recommends using a blood conserving device or equating the discard volume to double the dead space of the arterial line from the catheter tip to the sampling port. Given the compromised immunity of patients in an oncology center, it was determined that a closed system was not optimal for our institution. Based on the research, 3ml was calculated to be double the dead space of the arterial catheters in use at our institution, thus a dedicated 3ml waste tube was our solution to achieve standardization. These findings were presented to our multidisciplinary partners in the ICU, PACU and Clinical Laboratories. Consensus was achieved and approval was given to implement a dedicated 3ml waste tube in critical care areas.

Implementation of this practice change has provided standardization and decreased our current discard volume from 9ml to 3ml. In addition to minimizing the waste volume, there are numerous safety advantages of the dedicated waste. It is plastic as opposed to glass and it is distinct from our current inventory of laboratory tubes to avoid being mistakenly analyzed by the laboratory as a diagnostic test. The waste tube is significantly more cost effective than the test tube formerly used for wasting blood. The use of a dedicated 3ml waste tube has allowed us to maintain accurate test results while minimizing blood loss to the critically ill patient.
O-08 HEARING THE PATIENT VOICE IN HEALTH CARE REFORM: A LEADERSHIP IMPERATIVE FOR NURSES
Margaret I. Fitch.
Odette Cancer Centre, Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

Funding has been made available for five years to implement the Canadian Strategy on Cancer Control, through the auspices of the Canadian Partnership Against Cancer. One of the eight action groups charged with specific mandates is the Cancer Journey Action Group. Its mandate is to provide leadership to change the focus of the cancer system so that patient, survivor and family member needs are better served.

Intentional efforts have been made to incorporate the patient/survivor perspective (voice) in our planning processes for a national cancer control strategy. Use has been made of qualitative and quantitative methods to gather data and patient representatives have been actively involved in panels, committees, and task teams. Throughout the work there has been a commitment to find out what patients think constitutes a person-centered approach and not rely solely on viewpoints of health care professionals.

To truly achieve the goal to have a person-centered cancer system, the authentic patient voice must be incorporated throughout the process to influence decision-making about priorities, actions and innovative ways need to be implemented and evaluated to ensure patient input and involvement in cancer control planning. This work presents an excellent opportunity to identify what patients think is important in their care and thus make relevant improvements in care delivery processes.

O-09 THE ABC’S OF WEB-BASED SURVEY METHODS
Rebecca B. Donohue, MSN, FNP-BC, AOCN, APNG.
Acadiana Medical Oncology, Lafayette, LA, USA.

Survey research methods have traditionally been in the modes of mail, telephone or the face-to-face interview. Recent global technological advances have exploded the possibilities for research with the use of email and web-based modes of survey administration. It is commonly understood that forms and surveys used to collect data are only as good as their prior evidence for reliability and validity. Internet surveys are relatively new and questionnaires previously shown to have adequate reliability in a paper and pencil or telephone mode may not be reliable when the questionnaire is converted to the web format. Thus, a thorough well-planned process is essential for converting traditional validated mailed surveys to valid web-based surveys.

Creation of a web-based survey by conversion of a previously validated mail survey generates unique problems with survey error from coverage, sampling, measurement, and non-response. Diligence with a step-by-step process in the web-survey development following principles set forth by Dillman (2007) will help to reduce these errors. After creation of the web-based survey a pilot test is needed to assist with determination of feasibility, to assess for the clarity of the questions/answers, participant burden, and the conversion of the responses into the statistical program to be used for analysis. Pilot testing also provides for validating the equivalency of the paper and web-based surveys. This comparison is needed to ensure that the results obtained with the web-based survey are legitimate.

Implementation and evaluation of the survey after the creation and pilot testing of the converted web-based survey is both efficient and economical. The number of contact points necessary to achieve high response rates with web surveys is fewer than those required for mailed surveys, and the data converted to a format conducive to analysis simplifies the running of statistical tests. Important opportunities exist with the ability to use technology to gather data and increase nursing knowledge for the improvement of outcomes for oncology patients. This presentation will outline the steps for creating, piloting, implementing and evaluating information for web-based survey research.

O-10 ADVANCING NURSING EXPERTISE IN THE CARE ELDERLY PATIENTS WITH CANCER: A PILOT STUDY OF THE APPLICATION OF DELIBERATE PRACTICE THEORY TO NURSING EDUCATION
Lorraine K. McEvoy, DNP, MSN, RN, OCN, Gay Bailey MBA, RN, OCN, Melanie Carmow, BSN, RN, OCN, Mary Elizabeth Davis, MSN, RN, AOCN, Linda Frierson, BSN, RN, OCN, Melinda Gooch, BS, RN, Jean Ricci, MA, RN, OCN, Jody Roth, MSN, RN, OCN.
Memorial Sloan Kettering Cancer Center, New York, NY, USA.

The fastest growing segment of the US population is individuals over the age of 65. This age group will account for approximately 20% of Americans by the year 2030. Aging is associated with increased rates of cancer, corresponding to an 11-fold greater incidence in persons over the age of 65 years versus those under age 65. According to the American Cancer Society (2006) by the year 2050, the number of cancer patients over age 85 is expected to increase fourfold. Related to the growing and aging population, there is a need to understand the treatment and care needs of elders.

This pilot study examined a method for advancing nursing expertise and analyzed the effectiveness of the approach. The project utilized multiple theoretical perspectives related to nursing practice and learning to formulate a conceptual framework in which the superior performance of a nursing expert would be achieved through Deliberate Practice.

The project assessed a conceptual framework based on Deliberate Practice in the training and development of registered professional nurses. The approach provided a three day educational offering to oncology nurses at Memorial Sloan–Kettering Cancer Center, who had no prior training in the geriatric oncology specialty. Data was collected and analyzed to assess the level to which outcomes of advancing expertise were demonstrated. Nurses participating in the program completed a pre-test and post-test to determine knowledge and practice both before and after the educational intervention. Data was collected to examine nurses’ assessment of elders for vulnerability and to grade the level to which outcomes of advancing expertise were demonstrated in nursing documentation.

The results of this pilot study support earlier work related to the application of Deliberate Practice and indicate that the methodology could have effectiveness beyond the specific application of advancing expertise.

O-11 OLDER AFRICAN AMERICAN BREAST CANCER SURVIVORS AND FUNCTIONAL STATUS
Costella H. Talley, Ph.D.,
Michigan State University, Holt, MI, USA.

Purpose
The purpose of this presentation is to examine the body of literature related to older female African American breast cancer survivors.

Background: Increasing age is a risk factor for the development of breast cancer. Breast cancer is the second leading cause of cancer death among African American women. African American breast cancer survivors that are older may be at greater risk for decline in functional status. Functional status is a strong predictor of mortality, health care cost and quality of life. Quality of life issues for this group of cancer survivors include maintenance of functional status, which may be negatively affected by the sequelae of cancer and its treatment.

Methods
Using the search words functional status, quality of life, elderly/older, female, breast cancer, cancer, African American, survivors, Pub Med and CINAHL were searched. Twenty-six articles were screened and ten were included within the sample.

Findings
The literature search yielded few evidence based articles that addressed the needs of this population. While many sources addressed functional status in women after cancer diagnosis and treatment, few offered pertinent information to inform the nurse caring for the older African American woman. Research fails to indicate significant numbers of African American women over the age of sixty-five in the larger more heterogeneous age or symptom group and fewer address issues related to functional status. Most studies focused on screening behaviors and epidemiology factors.

Conclusions
There is a paucity of research addressing the functional status of older female African American breast cancer survivors. Research is necessary.
on the meaning of functional status to older African American women and on the similarities and differences that may exist between socioeconomic, racial, or other groups of older women. Evidence based interventions are needed in order to ensure appropriate care. The conduct, analysis and dissemination of knowledge from research on the topic of functional status and older women provide the evidence for meaningful care to this growing subgroup of society.

O-12 SCREENING FOR CANCER IN THE ELDERLY: INDIVIDUALIZED DECISION MAKING
Dennis Graham, RN, NP, DNSc - Memorial Sloan Kettering Cancer Center. New York, NY, USA.

The literature and guidelines offer conflicting information regarding how and when cancer screening should be best applied in the elderly population. This conflicting information can be demonstrated by the different age groupings recommended by different guideline groups and organizations for cancer screening. Cancer screening decisions require accepting both the quantitative and qualitative factors when helping patients obtain cancer screening. The risk of cancer death and the benefits and possible adverse events related to this screening process is first based on quantitative data such as life expectancy, mortality associated with the cancer being screened and outcomes based on published data. The benefits of screening for the elderly are further complicated by the fact when life expectancy is less than 5 years there is unlikely to be any survival benefit for screening. There also exists the potential harm of detecting cancers that would never have become clinically significant. Walters & Covinsky support the use of the Framework for Individualized Decision Making to guide clinicians and elderly patients to make cancer screening decisions. This framework of individualized decision making recognizes the quantitative data of benefit vs risk and the patient's own values and preferences in making informed screening decisions. This presentation will review the limitations of screening tools for cancer in elderly patients and present the research results regarding the screening interval for major cancers, patients older that 75 years and use of individual decision making framework in helping the elderly obtain optimal cancer screening.

O-13 CANCER SURVIVORSHIP IN THE ELDERLY: ISSUES OF COMPLEXITY AND METHODOLOGY
Lanell M. Bellury, RN, MN.
University of Utah, Salt Lake City, UT, USA.

Cancer is predominantly a disease associated with aging. More than 60% of cancer diagnoses occur in those greater than 65 years of age. With improvements in early cancer detection, novel and expanding treatment options and the growing elderly population, the number of cancer survivors is burgeoning, estimated at nearly 12 million people, with over 6 million survivors in the 65 and older age group. Research has demonstrated the majority of cancer survivors enjoy a quality of life comparable to general population norms, however an estimated 20% of survivors often sustain treatment--or disease--related health problems that persist for years. The potential long term and late effects of cancer include ongoing symptoms, cognitive and functional decline, secondary malignancy, and cancer recurrence. Adding any of these cancer sequelae to the normal declines associated with aging compounds the problems and potential disability inherent in elderly cancer survivorship. The few research studies which have focused on older cancer survivors generally indicated that functional needs persist for years post diagnosis, that long term survivors have more comorbidities, poorer health, poorer quality of life, and poorer functional status than the non--cancer population. In the elderly a cancer diagnosis doubles the chance of poor health. Despite the impact of cancer for this aging population, issues of survivorship have not been carefully examined and need further exploration. Investigating individual component parts of survivorship or gerontology is unlikely to enhance understanding of the whole paradigm of elderly cancer survivorship. The challenge is to find an approach that will allow an integration of the disciplines of gerontology and oncology relevant to the elderly survivor population. Advancing computer technology has given rise to new opportunities to synthesize and understand complicated information in a holistic way. Essentially, holism in this context is the difference between looking at elderly survivorship metaphorically with a wide angle lens as opposed to a microscope. Both vantage points yield important information, but research efforts to date have not offered a wide angle, holistic view. This project will investigate the challenging paradigm presented by elderly cancer survivorship and suggest novel approaches to knowledge development including complexity science and information visualization.

O-14 SATISFACTION WITH THE INFORMATION ABOUT THE DISEASE AND HEALTH OUTCOMES IN CANCER PATIENTS
José C. A. Martins, RN, MS, PhD. Nursing School of Coimbra, Coimbra, Portugal.

Introduction
Every patient has the right to be informed about his health situation (WHO 1994). But the information should also be seen as a real benefit, as stated by several authors, who mention the beneficial effects when we give clear information to the patients (Brown et al. 1999; Sanchez et al., 2001; Sainio & Lauri 2002; Martins, 2003; Martins, 2004), influencing positively the prevention, treatment and disease recovery, change of behaviours, making the participation on the decision easier, the continuity of the cares and maximizing the health results. The aim of the study is to evaluate, for the Portuguese cancer patients, the possible relationship between the patient satisfaction with the information and same health outcomes.

Material and methods
We applied the Patient Satisfaction with the Information Questionnaire, the Hospital Anxiety and Depression Scale, the Euro Qol EQ-5D, the Rotterdam Symptom Checklist and the EORTC Patient Satisfaction Questionnaire to 254 hospitalized patients, after surgery, in a public Portuguese Oncology Centre, through a consecutive sample. The gathering of the data was preceded by the respective authorization request to the host institution which included the approval by the local Ethical Committe.

Results and discussion
The cancer patients present low levels of satisfaction with the information about the disease. This dissatisfaction is negatively reflected in some outcomes, and it is associated with a higher incidence and intensity of anxiety (p<0.001) and depression (p<0.001), a worse perception of the health situation (p<0.001), a lower satisfaction with the health care received during hospitalization and the health care in general (p<0.05) and with a higher physical (p<0.01) and psychological (p<0.001) morbidity.

Conclusion
The study reinforces the evidence that the information is important for the patient, not only because it is a right but also by the several associated benefits.

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Martins, José (2004) – Os enfermeiros e os direitos dos doentes à informação e ao consentimento: percepções, atitudes e opiniões. Revista Referência, 12, 15–26
Childhood cancer requires families to deal with many stressors, including decision-making in terms of their child’s treatment. Adding to the stress of families is that most children participate in clinical research trials. Minimal research has been done to explore parents’ decisions related to involving their child in childhood cancer clinical trials. Especially missing is a description of Canadian parents’ perspectives. Thus, an interpretive descriptive qualitative study was conducted to arrive at a detailed, in-depth understanding of Canadian parents’ participation in decisions about childhood cancer clinical trials.

Using a purposeful sampling technique participants were recruited from an outpatient pediatric cancer unit at the primary cancer treatment centre in a Western Canadian city. In total 31 parents from 30 families participated in the study. Only two of the parents had decided not to have their child take part in a clinical trial. Twenty of the parents were mothers and 11 were fathers. The parents ranged in age from 27 to 51 years. The majority of parents (n=27) were Caucasian and four were Aboriginal. All parents took part in person-centred, individual, open-ended interviews for a total of 31 interviews.

Data analyzed by the constant comparative method revealed that parents found their participation in decisions about childhood cancer clinical trials as a difficult and extraordinary experience that included six themes: (1) Living a surreal event; (2) Wanting the best for my child; (3) Helping future families of children with cancer; (4) Coming to terms with my decision; (5) Making decisions among many and (6) Experiencing a sense of trust. The six themes emerging from this study speak to the suffering that parents of children with cancer experience in relation to making decisions about participation in clinical trials. Parents in this study showed that their suffering was complicated by not only having to make decisions, but later having to come to terms with those decisions. However, their suffering was made more bearable because of the meaningful relationships that parents had with their child, other families of children with cancer, and health care team members adding support to the view that the childhood cancer experience is a relational process shaped by evolving intrapersonal, interpersonal, and transpersonal relationships and communication. This study reinforced that parents need more support in making decisions as well as living with their decisions related to their child’s participation in clinical trials. Nurses and other health care team members must strive to understand parents’ perceptions, expectations, and preferences regarding patient participation in clinical trials and how these influence the process of decision-making.

The ethical issues encountered in delivering home-based palliative care services to advanced cancer patients are reported to be stressful for health care providers. Contributing to this stress may be the divergent ethical perspectives nurses and physicians bring to bear when ethical issues arise. Differing perceptions of ethical problems, and the deployment of disparate frameworks for ethical reasoning provide fertile ground for conflict. Given that nurse-physician collaboration is critical in the delivery of palliative care, with an aim to identifying similarities and differences in ethical reasoning. Content analysis of transcribed semi-structured interviews suggests that physicians tend to view ethical situations from a biomedical framework and characterize ethical situations in terms of a dilemma. In contrast, nurses tend to adopt care-based theoretical approaches to situations, and cast experiences of the ethical as engendering moral distress. This work has implications regarding approaches to ethics education, interdisciplinary communication, and job satisfaction for health care providers.

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O-16 ETHICAL ISSUES IN THE PROVISION OF HOME-BASED PALLIATIVE CARE FOR ADVANCED CANCER PATIENTS: DO NURSES AND PHYSICIANS SEE THINGS DIFFERENTLY? O/B

Susan E. Mc Clement1,2.
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The ethical issues encountered in delivering home-based palliative care services to advanced cancer patients are reported to be stressful for health care providers. Contributing to this stress may be the divergent ethical perspectives nurses and physicians bring to bear when ethical issues arise. Differing perceptions of ethical problems, and the deployment of disparate frameworks for ethical reasoning provide fertile ground for conflict. Given that nurse-physician collaboration is critical in the delivery of quality palliative care, such conflict is troublesome. A lack of training in ethics, and uncertainty about how to handle ethical issues that arise has been identified as a major problem by community health workers. However, the nature of the problems encountered, and the ways in which nurses and physicians approach them not been well examined. The purpose of this qualitative pilot study was to identify the ethical issues nurses’ (N=6) and physicians’ (N=6) state arise in the provision of home-based palliative care, with an aim to identifying similarities and differences in ethical reasoning. Content analysis of transcribed semi-structured interviews suggests that physicians tend to view ethical situations from a biomedical framework and characterize ethical situations in terms of a dilemma. In contrast, nurses tend to adopt care-based theoretical approaches to situations, and cast experiences of the ethical as engendering moral distress. This work has implications regarding approaches to ethics education, interdisciplinary communication, and job satisfaction for health care providers.

O-17 DOES KNOWLEDGE OF BREAST CANCER PREDICT RISK TOLERANCE IN TREATMENT DECISIONS?

Gwen McChang, RN, MN, BA, Deirdre McCaughey, PhD, MBA, BMR(PT).
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Background Medical decision making research has shown that an individual’s risk tolerance in decision making has a significant relationship with the individual’s decision reference point. In other words, having previous experience or knowledge in a particular decision area tends to evoke greater tolerance for riskier decisions. This is relevant in breast cancer decision making as individuals are required to make cancer treatment decisions across a spectrum of choices with variable risk outcomes. Often it is assumed that greater knowledge equates to greater ability to make efficacious decisions. This study examined the relationship between breast cancer knowledge (knowing someone who has been diagnosed with breast cancer) and degree of tolerance for riskier breast health care decisions (e.g. breast exam versus preventative mastectomy).

Method: The data examined in this paper derived from a larger study conducted in a major Canadian city. 428 women (over the age of 18) responded to questions on the issues of health risks and health practices regarding breast cancer.

Results It was found that knowing someone with breast cancer was not a significant predictor of whether a person would pursue low-risk breast health practices (e.g. breast exam) versus high risk breast health practices (e.g. preventative mastectomy). In contrast to much of the medical decision making literature, in this sample, greater knowledge in a specific decision area is not significantly related to decision risk tolerance. Therefore, greater knowledge does not appear to equate to greater ability to make efficacious cancer treatment decisions.

Implications: Although this was a small study and further research is required, the results of this study highlight the importance of individualized breast cancer counseling and offer intriguing considerations for nurse researchers and clinicians in promoting evidence based treatment choices for individuals with breast cancer.

O-18 PERCEPTIONS AND ATTITUDES IN PATIENT PRIVACY AMONG CANCER PATIENTS IN TAIWAN

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Background Privacy is a basic human right. During hospitalization, however, patient privacy is often compromised, especially for those who need assistance with personal daily care, such as cancer patients.

Purpose The purpose of this study was to describe perceptions and attitudes in patient privacy among Taiwanese cancer patients.

Method: This is descriptive study with a convenience sample of 155 patients. There were 75 male and 80 female, aged 20 to 83 (M = 49, SD = 11.1) from a medical center in southern Taiwan participated. One-fifth of the participants were staying in a single room. A questionnaire was used to measure agreement with the patients’ privacy during their hospitalization, with responses from 1 (never) to 5 (always) for perceptions and 1 (strongly disagree) to 5 (strongly agree) for attitude.

Result The results showed that on average patients perceived that their privacy is often compromised, especially for those who need assistance with personal daily care, such as cancer patients.
health care professionals to patients during ward rounds (M = 2.15, SD = 1.42), and that “privacy” signs were only sometimes used when they were examined by health care professionals (M = 2.66, SD = 1.67). Participants agreed that their privacy should be protected (M = 4.01, SD = 0.39), but they did not agree that their visitors should be screened by nurses (M = 2.53, SD = 1.15). Conclusion: In general, cancer patients perceive that their privacy is often protected in Taiwan. Health care professionals should take better care to respect cancer patients’ privacy during contacting with patients as well as more concern patients’ perceptions. The patients’ perceptions and attitude toward maintaining privacy in the hospital must be taken seriously, and hospitals should strive to provide nursing that meets the patients’ needs.

O-19 USING TECHNOLOGY TO ASSESS QUALITY OF LIFE IN PEOPLE WITH CANCER
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Over the past 20 years, the technology explosion has changed the way cancer nurses report, collect and/or access patient information, such as quality of life outcomes. Over 600 instruments to collect quality of life data are currently available; most self-administered or administered by an interviewer. Obstacles, such as severity of illness and low literacy levels impede collection of quality of life data. Clinicians experience difficulty administering, scoring and interpreting instruments in the clinical setting. Lack of resources, lack of understanding regarding the concept of quality of life and missing data are examples of problems encountered by researchers. New technologies, such as personal digital assistants, computers and the Internet, make it possible to address some of the obstacles associated with traditional approaches for assessing quality of life. This paper provides an introduction to recent technological advances in quality of life data collection, as well as practical guidance for using technology to collect this information in a clinical or research setting. Several platforms for collecting QOL data are currently available and can be categorized as (1) telephone-based; (2) computer-based; or, (3) web/Internet-based. Telephone-based technology uses computer applications to gather quality of life data through landlines or cellular phones. Computer-based technology refers to computerized applications to collect QOL data installed on stand-alone computer devices so that the person of interest can evaluate and directly input their own QOL information. Web/Internet-based technology collects QOL information directly from the person of interest through a web-based program accessed on an Internet-ready computerized device. A wide variety of formatting options, such as choice of language, formatting options for the delivery of questions, and data management services are available depending on the specific technology. Choosing an appropriate technology for use in research and/or clinical practice primarily depends on the purpose for collecting quality of life data. In addition, people with cancer and their families frequently turn to the web as a source of information or even support. Because many of these sites are not monitored by health care professionals, the lay person will need assistance discerning reputable from disreputable information. As stakeholders in the health care delivery system and patient advocates, cancer nurses must be intimately involved in the evaluation and use of new technologies that impact quality of life and/or the delivery of care.

O-21 NUTRITION ADVICE DROP-IN CENTRE FOR NURSES IN ONE CANCER CENTRE
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This abstract outlines a pilot study undertaken from July – December 2009. The nursing staff of this cancer centre are involved in Patient Education. A high proportion of the patients undergoing anti-cancer treatments are poor and illiterate. Vulnerable patients receive diet supplements to help them combat the treatment side-effects and at risk patients are seen by the nutritionist. However, it was identified that the majority of nurses had very little knowledge about Diet and Nutrition and did not themselves follow the guidelines. It was decided to develop a Nutrition Advice Drop-In Centre and attempt to raise the nurses awareness of this important topic with the aim of bringing better quality of patient information to the patients and their families.

O-22 PROMOTING QUALITY OF FOLLOW-UP CARE FOR ENDOMETRIAL CANCER SURVIVORS.
Lynne J. A. Jolicoeur, MScN, CON(C); 1Sophie Lebel, PhD, C. Psych1, Monique Lefebvre, PhD, C. Psych1, Debra Balkner, RN, PhD3, Michael Fung Kee Fung, MD, BS, FRCSC2. 
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When well patient follow-up is provided by oncologists, the demand for follow-up care in tertiary care settings far exceeds capacity. Thus, it may be that the professional skills of other health care providers such as general practitioners, gynaecologists and advanced practice nurses are under utilized. In efforts to meet the demands for follow-up, a transition of care process was implemented for women with endometrial cancer. In this process,
women who had completed their treatment were transferred back to their primary care provider (PCP) in the community. To support this process, the Cancer Care Ontario Guideline for follow-up care in endometrial cancer was summarized in two documents utilized as transition tools (PCP, patient).

A mixed method evaluation of this transition process with patients and PCPs was conducted. Sixteen women with endometrial cancer took part in telephone interviews. They also completed and mailed the Fear of Cancer Recurrence Inventory (FCRI). A focus group was conducted with PCPs to obtain their perception of the transition process. Data was analysed using Nvivo8.

Women with higher fear of cancer recurrence and higher informational needs had lower satisfaction with transition of follow-up care to their PCP. Primary Care Providers reported that traditional method of communication with cancer centres was ineffective; they favour the use survivorship care plans. Results from this study will be presented as well as implication to practice (psycho educational workshops, survivorship care planning and shared care model of care).

O-23 PATIENT AND HEALTH PROVIDER STORIES OF TOBACCO USE AND PROHIBITING SMOKING ON HOSPITAL PROPERTY

Annette S. H. Schultz, PhD, RN 1, Margaret Kvern, MN, RN 2, Candace I. J. Nykyforuk, PhD 3, Barry Finegan, MD 4, Jula Oosterveen, MA 5.

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Tobacco use and exposure to tobacco smoke increase the incidence of cancer and negatively influence health trajectories of patients with cancer. Over the last thirty years, implemented tobacco reduction strategies have created dramatic changes in hospitals; such as, people are unable to purchase cigarettes and where one is permitted to smoke is diminishing. In deed, protection strategies have been central to reducing tobacco use in hospitals. Unfortunately, more comprehensive tobacco reduction strategies have not kept pace, even though the 2003 World Health Organization’s “Framework Convention for Tobacco Control” suggests such changes. The dearth of research that explores the culture of tobacco use in hospitals limits our ability to build on the strength of established protection strategies and influence tobacco reduction norms. The purpose of this presentation is to discuss patient and health provider experiences related to tobacco use in hospitals where smoking is prohibited on the property.

An ethnographic study explored the culture of tobacco use and tobacco use management at two large Western Canadian tertiary hospitals with implemented policies prohibiting smoking on hospital grounds. At each site, four adult in-patient units participated in the study. Synthesis of patient and health provider experiences draw on findings from 82 interviews with patients (44% smokers; 37% former-smokers) and 16 focus groups with health providers (n=81; 16% smokers; 17% former smokers; 67% registered nurses). Three key themes relevant to the experiences and perspectives of patients and providers were derived: (1) smoke-free grounds policy, (2) tobacco use and users, and (3) the role of families in managing tobacco use. Issues of compliance and enforcement, education about the restriction boundaries, and attitudes toward the policy underlie the first theme concerning the policy. Topics related to the second theme, tobacco use and users, commonly focused on attitudes towards smoker, identifying who smokes, and why people smoke. Finally, comments about how patients’ family members influence tobacco use are found in the third theme. Diminishing tobacco use is a global public health priority. As we embrace stricter protection policies in hospitals, emerging views from those most affected will guide future tobacco reduction strategies in these settings.

CONCURRENT SESSION A4
“TREATMENT DEVELOPMENTS”
(INTERNATIONAL F)
CHAIR: KEITH COX

O-24 MANAGEMENT OF TUMOUR LYSIS
Keith M. Cox, NP RN ONC CERT.
Sydney Cancer Centre Royal Prince Alfred Hospital, Sydney, Australia.

Tumour lysis syndrome (TLS) is an oncologic emergency caused by massive, rapid lysis of cancer cells after chemotherapy or other cancer treatments. TLS is characterised by a range of metabolic abnormalities including hyperuricaemia, hyperkalaemia, and hyperphosphataemia with associated hypocalcaemia. TLS is commonly complicated by renal failure, and can also impact upon the heart, central nervous system, and musculoskeletal system. The syndrome is potentially fatal if left untreated. The most effective strategy against TLS is prevention through identification of those at risk. Effective preventive strategies can minimise TLS complications even in high-risk patients. Goals are to prevent or treat electrolyte anomalies and to prevent organ dysfunction. Certain strategies to avoid the metabolic abnormalities should be commenced prior to a patient undergoing cancer treatment. Health care professionals responsible for the care of the cancer patients should have a strong understanding of TLS and how to manage patients throughout the high-risk period. An overview of the risk factors, Patho physiology and therapeutic options will be presented.

O-25 CUTANEOUS TOXICITIES ASSOCIATED WITH CANCER TREATMENT: DETERMINING THE ROLE IN SYMPTOM BURDEN.
Kate White, Natalie D´Abreu.
University of Sydney, Sydney, Australia.

Background

Developments in cancer treatment have led to significant improvements in disease control. The side effect profiles of both chemotherapeutic agents, new biological agents and epidermal growth factors are providing new challenges for patients and clinicians. Cutaneous toxicities associated with cancer treatments are well known, but in recent years there has been a substantive increase in the number and type of cutaneous toxicity. A review by Bauer and colleagues (2009) identified a significant variation in how cutaneous toxicities were reported in phase II and III studies. Routine recording of cutaneous toxicities clinical settings, approaches to evaluating severity of the dermal toxicity and the role of cutaneous toxicities in symptom burden all require further investigation.

Project

The overall aim of this project is to develop approaches to evaluate the impact of cutaneous toxicities on symptom burden, cancer treatment dose, and develop approaches to monitor the occurrence of cutaneous toxicities in the clinical setting.

Aims

1. To undertake a systematic review of literature on cutaneous toxicities associated with cancer treatments;
2. To identify and review current grading scales for cutaneous toxicities associated with cancer treatments;
3. Drawing on the outcomes from aims 1 & 2 develop patient report measure to evaluate the symptom burden of cutaneous toxicities for patients. Drawing on the Cochrane Collaboration (CC) Guidelines a search strategy, using key terms associated with cutaneous toxicities, and the CC methodology search strategy was undertaken. Data bases Medline, CINNAHL, EMB Reviews were searched. Currently data extraction is underway. This paper will present the results of the systematic review and overview of assessment scales. It is of note that to date most studies have suggested a significant under-reporting of cutaneous toxicities in the cancer population, and the potential for adverse impacts on the individual. The paper will briefly explore the role of nursing interventions in preventing or reducing the severity of cutaneous toxicities.

0-26 MAKING IT PERSONAL - RESEARCH NURSES, TISSUE BANKS AND THE FUTURE OF CANCER TREATMENT
CATHERINE A. LLOYD-BENNETT.
WALES CANCER BANK, SWANSEA, United Kingdom.

In order to tackle the complex and varied disease of cancer an individualised approach needs to be taken. Just as patients are different, their tumour biology is different and the conventional approach of ‘one treatment fits all’ is as questionable as fashion retailers telling us ‘one size fits all’! A better understanding of tumour biology can only be achieved by studying large collections of well annotated, high quality human tissue and linking the information with treatment and outcome data. If patterns then emerge linking outcomes with specific biological traits then treatment can be tailored to individuals and patients may be spared toxic treatments that may not have any proven benefits.

Biobanks are being created all over the world with this in mind,1 collecting tissue surplus to diagnostic requirements from routine surgical procedures and the level of consent required for this has become a hot topic. In the UK, new legislation was introduced a few years ago that made consent for tissue donation the ‘gold standard’. As a Research Nurse consenting pre-operative Oncology patients for tissue donation, views of patients regarding levels of information/provision are of interest. Donation carries low risk of harm and is only making use of waste material. Do patients feel an in-depth explanation of what happens to tissue after it is removed from their body is necessary for them to give consent? Have adverse reports on events in the UK in the late 90s made the public wary of tissue donation, or do they feel that new guidance is merely ‘red-tape’ in providing advances on better treatments for disease?

Samples from the tissue bank have been supplied to numerous research groups in the UK and Europe and interesting questions that may have an impact on patient treatment and care, are being raised as the level of sample handling knowledge rises. Do changes in the hormone receptor profiles in breast cancer vary because of post acquisition variables? If so, are there more patients out there who may benefit from hormone therapies?

These questions and more are vital if the quality of treatment is to be improved over the coming decades and biobanks will be at the forefront of facilitating these improvements.

1 Biobanking for better healthcare
2 Consensus recommendations on estrogen receptor testing in breast cancer by immunohistochemistry

0-27 DEVELOPING A RESOURCE INTENSITY TOOL FOR PARENTERAL CHEMOTHERAPY DELIVERY
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Beginning in 2007, a group of oncology nurses, leaders and a health economist worked on the development of a Resource Intensity Tool identifying chemotherapy delivery units. Chemotherapy protocols are established through evidence-based guidelines. Through a review of the current database from the Oncology Patient Information System (OPIS), we uncovered over 200 protocols for all disease sites in the cancer system.

The development of the Resource Intensity Tool involved the following components: establishment of the core elements (VAD access and disconnect; prep time; education; documentation; toxicity assessment and symptom management; anti-emetics, pre-meds or additional meds; regimen nursing time delivery; hydration; observation during and post; probability of reaction; average reaction; bring in and turnaround; and safety standards); calculation of these elements (A+B+C+D+E+F+K+L); a Multi-task adjustment of 33% (fixed time); and final calculation of Nurse Intensity Time (G+H+I+J+M). The group reached consensus on the time for each core element for each of the >200 protocols. Only protocols given intravenously to ambulatory patients are included; excluded are inpatient protocols, oral anti-neoplastics and clinical trials. The results have been applied in all the regional programs to increase funding relevant to the workload associated with intravenous chemotherapy delivery. The work continues to evolve to include new protocols to update the system. The presentation will highlight the work to date and next steps.

0-28 THE NURSING CARE OF THE TISSUE IMPLANTATION WITH RADIOACTIVE PARTICLE 125I IN ELDERLY PATIENTS WITH LUNG CANCER
Di Gu, Jr.
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Purpose
To investigate the effect of the tissue implantation with radioactive particle 125I and nursing care in elderly patients with lung cancer.

Method
Twenty patients who were not the right cases to have surgery were the right candidates for tissue implantation of radioactive particle 125I. Nursing care was given before, intra and after the treatment, respectively. All patients were older than 75 years, and pathologically diagnosed as local advanced NSCLC. Their diagnosis and physical condition all met the indication of implantation with radioactive particle assessed by the professional, and could tolerate the dose of the radiotherapy which would be given according to the TPS. R. The patients with recurrence were required to have at least 3-month interval after having chemotherapy. And the results of their mental and physical examination met the requirements receiving radiotherapy. The informed consent forms of all the patients were obtained before starting the treatment. The therapeutic effect were assessed.

Results
All the 20 patients were re-evaluated a month after the treatment. All the symptoms such as chest and back pain, cough, chest distress were much relieved. The appetite of the patients were also improved. The tumor-associated indexes of 18 patients were all decreased, and the diameters of the tumor examined by CT were become smaller around 0.5cm–2.5cm. The other two patients of which tumor size didn’t change markedly. All the patients were followed up for at least 2 years.

Conclusion
Tissue implantation with radioactive particle 125I is a new anti-tumor therapy which is safe and effective for cancer patients. It can be used as palliative treatment in the elderly patients with advanced lung cancer. The key points of nursing care are to prepare the patients carefully before the treatment, and assist the doctors with the procedures during the operation to reach the purposes of delivering the treatment correctly, timely and safely. Observe carefully and actively prevent the occurrence of complication in the patients after the operation, and pay more attention to the radioprotection.
evidence of active disease. Anecdotal evidence suggests that the period of time at the end of treatment and continuation of daily living away from the hospital environment can be a very frightening and anxious time – with the feeling of a safety net having been taken away.

The Haematology Clinical Nurse Specialist (CNS) wished to ensure that this transition period would be supported and any concerns explored. The CNS addressed this issue through the development of a ‘self-help’ course for patients and their carers.

‘Moving Forward’

The title ‘Moving Forward’ was chosen to reflect the continued care and support through the transition period.

The course was developed embracing key ‘survivorship’ issues identified at a joint Macmillan Cancer Support and Department of Health (DoH) user’s workshop in March 2008.

Six sessions were included in the programme covering the following:

- Relaxation Techniques
- Diet/Nutrition
- Benefits/Finances
- Specialist Information and Support
- Occupational Therapy – ‘Everyday Activities’
- Clinical Psychology – ‘Living with Cancer’

Participants were identified and recruited through colleagues in the cancer centre. An AS leaflet was designed and distributed within the cancer centre and to other District General Hospitals, throughout the West of Scotland.

To enable participants the opportunity to engage in discussion, share experiences and ask questions, places were restricted to 14. The first course ran from February to April 2009, eight patients and one carer participated. The course was held in a private, non-clinical, warm environment in the cancer centre over two hours. Time was included to provide coffee, tea and biscuits.

Each session was facilitated by the Haematology CNS.

Findings

The evaluations were very positive overall. Comments from participants included:

- ‘I found every session was very helpful, informative and friendly.’
- ‘The best part of the course was meeting with other patients and having the opportunity to chat/share experiences.’

The Diet/Nutrition and Clinical Psychology sessions were in particular very well received.

Future Developments

Following evaluation, very minor amendments are required. These include participants requesting a more formal introduction on day one of the course.

A practical demonstration of other complementary therapies would also have been welcomed. This may be a possibility in the future. The second course was held in April-June 2009, of which 14 patients and carers booked to participate. Also included on the final session, a previously expressed desire to continue exercising regularly.

O-30 THE GROUP COHESION FACTOR OF A DRAGON BOAT RACE TRAINING PROGRAMME FOLLOWING TREATMENT FOR BREAST CANCER IN THE UK

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2Sheffield Hallam University, Sheffield, South Yorkshire, United Kingdom,
3Kendal Lymphoedema Centre, Kendal, Cumbria, United Kingdom.

Background

There is increasing evidence that exercise and physical activity after breast cancer treatment can attenuate treatment related side effects and accelerate both physical and psychological recovery. However, the numbers of survivors engaging in physical activity and exercise after completion of treatment are low owing to lack of motivation and self-discipline, and to over cautious advice from health-care professionals. Dragon Boat Racing is a team sport that has been adopted recently by breast cancer survivors, which was first evaluated for its safety and beneficial effects on arm lymphoedema in Canada by McKenzie in 1996.

Group cohesion is an important factor in team based training, which impacts performance in athletes. Amongst breast cancer survivors this factor can be viewed as a mechanism for active social support and potentially provide a significant motivational force which supports adherence to a beneficial structured exercise programme.

Aim and Method

A single cohort longitudinal study was designed to explore group cohesion from participating in a 20 week Dragon Boat Race Training Programme with fellow breast cancer survivors culminating in a competitive race. A progressive exercise training programme was designed to develop sport specific fitness. Opened ended questionnaires and complementary focus groups were used to gather qualitative data from a sample of 13 self selected women at four time points: baseline, 6 weeks, 20 weeks, and 3 months post intervention. All participants were at least 3 months post treatment (excluding hormone therapy) for primary breast cancer and ranged between 36–72 years of age. Four women had clinically diagnosed mild arm lymphoedema. Scientific and ethical reviews were obtained.

Results

Exceptional motivational support was recounted by participants and reflected in training adherence rates up to 94%. From self reports, adherence was due to commitment, partner support, group support, responsibility to the group and camaraderie. Participants felt that the Dragon Boat race training experience provided fitness, fun, laughter, pride and a sense of belonging. The most beneficial aspect of being part of the group was realizing the potential of people, friendship, respect and encouragement. Difficulties included family commitments and sometimes self motivation when energy levels were low and body was aching.

Conclusion

The group cohesion factor was observed in the high levels of motivation and adherence to the training programme. Upon completion, most women expressed the desire to continue exercising regularly.

This structured, team–based group training programme has useful implications for health care professionals and breast cancer survivors to assist rehabilitation and promote an active lifestyle.

O-31 INCORPORATING CANCER SURVIVORSHIP CARE INTO NURSING PRACTICE

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There are an estimated 24.6 million people worldwide who have had a cancer diagnosis in the past five years and many more long-term survivors. Survivorship care is receiving greater attention, but this has not yet translated into access to survivorship care for all cancer patients. A lack of official guidelines and resources, both financial and practical, may contribute to this problem. Unfortunately, a lack of survivorship care can ultimately result in higher healthcare costs and undue suffering for survivors.

In the United States, it has been proposed that all cancer survivors receive a survivorship care plan at the time that therapy is completed to guide cancer screening, monitoring for recurrence and late effects of cancer therapy. Ideally, survivors will become active participants in their post-cancer care, coordinate between primary care and specialists, monitor for symptoms of late effects, undergo appropriate cancer screening and adopt a healthy lifestyle. To achieve this, survivors require education about their health risks and advice on taking steps to a healthier life. Oncology nurses have unique expertise in patient education, making their role in survivorship care a natural fit. Despite this natural role, late effects issues have not traditionally been part of oncology nursing education and many nurses may not have a full understanding of their patient’s educational needs. In addition, the time required to prepare an individualized cancer survivorship care plan is not available in many busy practices.

Through the use of an online tool to create individualized survivorship care plans, nurses can provide patients with the information needed to transition to a survivor role. The plan provides the survivor with information related to late effects of surgery, medical and radiation therapy, coordinating care between specialties, risk of second cancer diagnoses and steps toward healthy living, among other issues. The online tool has created over 6000 plans since it’s inception in May of 2007, with an average plan completion time of 6 minutes. Of the users, 23% have been healthcare providers and, of these, 85% are nurses (RN, NP). Eleven percent of users reported residing outside of the U.S. Breast cancer ac-
counts for the most common diagnosis, followed by gastrointestinal and hematologic malignancies. Only twelve percent of patient users report having previously received survivorship information. Interestingly, of European users, only 6% reported previously receiving survivorship information. This online tool can be a valuable part of a nurse led survivorship program without consuming valuable resources from other areas of patient care. Incorporating survivorship education into the nursing role is a step toward achieving appropriate survivorship care for all cancer patients worldwide.

O-32 A SURVIVORSHIP INTERVENTION: RETREATS FOR WOMEN CANCER SURVIVORS
Pamela J. Haylock, PhD RN1, Cynthia A. Cantrell, RN MPH2, 1Association of Vascular Access, Herrington, UT, USA, 2Marin Cancer Institute, Greenbrae, CA, USA.

Introduction
Life after cancer treatment often poses significant challenges for survivors. The unmet medical and non-medical needs that survivors experience after treatment is well documented in the literature. Long-term side effects – anxiety about recurrence, occupational and relationship challenges, and health maintenance strategies – are concerns for cancer survivors. Yet, evidence-based interventions addressing these needs are not well documented. Successful interventions are increasingly sought after by caregivers and patients. This presentation describes the design, implementation and participant-reported benefits of retreats for women cancer survivors. The authors have planned, led, and presented information at retreat settings that include retreat centers, lodges, ranches, and an internationally known wellness center in the United States. Most importantly, the authors believe a significant element of this supportive care model is that it can be replicated in a variety of settings around the world.

Retreat Components: Several retreat experiences are reported in the literature. They vary in duration from one day, three day, and week-long. For purposes of this presentation, a three-day immersion model is described in which women gather for the weekend, sharing accommodations and dining facilities, didactic and experiential sessions. This experience allows women to get away from day-to-day obligations, worries, and concerns and gives them the chance to commune with other women facing similar challenges. The guiding principles for retreat-planning include mind-body-spirit activities. Activities include: professional presentations about long-term effects and suitable interventions, women’s health, yoga, massage, meditation, art, walking, movement therapy, and discussions about fear of recurrence and the effects of cancer on relationships. All retreat experiences aim to address the loneliness and isolation many survivors report after treatment.

Participant outcomes: For many women, the retreat setting is the “first opportunity” they give themselves to integrate the diagnostic and treatment phases of the cancer trajectory, and begin to explore a “new normal”. Allowing a “safe and nurturing space with other women who truly understand” frames and supports their lives after cancer diagnoses and treatment. Participants report renewed emotional strength, knowledge, and hope for the future. Professional caregivers who present information also report increased awareness and sensitivity surrounding cancer survivor’s needs and experiences. The shared experience facilitates patient and provider communication and understanding.

O-33 CANCER SURVIVORSHIP: SUPPORTING ONCOLOGY NURSING PRACTICE THROUGH THE CREATION OF A SELF LEARNING MODULE.
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1Juravinski Cancer Centre at Hamilton Health Sciences, Hamilton, ON, Canada, 2River Valley Health, Fredericton, NB, Canada.

Survivorship has emerged as a new term in the culture of cancer care as more and more people survive longer living with active disease or live beyond detectable disease. The number of people living with cancer as part of their story continues to climb but our knowledge of their needs and the gaps in care that they experience is only starting to be understood. There is evidence now about how nurses can make a difference in the lives of cancer survivors. A unique, self-learning module focused on survivorship is being created to provide background information and tools to help nurses create and evaluate innovative and dynamic care plans for patients and families, provide psychosocial support, and address long-term physical side effects from the cancer and its treatment. This presentation will describe how this national organization is taking action to support nurses through the development of a self-learning module about survivorship and identify how nurses can use it to enhance care and support patients and families to thrive as they survive after a diagnosis of cancer.

O-34 CANCER SURVIVORSHIP: AN AGENDA FOR PRIORITY ACTION
Margaret I. Fitch, Odette Cancer Centre, Sunnybrook Health Sciences Centre, Toronto, ON, Canada.

The number of individuals who are living after a diagnosis of cancer is growing steadily. In developed countries, as many as 78% of pediatric patients and 60% of adult patients are alive five years following their diagnosis. With the anticipated increase in the incidence of cancer, and the success of treatment approaches, these numbers will continue to grow.

Survivors experience ongoing challenges and few specifically designated programs exist across our country. Cancer survivorship does not come with out cost. Late and long term effects can emerge that compromise quality of life and increase the burden of suffering.

The Canadian Strategy on Cancer Control identified cancer survivorship as a priority for action. An environmental scan was undertaken and a national workshop was held with a broad range of stakeholders. Two provincial workshops were held to assess the unmet needs of survivors. The work has begun to build an agenda for priority action in our country and to mobilize a research platform.

Cancer survivors are a vulnerable population and new approaches are needed to provide appropriate care and overcome unremitting anxiety.

Concurrent Session A7
“Supportive Care” (International H)
Chair: Deena Gilland

O-35 DEVELOPMENT, IMPLEMENTATION AND PILOTING OF AN EVALUATION FRAMEWORK FOR A BREAST RECONSTRUCTION INFORMATION RESOURCE FOR WOMEN CONSIDERING BREAST RECONSTRUCTION FOLLOWING MASTECTOMY.
Olivia Hill, BN(Hons), University of Sydney, Sydney, Australia.

Background
A significant proportion of women diagnosed with breast cancer in Australia still require mastectomy as principle surgical treatment for breast cancer. The overall proportion of women who undergo breast reconstruction in Australia is relatively low, with the last reported estimate as approximately 20% of those women requiring mastectomy. Decision making about breast reconstruction is multi-faceted and often undertaken within the context of a breast cancer diagnosis. All of these factors impact on the woman’s ability to retain, collate and process information required to make breast reconstruction treatment decisions. Increasingly, women are seeking more information about their breast treatment options.

Aim: to develop and evaluate an information resource to support and provide timely access to information on breast reconstruction for women who undergo mastectomy.

Methodology
Evaluation research utilising a collaborative framework has guided this study. A collaboration was formed with the Breast Cancer Network of Australia; the peak consumer group for women with breast cancer.

The evaluation framework: was collaboratively developed by the project advisory panel made up of consumers and health care stakeholders. The framework included collaborative resource content development, development of evaluative surveys, recruitment strategies, methods for comprehensive prospective and retrospective evaluation, and involved key personnel to ensure a contextually appropriate resource and framework was developed.

The information resource: The resource is in the format of a paper based information booklet with a supported CD-Rom. The resource outlines the different types of breast reconstruction available, external factors that can influence women’s options for breast reconstruction, practical information regarding postoperative physical and psychosocial recovery, and access to...
O-36 RESULTS OF A HOME-BASED WALKING INTERVENTION FOR PATIENTS UNDERGOING CANCER TREATMENT
Jennifer Wenzel, PhD, RN1; Kathleen Griffin, PhD, RN2; Jingjing Shang, PhD, RN2; Carol Thompson, MS, MBA1; Hasy Healin, PhD2; Victoria Mock, PhD, RN, FAAN1.
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Introduction
Prior exercise studies among cancer patients/survivors indicate that this health-promoting activity has many benefits and few notable risks. We evaluated the impact of a home-based walking intervention implemented during cancer treatment on fatigue, emotional distress, symptom experience, sleep disturbance and quality of life.

Methods
126 patients with breast, prostate, and other cancers were randomized to a home-based walking intervention or usual care. Exercise dose was assessed using a 5-item Cooper Aerobics Center Longitudinal Study Physical Activity Questionnaire. Outcome measures included: the Piper Fatigue Scale (PFS); Profile of Mood States Scale Shortened (POMS); The Symptom Distress Scale (SDS); and the Pittsburgh Sleep Scale. Quality of Life was measured by the Medical Outcome Study (MOS) 36-item Short Health Survey.

Results
The mean (SD) age of all study participants was 60.2 (10.6). Diagnoses included prostate (52.3%) and chemotherapy (34.9%). Among exercisers, 68% adhered to their exercise prescription, while 12% of control participants exercised at a level > to that assigned to the exercise group. Because of this crossover, expected outcome differences were less evident in the Intent-to-Treat analysis. However, in the dose response model, increased aerobic exercise was significantly associated with less fatigue when measured by the PFS (p < 0.05), the SDS fatigue subscale (p < 0.01) and the POMS fatigue subscale (p < 0.01) after controlling for exercise group assignment, age, weeks of cancer treatment, and baseline exercise and fatigue levels. Participants who exercised self-reported significantly less fatigue (10%) less fatigue by end of treatment (p < 0.001) than participants who were less active, controlling for the covariates. Participants who exercised throughout the study period had 13% more vigor on the POMS subscale (p < 0.01). With respect to quality of life, those who exercised had 3% less emotional distress on both the POMS and the MOS Emotional Well-being subscale than those who were less active.

Discussion/Conclusions
The present study included patients with a variety of cancer diagnoses and demonstrated that a low-cost, flexible exercise program can provide benefits attainable for many patients. Findings suggest that patients who exercise during cancer treatment experience less fatigue, more vigor, and less emotional distress than those who are less active.

O-38 APPRAISAL OF NON-PRESCRIPTION PRODUCTS FOR XEROSTOMIA TREATMENT
Robin Eads, MSN, RN1; Janet S. Fulton, PhD, RN2.
1St. Francis Hospital, Indianapolis, IN, USA, 2Indiana University School of Nursing, Indianapolis, IN, USA.

Purpose
The aims of this project were to identify 1) non-prescription products for treatment of xerostomia; 2) active ingredients and intended therapeutic purposes (described by the manufacturer) 3) side effects and contraindications for the products and/or active ingredients; 4) empirical evidence of product efficacy.

Methods
The study used a qualitative descriptive approach. Data included product information available in the public domain or supplied by the manufacturer/vendor. Products were identified by internet search, and national retail pharmacies were visited. Products were obtained and information taken from product labels. Manufacturers or vendors were contacted and for a list of active ingredients, empirical evidence supporting recommendations for use, and evidence documenting potential adverse side effects. Scientific literature was searched using MEDLINE and CINAHL databases using terms inclusive of active ingredients derived from the product information. Findings: Sixteen products were identified, 13 products were available for inclusion in the review; 12 were categorized as salivary substitutes and 1 as salivary stimulant. Fourteen active ingredients were identified; most common ingredients were glycerin, a humectant, and carboxymethyl cellulose. Other ingredients found alone or in combination were lysozyme, lactoferrin, glucose oxidase, and lactoperoxidase. For 11 ingredients, no

O-37 PHILOSOPHICAL BELIEFS: EXPLORING THE USE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE BY TAIWANESE PEOPLE WITH CANCER
Shou Yu (Cindy) Wang1, Carol Windsor2, Patsy Yates2.
1Hung Kuang University, Taichung, Taiwan, 2Queensland University of Technology, Brisbane, Australia.

Because of the long history of Chinese medicine in Taiwan, people have traditionally incorporated this knowledge into their health care. With the appearance and growing acceptance of Western medical practices, multiple medical approaches have become more and more popular in Taiwan. The focus of this research is the contextual construction of meanings about complementary and alternative medicine (CAM). The context for the study is Taiwan, the principal researcher’s home country. The purpose of the research is to explore the processes by which, Taiwanese people with cancer incorporate CAM into their cancer treatment journey. Utilising a grounded theory approach, this research sought to explore the social processes by which Taiwanese people with cancer come to use CAM. Twenty four in depth interviews with cancer patient participants from two hospitals in Taiwan at varying stages of their cancer journey were undertaken in the study. The findings of the study demonstrate that the interactions between people with cancer and their use of CAM are complex. Taken-for-grantedness emerges as the core category in the study. More specifically, the meanings attributed to CAM are embedded in the philosophical beliefs (traditional Chinese philosophy, religious practices and Chinese proverbs and self destiny) that constitute the lives of the participants. These findings suggest implications for our understanding of the co-existence of CAM and Western medicine by Taiwanese people with cancer and the social processes with which they engage. Furthermore, suggestions regarding clinical care and patient safety regarding patients’ use of CAM are also provided.

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Robin Eads, MSN, RN1; Janet S. Fulton, PhD, RN2.
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Purpose
The aims of this project were to identify 1) non-prescription products for treatment of xerostomia; 2) active ingredients and intended therapeutic purposes (described by the manufacturer) 3) side effects and contraindications for the products and/or active ingredients, 4) empirical evidence of product efficacy.

Background
Oral hygiene products and mouth moisturizers are available without a prescription (over-the-counter) to help manage xerostomia (perception of dry mouth) by increasing salivary production or providing substitute moisture. Mode of action varies. Only modest information is available to explain use, side effects, and safety profile. Some products may not be helpful or may be contraindicated for cancer patients. Significance: Patients and nurses often are unaware of the ingredients, indications, and side effects associated with over-the-counter products for management of xerostomia.

Methods
The study used a qualitative descriptive approach. Data included product information available in the public domain or supplied by the manufacturer/vendor. Products were identified by internet search, and national retail pharmacies were visited. Products were obtained and information taken from product labels. Manufacturers or vendors were contacted and for a list of active ingredients, empirical evidence supporting recommendations for use, and evidence documenting potential adverse side effects. Scientific literature was searched using MEDLINE and CINAHL databases using terms inclusive of active ingredients derived from the product information. Findings: Sixteen products were identified, 13 products were available for inclusion in the review; 12 were categorized as salivary substitutes and 1 as salivary stimulant. Fourteen active ingredients were identified; most common ingredients were glycerin, a humectant, and carboxymethyl cellulose. Other ingredients found alone or in combination were lysozyme, lactoferrin, glucose oxidase, and lactoperoxidase. For 11 ingredients, no
side effects or contraindications were listed. When listed, most frequently cited side effects were mild burning, bad taste, and "sticky sensation". The literature was searched for evidence of efficacy of the active ingredients. Limited efficacy support was identified.

Conclusions
Non-prescription products are readily available for treatment of xerostomia; however, there is limited evidence of efficacy for these products. Selection and use is dependent on patient preference and palliative needs. No evidence of safety or efficacy could be found for use of the products in cancer patients experiencing xerostomia. Nurses need to monitor patient use non-prescription products as part of oral health assessment and maintenance.

O-39 FACTORS INFLUENCING TIME PERCEPTION IN PATIENTS USING VIRTUAL REALITY DURING CHEMOTHERAPY
Susan M. Schneider, PhD, RN, AOCN, FAAN.
Duke University, Durham, NC, USA.

Chemotherapy treatments are intense and difficult to endure. Previous studies have demonstrated that using virtual reality (VR) during chemotherapy resulted in a significant elapsed time compression effect, validating the attention diversion capabilities of VR. This presentation discusses factors which influence the effectiveness of VR as a distraction intervention to help patients tolerate chemotherapy treatments. The purpose of this study was to explore the influence of age, gender, state anxiety, fatigue, and diagnosis in predicting the difference between the actual time elapsed for patients receiving intravenous chemotherapy versus the time the patients perceived elapsed while receiving chemotherapy treatment when immersed in a VR environment. The Information Processing model which identifies factors related to time perception guided this study. This was secondary analysis of data from three previous studies, conducted at two comprehensive cancer centers. The sample of 137 adults had a mean age of 52.4 yr (SD 10.8, range 27–78); 81.7% were female; 86.9% were Caucasian, and 8.8 were African American. The sample included 91 patients with breast cancer (66.4 %), 28 with lung cancer (20.5%), and 18 with colon cancer (13.1%). During chemotherapy infusions, participants wore a head-mounted device to display encompassing images and block competing stimuli. Demographic data (age, gender, and diagnosis), the Piper Fatigue Scale, and State Anxiety Inventory were used as measures of the independent variables. Both instruments have demonstrated reliability and validity. In a forward regression model, three predictor variables; diagnosis, gender and anxiety, explained a significant portion of the variability for altered time perception (F = 5.06, p = 0.008), with diagnosis being the strongest predictor. Patients with breast cancer underestimated the time elapsed in VR by an average of 23 minutes, while those with colon underestimated their time by an average of 12 minutes. In contrast, VR times estimated by lung cancer patients averaged only 3.5 minutes less than the actual time elapsed. VR is an innovative, non-invasive, and cost-effective intervention that can make chemotherapy treatments more tolerable. Women with breast cancer are more likely to experience changes in time perception during VR. Lung cancer patients may experience more severe symptoms which can interfere with their ability to effectively use distraction. Understanding factors that predict which patients are likely to benefit from intervention can help nurses tailor coping strategies to meet patient needs. The data for these analyses were from studies funded by: the American Cancer Society, the Oncology Nursing Foundation through an unrestricted grant from Ortho Biotech Products, L.P., and NINR (1 P20 NR07791-01, Clipp PI).

O-40 ORAL ABSTRACTS
exploring the lived meaning and shared practices of individuals with similar experiences. Purposive sampling was used to recruit approximately 10 women for this initial study. Participants were recruited from the Facing Our Risk Empowered (FORCE) organization website and national conference. Interpretative hermeneutic phenomenological analysis will be followed to interpret the data. Preliminary results demonstrate the need for knowledge and support for women undergoing screening for hereditary breast cancer. Further analysis will be reported in the presentation.

Future Implications
This exploratory study will guide future nursing practice by helping women to effectively incorporate their risk and risk management into their everyday lives. It will also enhance health care providers’ knowledge of the needs of women who are making decisions regarding how to manage their breast cancer risk.

O-42 THE NURSES ROLE IN ASSESSING NUTRITIONAL STATUS IN WOMEN WITH GYNAECOLOGICAL CANCER USING THE PG-SGA: IS THIS A NEGLECTED AREA?
Mary Ryan1,2, Kate White2, Claudette Knight2
1Royal Hospital for Women, Randwick, Australia, 2The University of Sydney, Sydney, Australia.

Introduction
Malnutrition is recognised as a significant dilemma in women diagnosed with gynaecological cancer. Nutritional status can be impacted in a number of ways. Prolonged symptoms or pressure from a growing cancer leading to loss of appetite, reduced stomach capacity, bloating and other gastrointestinal related complaints all reduce both the amount and quality of nutritional intake. While surgery may improve the symptoms associated with cancer, poor nutritional status can lead women to have a delayed recovery from their surgery, require an extended hospital stay, or delay in receiving other anti-cancer therapies. Women’s nutritional status can also be undermined by the surgery and subsequent treatment delaying recovery. Despite this knowledge, nutritional status is not routinely undertaken in most gynaecological cancer (GC) centres, and no research has been identified that has investigated nursing strategies to ameliorate nutritional deficits in this group of cancer patients.

Study aims
The main aim of this study is to develop a multidisciplinary intervention to maximise nutritional status for women diagnosed with gynaecological cancer. The specific aims guiding the study are to:

1. Undertake a systematic review of the literature on the nutritional interventions for women diagnosed with GC.
2. Describe the impact of multimodal cancer treatment on nutritional status through prospective assessment across three time periods.
3. Drawing on the results from aims 1 and 2 develop and pilot test an intervention to maximise nutritional status for women diagnosed with GC.

Results
Data were collected prospectively from women diagnosed with GC, monitored at three time points; diagnosis, 3 and 6 months. The Patient Generated Subjective Global Assessment (PG-SGA) tool was used to measure nutritional status. To date 30 women have been recruited. Preliminary results have highlighted monitoring nutritional status is a feasible and important area of inquiry for cancer nurses. As well as presenting current data this paper will discuss approaches to nutritional assessment in the clinical setting, with a focus on the role of cancer nurses, and assessment tools such as the PG-SGA tool.

Conclusion
The data collected by this study will provide a framework for understanding the relationship between gynaecological cancer and nutritional status in women.

O-43 CERVICAL CANCER: DOES THE MESSAGE PROMOTE SCREENING? A PILOT STUDY
Lize J. E. Maree, D Cur (Pret), S C. D. Wright, D Tech Nursing, Tshwane University of Technology, Pretoria, South Africa.

Purpose
The purpose of the study was to determine if presenting information on cervical cancer in a non-stigmatizing manner, with the focus on self-protection, had the potential to promote cervical screening in women living in Soshanguve, Tshwane.

Methods
An exploratory quantitative door-to-door survey was conducted. Two approaches on how to prevent cervical cancer were explored. Approach A, which according to literature could be seen as stigmatizing was obtained from the website of a specific organisation in South Africa. This approach focussed on what women should know about cervical cancer. Approach B was designed in collaboration with female medical practitioners responsible for cervical screening and focussed on how a woman could protect herself against cervical cancer. The sampling method was convenient. The sample size totalled 105 (n=105). Self-reported data were collected by means of a structured interview. The data collection instrument was a questionnaire containing both open-ended and closed-ended questions. The data gathered were analysed by means of content analyses and descriptive statistics.

Results
The majority (67.6%: n=105) of the sample chose approach B. The motivation of 27.6% was that approach B explained to them how to get “tested” to know their “status”. The only reason for preferring approach A (15.2%) was that it was easier to understand. The majority of women (64.8%) did not consider approach A to be stigmatizing and 80% indicated that they would not be embarrassed if they were diagnosed with cervical cancer.

Conclusions
The study provided evidence that women living in Soshanguve did not perceive information about cervical cancer as stigmatizing. Focussing on self protection had the potential to promote cervical screening.

O-44 PREVENTING CERVICAL CANCER AND HPV IN WEST AFRICA
Angela Adjetey, RN, MPH, MA, FAACM1,2, Angela Adjetey, RN, MPH, MA, FAACM1,2
1Memorial Sloan Kettering Cancer Center, New York, NY, USA, 2National Cervical & HPV Cancer Coalition-New York Chapter, New York, NY, USA.

Disease prevention and health promotion continue to be important consistent need. Inadequate Healthcare infrastructure in rural areas and access to care, and limited resource for individuals and families remain important challenges in developing countries. The primary goal of the pilot project is to promote an educational program that tackle the problems and issues related to cervical cancer and HPV prevention and screening in West Africa. This proposal deals with a pilot program that has a great potential to grow with sufficient funding from Governmental and NGO’s. An educational mobile clinic would be used to target populations in the villages and cities in West Africa. The proposed pilot project has short-term effect on preventing and screening for cervical cancer and educating the public on HPV awareness. These include, the potential elimination of deaths related to cervical cancer and HPV as well as the long-term effects on decreasing maternal mortality in West Africa. Through education we can empower females to make educated decisions. These decisions have a direct effect on maternal mortality and with this program; we would improve the sexual health of female population in West Africa with the help of community leaders, village chiefs and elders. The proposed pilot project incorporates these goals and objectives:

1. Educate and empower communities, individuals and families to adopt healthy behaviors and lifestyles toward prevention and screening of cervical cancer/HPV.
2. Educate consumers to make informed health and healthcare decisions, and
3. Encourage communities to talk about how to improve health.

Objectives of the program:
- To decrease the maternal mortality and increase prevention and screening of Cervical and HPV cancer,
- To eliminate knowledge deficit among our young women related to sexuality,
- To encourage education and awareness, and to empower the young women to make educated sexual choices.

Advantages of the proposal:
- The project is culturally neutral therefore it could be implemented, and replicated regardless of the chosen country or culture in Africa.
- It does not require extensive funding although it will entail NGO’s involvement to fund the project.
- It is relatively easy to measure the success of the program because the indicators and the evaluation tools are well defined.
• After taking a closer look into the best practices this program is proven to have positive outcome on maternal mortality, cervical cancer and HPV awareness.

• The project is cost effective

Recommendations/Implementation:
• Purchase a mobile clinic/Van.
• Get approval from the leaders of the village.
• Employ debt forgiveness program, placed health science interns in community-based education and outreach programs in partnership with government and NGO’s.
• Prepare age appropriate education material.
• Attention must be paid to illiteracy.

O-45 FOCUS GROUP DISCUSSIONS WITH 30-YEAR OLD WOMEN ABOUT CERVICAL CANCER AND ITS PREVENTION IN URBAN SWEDEN
Karinf Blomberg1,2, Catarina Widmark1,3, Britt-Marie Temesdet4,5, Sven Törnberg6, Carol Tishelman1,3
1Karolinska Institutet, Dept. of Neurobiology, Care Sciences and Society, Stockholm, Sweden, 2School of Health and Medical Sciences, Örebro University, Örebro, Sweden, 3Department LIME, Medical Management Centre, Karolinska Institutet, Stockholm, Sweden, 4Department of Palliative Care Research, Ersta Sköndal University College, Stockholm, Sweden, 5Research and Development Unit, Stockholms Sjukhden Foundation, Stockholm, Sweden, 6Cancer Screening Unit, Oncological Centre, Karolinska University Hospital, Stockholm, Sweden.

We previously found that women’s decision-making about cervical cancer screening (CCS), differed by age cohort. Recent literature in the field of cervical cancer prevention primarily focuses on adolescents targeted for HPV vaccinations, while perspectives of women who need to continue CCS with Pap smears are addressed to a lesser extent. In this presentation, we explore how 30-year-old women reason about health, illness, health maintenance and disease prevention, in relation to cervical cancer, its prevention and screening. Through a population-based CCS registry, we randomly sampled women to attend focus group discussions (FGDs), stratified by previous screening patterns and test results. Nine FGDs with 38 women were inductively analyzed. Women’s self-definition of being in transition between youth and adulthood appears to strongly influence their reasoning about CCS. Matters related to sickness, including cancer and its prevention, were generally described as distant and not prioritized in this period of life, this was compounded by lack of appropriate information.

Our data suggest the way women position themselves in a transition from youth to adulthood is an important factor in their reasoning about CCS attendance. CCS programs may be challenged to adapt both information and organizations to new cohorts of women with different needs and life situations.

RNDTABLE SESSION A9
“WORKFORCE AND HEALTHY WORKPLACE ISSUES” (ROSWELL I)
CHAIR: MARIA VINCENT

O-46 MENTORING IN NURSING EDUCATION
Dorothy L. Normile, Masters.
MCNHS, Manchester NH, USA.

The National League for Nursing (NLN, 2006) in a statement to the Board of Governors in January of 2006 to discussed the issue of mentoring nurse faculty. The NLN advocates for the use of mentoring as a method of recruiting and retaining nurse faculty. Mentoring has become an even more important issue in nursing education when you consider that there is a wide spread nursing faculty shortage (NLN, 2006). Many new nursing faculty have not had formal training in education and therefore are not prepared for the expectations placed upon them by the institutions that employ them. They are expected to go into the classroom and teach students material that they may not be familiar with themselves. In addition, they are expected to understand the complexities of the healthcare system and prepare graduates to think critically, make decisions, take risks, facilitate change, and communicate effectively. While doing all of this they are expected to conduct research, advance the practice, and provide service to the profession as well as their academic institutions. Their role does not end there however; they must maintain clinical competence as well as continued professional growth (NLN, 2006).

Schriner (2007) conducted a qualitative study to describe how cultural differences and similarities affect the transition of nurses from the clinical role into the faculty role. Seven faculty members were interviewed and six themes emerged from the data. The one theme that was significant was “Deficient Role Preparation”. One of the faculty member who was interviewed for this study talked about her strong clinical skills but said she repeatedly questioned her ability to teach effectively (Schriner, 2007). This may be a significant issue when it comes to retaining nursing faculty. In the clinical area the nurse may be an expert in his/her Mentoring 3 field but they may be a novice in a classroom. A qualified mentor can help the novice to work through some of the frustrations that can develop when changing from a clinical to an academic role in nursing.

Mentoring 4

References

O-47 CREATING A MODEL OF EXCELLENCE IN ONCOLOGY NURSING CARE - A PROVINCE WIDE EDUCATIONAL APPROACH
Mary Jane Esplen, RN, PhD, Jiahui Wong, PhD, Susan Clarke, RN, MN, PhD (cand.), CPMHN(C). de Souza Institute, Toronto, ON, Canada.

This round table discussion is to share new education programs in our institute which has a mandate to develop and provide innovative education and mentorship programs for oncology nurses across the province. Information technology tools will enable the Institute to reach out into every corner of the province to provide a mix of academic instruction using telehealth and other e-learning methods.

The selection of curriculum topics and the roll out for the 2009/10 educational initiatives are based on the following elements: needs assessment eliciting generational difference in learning style and areas for support, steering committee input on the priority areas, stake holder consultation on the feasibility and local buy-ins, and the availability of evidence based best practice guidelines and standards developed in Canada and internationally. For all our educational initiative, patient centered care is built in as an essential component of the curriculum.

This round table session will include presentations of the following three educational initiatives: 1) “Establishing a deep understanding of the needs of oncology nurses using narrative methodologies” (2009-O-310-ICCN), 2) “Promoting quality through a standardized provincial chemotherapy education program” (2009-O-155-ICCN), and 3) “Teaching evidence-based pain management in cancer care” (2009-O-326-ICCN).

Each presentation will highlight project objectives and unique challenges for oncology nurse educators. For example, a wide range of cancer care settings from community care to tertiary care, and different learning needs for nurses from cancer prevention to treatment to palliation to survivorship. Geographical access barrier for rural and remote communities is another important consideration incorporated in the curriculum development and implementation.

Success factors for the educational events to date at this institute include: strong leadership, continuous organizational support and a committed project team with a common goal to provide high quality oncology nursing education, all of which ensure that these educational programs are delivered in a timely and holistic manner. The importance of involving local champions and incorporating their insights into the implementation cannot be more emphasized.

Finally, the evaluation methods applied in these three projects will be described which include pre, post evaluation on knowledge and confidence, session feedbacks, preceptorship, simulation and observer ratings. The effectiveness of using information technologies to reach all nurses in the province will be discussed. Preliminary results from these evaluations including user feedbacks will be shared with the round table participants.
O-47 ESTABLISHING A DEEP UNDERSTANDING OF THE NEEDS OF ONCOLOGY NURSES USING NARRATIVE QUALITATIVE INQUIRY METHODS

Laura L. Rashleigh, RNC, BScN (C), 1 Diana Incelkol, BScN1,2, 1Jiahui Wong, PhD1, Esther Green, MSc(T)1.
1de Souza Institute, Toronto, ON, Canada. 2Princess Margaret Hospital, UHN, Toronto, ON, Canada.

As the number of people who are living with cancer in Canada continues to increase, oncology nurses require advancing knowledge and career support. Our innovative institute of excellence supports the professional development of all oncology nurses across the province through career and education support. In order to fully ascertain the complex needs of oncology nurses within our geographical area, a comprehensive provincial needs assessment is necessary.

A key area of focus in this needs assessment will be that of the generational learning differences that exist, along with the geographic barriers that nurses face across the province. The issues oncology nurses face are becoming increasingly complex due to the fact that the nursing workforce is comprised of three generations of learners each with unique needs and expectations for learning. Literature suggests that nurses who are “Baby Boomers,” “Generation X,” or “Generation Y” (a.k.a. the “Net Generation”) each seek distinct methods of being taught and receiving information. Further complicating the matter is the fast geographic spread of the province and the critical nursing shortage in rural areas. Distance education has the potential to bridge the gap in accessing nursing education as it can be difficult to access academic campuses or because work, family, or economic considerations preclude full-time, on-site education. Moreover, educators point out, distance courses fight “brain drain” from rural areas: students who learn within their own communities are more likely to practice there, and working nurses taking advanced degrees via technology can continue to serve their patients.

In order to appropriately plan curriculum and course development, it is important to explore themes among these groups identifying common needs and expectations. The goal of this research project will be to elicit generational differences in learning style, issues influencing recruitment and retention, and areas for educational and career support within oncology nursing. An innovative narrative descriptive methodology (e.g. photographic journaling) will be used in combination with qualitative descriptive interviews with nurses, allied health professionals, and cancer patients. Sampling will be determined based on geographic location, and area of patient care within the provincial health networks. 4 key sites will be considered: Metropolitan, Urban, Rural and Remote locations. Approximately 15 interviews are planned per site, in accordance with the following allocation: 6 nurses, 5 other ‘care team’ members, 2 current nursing students and 2 current or recent cancer patients. Preliminary findings and statistics will be discussed in the context of implications for shaping the view of oncology nursing provincially.

O-47 TEACHING EVIDENCE-BASED PAIN MANAGEMENT IN CANCER CARE: REGIONAL WORKSHOPS FOR ONCOLOGY NURSES USING STANDARDIZED PATIENTS AND SIMULATED CASE STUDIES

Cindy Shabbrook, RN (EC), MN, CON (C) CHPN (C), Jiahui Wong, PhD. de Souza Institute, Toronto, ON, Canada.

Comprehensive pain assessments and effective communication is an important part of pain management and care. This project explores the process and preliminary outcomes of a provincial initiative to provide cancer pain management education to oncology nurses. This project is led by an expert nurse practitioner in pain management from an institute with a special focus on nursing education, in collaboration with local nursing leaders and educators across the province. Regional workshops combine multiple teaching strategies, including didactic lecture, small-group interactive discussion and standardized patient-simulated case studies. Key areas covered in the workshop include a review of common misbeliefs impeding effective pain management; an overview of best practice approaches to cancer pain assessment and practice guidelines for pharmacological intervention; an exploration of strategies to identify and manage adverse effects; and an examination of pain management and communication issues in vulnerable oncology populations.

The aim of the presentation will be on the use of standardized patient-simulated cases to teach principles of comprehensive pain assessments and effective communication strategy. The project team works closely with local standardized patient (SP) programs to ensure that the SPs simulate issues commonly encountered in cancer care. Oncology nurses participating in the workshop will rotate through 3 SP stations and will have an opportunity to “interview” the SPs. Examples of the 3 SP stations include a) a young post-surgical cancer patient with poorly controlled pain and a family history of substance abuse; 2) an elderly patient with advanced cancer and mild cognitive impairment; and c) an interprofessional team member who is critical of the nurse’s assessment. Challenges include how to gather history, communicate assessment findings and negotiate care in a succinct and confident manner. Following SP encounters, participants will receive feedback from the SPs on their approach and communication skills. The workshop leader and local facilitators will further comment on pain assessment content and the observed areas for improvement, in a supportive and constructive manner.

The project is ongoing. A systematic evaluation has been developed to assess nurses’ knowledge and confidence in cancer pain management before and after the workshop. In addition, the effectiveness of using SPs as a teaching method will be explored, stressing the usefulness of SP encounters to illuminate assessment and communication challenges, teach opportunities for being present with families and patients experience pain, and exploring misbeliefs held by families and providers around pain, suffering and pain management.

O-47 PROMOTING QUALITY THROUGH A STANDARDIZED PROVINCIAL CHEMOTHERAPY EDUCATION PROGRAM: ONE INSTITUTE’S STORY

Ashleigh Pugh, RN, BScN, MN, Jiahui Wong, PhD, Mary Jane Esplen, PhD, RN. de Souza Institute, Toronto, ON, Canada.

Nurses play a vital role in caring for patients throughout the cancer journey. Two common treatments used on this journey are chemotherapy and biotherapy. However, as new emerging antineoplastic treatments are introduced at an ever increasing rate, nurses, regardless of their clinical experience or practice setting, face challenges in sustaining and furthering competence in providing high quality, safe care to patients. In recent years, there have been calls for a standardize chemotherapy and biotherapy training programs across the province. To address this, a standardized chemotherapy and biotherapy education program has been developed by a provincially sponsored institute of oncology nursing excellence, using innovative, accessible information technologies. Three standardized curriculums are currently being implemented in the standardized chemotherapy and biotherapy program: a three day wholistic course for nurses administering chemotherapy and biotherapy; a one day local facilitator training course; and a chemotherapy preceptorship curriculum designed for facilitators to implement in their home centres. The program incorporates provincial, national and international standards, as well as theoretical perspectives guiding adult teaching-learning and specialized oncology nursing practice. A graduated competency process was developed to enable nurses in diverse practice areas to receive a certificate level relevant to their practice needs that is sustainable over time. The commitment in this program remains to enable quality and excellence in oncology nursing practice, enhancing outcomes for all patients living with cancer in our province.

A rigorous evaluation method is being implemented to assess the impact of this new initiative, including pre and post measures to assess change in knowledge and confidence among nurses, and to ensure competencies leading to quality patient care. The effectiveness of information technologies as distance education tools will be assessed. During the facilitator training program, interrater reliability assessment will be used to ensure high fidelity of all facilitors’ ratings of the standardized chemotherapy administration scoring system. This ensures all nurses receiving a certificate of completion reach the same standard of excellence, regardless of facilitator or training setting. In addition, to maintain high quality of the curriculum delivered across the province, randomly selected video tapes of facilitators’ teaching activities will be reviewed by an expert panel and feedbacks will be provided. Preliminary results from the pilot and year one implementation will be described with strengths of a standardized approach, lessons learned and implications for other jurisdictions.
O-49 LIVING "THE MOTHER STANDARD (R)" OF CARE - ACUITY ADAPTABLE NURSING UNITS IN ONCOLOGY.
Sandra J. Davidson, RN, MSN, CNE, PhD(c). Diane Drexler, RN, BSN, MBA, FACHE. Paula Hovesten, RN, MSN. Western Regional Medical Center, Goodyear, AZ, USA.

Acuity Adaptable Nursing Units in Oncology
Cancer Treatment Centers of America® (CTCA) is the home of integrative and compassionate cancer care. At the heart of our organization’s philosophy is the Mother Standard of Care®. Simply stated, every patient who visits a CTCA facility is treated with the same care and compassion that we would wish for our own family. We are committed to treating each patient like our own mother, father, brother or sister. Our interdisciplinary team of cancer experts delivers the latest medical treatment options combined with a full array of complementary therapies to mitigate treatment side effects and improve quality of life. We provide whole-person care and unparalleled service. Western Regional Medical Center (WRMC) is the newest facility within the CTCA network. WRMC opened its doors on December 29th, 2008 in Goodyear, Arizona. As the newest facility to CTCA, the leadership and clinicians at WRMC have embraced many innovative strategies and treatment opportunities to provide our patients with an experience of healing and an environment that promotes hope and wellbeing. One of these strategies is the adoption of a model of care on the inpatient unit that fosters high patient and family education, while concurrently promoting cancer prevention and early detection. Nursing roles are becoming more specific and specialized. Oncology nurses become specialists in genetics, chemotherapy, radiation therapy, and navigation of care. While specializing, nurses continue to hold pivotal roles in all aspects of cancer care, from prevention through diagnosis, treatment and follow-up. Nurses are a key resource for the patient and for the family, whatever their specialty. Therefore, collaboration, communication, and an established referral process with their peers can support nurses in meeting this individual and professional commitment to quality care and the commitment to education for the patient and the family. Nurses can change immediate outcomes for the patient and longterm outcomes for the family. This roundtable will describe the development of a successful referral process and collaborative program relationship between a Breast Care Program and Family Risk Assessment Program in a community cancer center setting in the Northeast United States. The roundtable will highlight the complementary roles, referral patterns, and collaboration for improved care. It will present a model for using practices, performance improvement tools, data collection tools, tracking systems and staff education opportunities. It will describe how the promotion of the relationship between nurse navigators and risk assessment nurses can improve screening, early detection and identification of higher risk patients for higher risk screening modalities. It will discuss the importance of these improvements for the patient, family and health care system. The model presented was developed through the collaboration of a breast care coordinator and family risk assessment nurse, but is applicable to other navigator focli and collaborative relationships.

O-50 DISTRESS IN CANCER PATIENTS.
Kathey R. Huey, RN, BSN, Lynn R. Marzinski, RN, MSN, AOCN, Lynne Connelly, PhD, RN. University of Kansas Cancer Center, Westwood, KS, USA.

The National Comprehensive Cancer Network has found that distress is a growing concern with this population of patients and has developed guidelines regarding distress. The goal of this retrospective descriptive correlation study is to describe the levels of distress that are experienced by those with a cancer diagnosis and to identify any connections linking distress levels and types of cancer, treatments and demographic data. Distress appears to be associated to quality of life, but is not the same concept. If not dealt with promptly, distress may have a negative effect of the patient’s overall well being. Over 6000 patients seen at the University of Kansas Hospital Cancer Center, between July ’07 – July ’08, received routine screenings to assess their level of distress using a tool called the Distress Management Scale. This tool is similar to the pain scale using a 0 to 10 scale to rank the level of distress. This scale was used to assess a combination of five areas that can contribute to distress: practical, relationship, emotional, spiritual and physical. Analysis of 400 patients with cancer is currently being performed. Preliminary results include an average distress score of 2.57 on a 0 to 10 scale for all patients. The average number of stressors was 5 with a range of 0 to 30. The analysis will also examine correlations among distress, age and gender. The results will assist nurses and other healthcare workers to ascertain the effects of distress in cancer patients receiving treatment or follow-up. The findings may lead to ideas for further research to include interventions to improve overall outcomes for this population of patients.

O-51 THE KNOWLEDGE OF BREAST SELF EXAMINATION AND BREAST CANCER AMONG WOMEN ATTENDING SCREENING SERVICES AT OCEAN ROAD CANCER INSTITUTE – TANZANIA
Rendo B. M. Bakari, IV. Ocean Road Cancer Institute, Dar es Salaam, Tanzania, United Republic of.

Introduction
In Tanzania, where breast cancer ranks number two after cancer of cervix, experience shows most women do not undergo breast examination, or stay long with painless lumps, only to present in hospitals where cancer is discovered. The aim of this study is to determine the knowledge of women in breast self examination and breast cancer from the fact that there is scarcity of information suggesting the magnitude of breast cancer and other breast conditions among women. However, the approaches for early detection through breast self examination (BSE) and breast clinical examination (BCE) are less practiced in the Health facilities and the community as a whole. The study aimed at finding out the proportion of women who knew about BSE, breast cancer and were practicing BSE.

Methodology
A cross sectional descriptive study design was used to collect data. The study was conducted in November 2006. Fifty (50) women aged 20-60 years attending ORCI for Cervical Cancer Screening were interviewed using structured questionnaires. The data was entered and analyzed using EPI – INFO software. All study participants had to consent before their inclusion into the study.

ROUNDTABLE SESSION A9
"MODELS OF CARE DELIVERY" (ROSWELL I)

2009-O-167-ICN
O-48 CANCER CARE NAVIGATORS AND RISK ASSESSMENT NURSES: TEAMED FOR SUCCESS
Jacqueline M. Allen, APN C, AOCN. Hunterdon Regional Cancer Center, Flemington, NJ, USA.

Nurses in cancer care remain committed to providing the highest quality care and patient / family education, while concurrently promoting cancer prevention and early detection. Nursing roles are becoming more specific and specialized. Oncology nurses become specialists in genetics, chemotherapy, radiation therapy, and navigation of care. While specializing, nurses continue to hold pivotal roles in all aspects of cancer care, from prevention through diagnosis, treatment and follow-up. Nurses are a key resource for the patient and for the family, whatever their specialty. Therefore, collaboration, communication, and an established referral process with their peers can support nurses in meeting this individual and professional commitment to quality care and their commitment to education for the patient and the family. Nurses can change immediate outcomes for the patient and longterm outcomes for the family. This roundtable will describe the development of a successful referral process and collaborative program relationship between a Breast Care Program and Family Risk Assessment Program in a community cancer center setting in the Northeast United States. The roundtable will highlight the complementary roles, referral patterns, and collaboration for improved care. It will present a model for using practices, performance improvement tools, data collection tools, tracking systems and staff education opportunities. It will describe how the promotion of the relationship between nurse navigators and risk assessment nurses can improve screening, early detection and identification of higher risk patients for higher risk screening modalities. It will discuss the importance of these improvements for the patient, family and health care system. The model presented was developed through the collaboration of a breast care coordinator and family risk assessment nurse, but is applicable to other navigator foci and collaborative relationships.

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ROUNDTABLE SESSION A9
"PREVENTION AND SCREENING" (ROSWELL I)
Results
The results show that 60.4% have no knowledge and 39.6% have little knowledge on BSE and Breast cancer. Among all studied participants 80% had never done BSE and only 20% had previous BSE done.

Discussion
Promotion of BSE, BCE and Breast cancer awareness in the country is important with the establishment of training programs to health workers on BSE and BCE. Integration of breast cancer screening programs at ORC I through collaboration with Ministry of Health to enhance early detection and treatment is crucial to be carried countrywide through this health information and knowledge transfer to all stakeholders and the public in general can be achieved cubing the social cultural barrier on different beliefs in cancer among Tanzanian communities.

O-52 SEXUAL REHABILITATION IN CANCER CARE: PART OF GOOD NURSING PRACTICE OR SPECIALIST INTERVENTION?

Danja Brandenburg, Lynne Dodson.
Pan Birmingham Cancer Network, Birmingham, United Kingdom.

Presentations (approx 30 mins)
- Cancer Nurse Guidance, examples around the world
- Obstacles to addressing sexuality in everyday nursing practice
- Specialist Sexual Rehabilitation Services & a combined model
- Facilitated Discussions (approx 60 mins):
  - What currently happens?
  - What Best Practice might look like?
  - What are first steps towards achieving this?

O-53 THE ELECTRONIC HEALTH RECORD AS A TOOL TO INTEGRATE ONCOLOGY PATIENT CARE

Denise Geuder1, Michelle Szolnicki, RN, BSN, MA2, Diane Dresler, RN, MBA, FACHE3.
1Cancer Treatment Centers of America, Tulsa, OK, USA, 2Cancer Treatment Centers of America, Philadelphia, PA, USA, 3Cancer Treatment Centers of America, Phoenix, AZ, USA.

The topic will be presented by Nursing Executives from each of the four sites of Cancer Treatment Centers of America (CTCA) a specific full-service provider of integrated oncology patient care. CTCA implemented a fully integrated patient care record in March of 2008 that includes inpatient and outpatient documentation, computerized provided order entry, chemotherapy and other oncology specific order sets and medication management modules. The nursing executives will address the various challenges and benefits of the electronic health record as a tool to improve oncology patient care.

O-54 DEVELOPMENT OF A COMMUNITY CANCER CENTER SURVIVORSHIP PROGRAM: TOOLS TO ENHANCE IMPLEMENTATION

Mary Ann Heddon, RN, MSN, Martha D. Griffin, RN, BSN, OCN, South Georgia Medical Center Valdosta, GA, USA.

While survivorship issues have been well documented for over 20 years, the adult survivorship movement has only gained traction in the last 5 years. As is true for all advances in cancer care, leadership for the movement comes primarily from academic centers, larger medical centers, and national oncology organizations. However, it has been estimated that 85% of cancer patients in the U.S. receive their care in community cancer centers. It is unclear whether the programs developed to meet the needs of patients receiving care at these larger institutions will readily translate to the smaller community cancer center. We believe it is important to develop a model survivorship program that can be implemented in the facilities charged with the responsibility of caring for the vast majority of survivors in the U.S. The shared care model is probably the most useful paradigm for managing chronic illnesses such as cancer in the community setting.

Primary care physicians share the responsibility of caring for long-term survivors with the oncologist, assuming a larger role as patients move further from completion of cancer therapy. This enables the specialist to focus on the more critical needs of newly diagnosed patients and those under treatment. The success of this model requires good communication between the oncologist and the primary care physician and provision of education to the primary care team on the expected persistent and long-term consequences of cancer therapy. To facilitate integration of this model in our region, we have developed a series of presentations and tools for cancer centers, and to a lesser extent, primary care practices. The materials have been assembled in a Survivorship Program Kit, which will be distributed to our regional community cancer centers. The kit contains the Institute of Medicine’s Lost in Transition video, PowerPoint presentations for education of cancer center staff, hospital administration, survivors, community physicians, and other health care providers; survivorship class curriculum and materials; a needs assessment for patients completing treatment to establish a baseline for survivorship; a survivorship care plan template; a brochure for patients and one for cancer center staff; budget guidelines; and tables that detail the late effects of chemotherapy and radiation in adults. We are also establishing a web forum for other developers of adult survivorship programs. The forum is designed to provide a meeting place for dialogue and exchange of ideas and educational materials. This is an opportunity to share our experience and tools with others who recognize the importance of survivorship care and to advance the long overdue care of patients completing treatment in community cancer centers. This effort was supported by the Southwest Georgia Cancer Coalition.

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Data from the initial phases are being analysed. Phase I involved 141 individuals with a personal or family history of cancer or huntington disease who are awaiting for genetic test results. A candidate scale was generated from literature review, expert feedback, and data from the 141 participants. Results from the Phase I data indicated that the revised 25 item GPRS scale has a high internal consistency (Cronbach's Alpha 0.8). Principal Component Analysis showed a four factor structure of this screening tool: Current mood (Eigenvalue 4.36, 15.8% variance), Perceived impact (Eigenvalue 2.54, 12.3% variance), Past cancer related trauma (Eigenvalue 1.77, 11.9% variance) and Work about children (Eigenvalue 1.67, 9.3% variance). Phase II validation of the GPRS is ongoing which includes screening and follow up of a separate sample of 600 individuals undergoing genetic testing, from 6 cancer centres across Canada. Of the 600 participants, 249 have received their genetic test results and completed follow-up. Initial analysis revealed that 17% reported ongoing sad feelings and worries, 6.2% scored above threshold for Hamilton Depression Scale and 11.2% for Hamilton Anxiety Scale. We will continue our follow up with the remaining participants and report the overall validity of the GPRS tool in identifying genetic testing related psychiatric distress at the conference. The implication for nurses working with oncology patients and their families will be discussed.

O-56 GENETICS ACTIVITIES IN PRACTICE - AN EVIDENCE BASED TOOL TO IDENTIFY INDIVIDUAL LEARNING NEEDS
Candy Cooley, Michelle Bishop, Peter Farnond.
National Genetics Education Centre, Birmingham, United Kingdom.

As the genetic cause of more cancer conditions are being identified, patients are increasingly seeking advice about the risk to other family members and the possibility of genetic testing. Cancer nurses in clinical settings are increasingly being asked for information by their patients with the expectation that they will have the relevant knowledge to understand and respond to these issues.

This paper will discuss the recognition of the importance across the UK’s National Health Service of a level of competence in genetics for cancer health care professionals, to ensure the quality of care for cancer patients. An evidence based tool has been developed based on the UK Workforce Competencies for non–genetic specialists to enable individuals to identify their personal learning needs. The Workforce Competencies include nine genetic activities (competencies) that cover the pathway of care for a patient with, or at risk of, a genetic condition and have been ratified as National Occupational Standards. These workforce competencies describe how and what activities should be carried out in clinical practice and the underpinning knowledge, skills and attributes required. While it is recognised that not all practitioners will need to cover the nine activities within their clinical practice, the development of this tool has allowed cancer nurses to recognise which of these genetic activities are relevant to their practice and to identify their individual learning needs. Cancer nurses can then work with their managers to ensure these genetic activities are imbedded within job descriptions and learning needs are addressed through service development to meet the needs of patients and families, and enhance overall patient care. We will also discuss the development of education initiatives to support learners and teachers to meet these identified learning needs.


O-57 WOMEN AND BREAST CANCER: FEMINIST APPROACHES TO GENETIC INFORMATION
Helen S. Mitchell, BSc (Hons) MA MSc DMedEth.
Christie Hospital, Manchester, United Kingdom.

41,000 women are diagnosed with breast cancer in the United Kingdom each year (Breast Cancer Care, 2006). 5–10% of these cases are considered to be caused by a genetic mutation, most often Breast Cancer 1 (BRCA 1) or a Breast Cancer 2 (BRCA2), which each confer a strong predisposition to breast cancer and to a lesser degree, ovarian cancer. The isolation of such genes has resulted in a perceived moral responsibility to access, disclose and disseminate information to other family members who may be affected. As breast cancer is statistically less common in men, with only 1–2% of the total number affected being male, one may legitimately regard this as a predominantly female condition which, as such, may benefit from a feminist perspective in examining the issues involved. Gilligan’s (1982) research in particular, supports the view that when women are faced with moral conflicts, they tend to focus on their caring commitments and responsibility towards others (an ethic of care), in contrast to men who, more frequently adopt a justice/rights based approach. This is particularly relevant to the field of genetics, where family relationships are an integral factor in disseminating information.

Ethical issues encountered in accessing genetic tests include insurance and employment discrimination, privacy, confidentiality, and the right to access, keep private or disseminate genetic information. How individual autonomy may impact on these issues will be considered and the view that a more ‘relational’ concept may be more appropriate, in particular, for women, will be considered.

O-58 TECH-GENA: DEVELOPING AN INNOVATIVE METHOD TO TEACH GENETICS TO NATIVE AMERICANS
Linda U. Krebs, PhD, RN, AOCN, FAAN, Linda Burhanstipanor, MPH, DrPH.
Native American Cancer Initiatives, Pine, CO, USA.

Based on the successful Genetic Education for Native Americans (GENA®) [NHGRI, HG01866], Tech–GENA is a Phase I SBIR (NCMHD, 1R43MD3053–01) designed to develop one prototype aspect of a Web and DVD–based curriculum to teach the basics of genetics to Native Americans. Using focus groups (FGs), Informant Interviews (Ils) and pilot tests (PTs), the goal was to develop an interactive, easy to use and understand genetic education module that could be specifically tailored for use by Native Americans of any tribe and all ages. The initial draft prototype, “What is a cell?” uses culturally acceptable images, analogies and explanations to describe the components of the cell and, when completed, will allow viewers to virtually and/or physically create a human cell using everyday household items.

Four FGs were held in diverse areas of the US (Utah, New Mexico, Washington and Michigan). Two IIs, in which Native Elders could individually share their opinions, followed each of the last three FGs. A total of 39 Native American adults (ages 18 to > 65) from more than 18 different tribes took part in the FGs and IIs. An audience response system (ARS) was used to collect anonymous demographic and opinion data. During the FGs and IIs, the prototype was reviewed via PowerPoint and then a series of questions was asked to generate discussion about the prototype’s use, format, flow, images, cultural appropriateness and cost. The prototype was revised following FGs I, II, and IV based on participant suggestions which included ways to make the prototype more understandable, useful, interactive and culturally appropriate. In addition, participants suggested modifications for use with different age groups and different tribes and/or regions as identified by the Indian Health Service. The final prototype was evaluated by 9 Natives through two pilot tests, one in Colorado (N=4) and one in Nebraska (N=5).

More than 90% of FG, II and PT participants felt the prototype curriculum would be of benefit to their communities and stated they would be willing to pay at least $10 for the product. They proposed the product be available via the Web and through DVD and FG and II participants suggested that a kit of “cell materials” be created for purchase so that a viewer could make the cell at home. All felt the prototype was culturally appropriate although suggestions were proposed to allow for individual tribe/region and age variations. Phase II SBIR funding will be sought to develop the prototype into a product, create interactivity and further evaluate marketing possibilities.

O-59 DEVELOPMENT OF A PSYCHO-EDUCATIONAL TELEPHONE (PET) INTERVENTION FOR MANAGING UNCERTAINTY FOR INDIVIDUALS WITH INCONCLUSIVE BRCA1/2 GENETIC TESTING RESULTS
Christine Mahieu, RN, PhD†, Mary Jane Esplen, RN, PhD†, Wendy Meschino, MD‡, Joanne Honeyford, RN, MSN§, Ingrid Ambus, MSC‡, Xin Gao, PhD†, †University Health Network, Toronto, ON, Canada, ¶North York General Hospital, Toronto, ON, Canada, §York University, Toronto, ON, Canada.

Title
Development of a psycho–educational telephone (PET) intervention for man-
aging uncertainty for individuals with inconclusive BRCA1/2 genetic testing results. Conceptualization of phenomenon: Current findings suggest that individuals receiving inconclusive results for breast cancer susceptibility (BRCA1/2 genetic testing) exhibit similar distress levels as individuals known to have a cancer mutation. Our proposed pilot study addresses an urgent need aimed at developing an intervention that focuses on the emotional and behavioral impact of receiving inconclusive result to enhance the comprehension of genetic testing experience of individuals and to promote optimal coping and screening behaviors.

Purpose

Develop, describe and standardize a psycho-educational telephone intervention for individuals with a personal and family history of breast cancer who test inconclusive for BRCA1/2 and to examine the impact of this intervention on pre- and post- intervention measures. The primary study outcomes will include psychosocial functioning and levels of uncertainty.

Research Method

Single-arm pilot study. Individuals are recruited from a hereditary cancer program in Toronto. Statistical analyses (ANOVA) will be employed to assess the differences and changes over time. Individuals are tested before and after they receive genetic testing, at three and twelve months after receiving the intervention. The intervention consists of pamphlet with a education CD followed by a one-time telephone intervention one month following receipt of pamphlet.

Results

Recruitment is ongoing. Descriptive data will be presented. Relevance of the project to breast cancer research- Our proposed research has direct implications for the development of new clinical genetic services and for improving the quality of life of breast cancer survivors.

O-60 FAMILY IMPACT OF PREDICTIVE GENETIC TESTING FOR HEREDITARY CANCER SYNDROMES

Patricia J. Friend1, Lauren Bowling, MS2, Marianne Huml, MS, APRN1.

1 Loyola University Chicago, Maywood, IL, USA, 2 Loyola University Medical Center, Maywood, IL, USA.

Genetic discoveries are advancing medicine, particularly cancer care. The ability to identify a genetic predisposition to cancer has prevention, screening, diagnostic, and therapeutic implications. To date, the greatest impact of genetic discovery across the cancer continuum has been in the area of hereditary cancer syndromes; in the ability to predict cancer risk or identify inherited susceptibility to certain cancers through genetic testing. Hereditary cancer risk is inherently a family issue that demands a family systems approach of inquiry and intervention, yet very little research has approached this area from a family perspective. As such, there is an urgent need to better understand the family experience of facing a hereditary increased risk for cancer. This retrospective, descriptive study will employ a convenience sample of individuals that have undergone genetic testing for gene mutation known to be associated with hereditary cancer risk, and their associated family members. This study, guided by the Family Systems Genetic Illness model (Rolland, 2005), as well as Olson’s Circumplex model of family functioning (2002), addresses the family’s experience of predictive genetic testing for increased cancer risk. Specific aims are as follows: 1) to describe the family’s experience of the testing process; 2) to assess family level of genetic literacy; 3) to assess family functioning (cohesion, flexibility and communication) and lastly, 4) to assess satisfaction with the counseling and testing process and ascertain areas for improvement. A semi-structured interview as well as reliable and valid instruments will be used to address the research aims (FACES IV, Genetic Counseling Satisfaction Scale, Openness to Discuss Hereditary Cancer in the Family Scale, Multidimensional Impact of Cancer Risk Assessment Questionnaire). Data analysis will include descriptive statistics as well as thematic analysis of the interviews. By knowing the acceptance, utilization and expectations of the cancer genetic testing process by families, as well as the challenges and opportunities for growth faced by families with hereditary cancer syndromes, a comprehensive model of longitudinal, family-centered care can be designed. Goals of care include: to clarify misconceptions about inherited cancer risk, increase genetic literacy, and promote optimal family functioning. Family members that are empowered by knowledge of genetic cancer risk may be more able to modify lifestyle and behavior as needed, engage in recommended cancer surveillance, or avail themselves of prevention options in order to modify cancer risk.

O-61 SO YOU ARE THE NURSE PRACTITIONER!

LYNNE A. PENTON, RN (EC) MN CON (C), CAROL HATCHER, RN MN.

William Osler Healthcare, Brampton, ON, Canada.

The Nurse Practitioner role has been developed since the 1960’s and yet in Ontario Canada is still mainly limited to family practice and academic teaching hospitals. In 2008 the College of Nurses of Ontario determined that Nurse Practitioner in all practice settings must successfully write a provincial exam and then be registered in the extended class with title protection. William Osler Healthcare in Brampton, Ontario is a multi site community hospital delivering cancer care to a population of over 450,000 people. The population is widely diverse culturally with a large percentage of South Asian patients and the out patient clinic has over 3300 visits per month. The in-patient oncology unit was the chosen practice area for the first ever nurse practitioner in this healthcare organization. The presentation will chronicle a brief history of the development of the nurse practitioner role in Ontario and describe the PEPPA framework (Bryant–Lukosius & Denson, 2004) and the STRONG Model (Mick & Ackerman, 2000) as it pertains to this successful implementation of oncology advanced practice nursing in an inpatient setting.

O-62 CANCER SPECIALIST NURSES ‘ONE SIZE DOES NOT FIT ALL’

Jon Burford, MSc MBA, Anne Sullivan, Peter Davies, Annie Young, Isabel Harrison.

3 counties cancer network, Gloucestershire, United Kingdom.

Specialist nursing roles in cancer care have within the UK attracted much interest, discussion and debate over recent times. The Cancer Reform Strategy (2007) highlights the worth of the Clinical Nurse Specialist (CNS) as keyworker, educationalist and clinical expert. The role has evolved over many years to encompass diagnostics, treatment and nurse led services. The subsequent effect of this has been a large investment of nurse time in the contribution to national and local performance targets. However anecdotal evidence has raised concerns as to the effect of this on clinical caseloads and available time of specialist nurses to provide supportive care. At a time of global economic turmoil affecting health care communities the need for an expanded evidence base around clinical outcomes in specialist nursing is paramount.

Lead nurses within the 3 Counties Cancer Network reviewed clinical caseloads of 41 nurse specialists across 10 areas of practice. The methodology comprised of face to face interviews with nurse specialists to review clinical caseloads. An additional indepth study of a lung Cancer Clinical Nurse Specialist revealed interesting data in respect to the impact of specialist practice at various points along the patient pathway. A weighting formula was designed to evidence this impact. This presentation details some key recommendations for the further development of clinical outcome measurement. The findings will find a global audience and can be translated across different health care communities.

O-63 MANAGEMENT OF FAMILIES AT RISK FOR BREAST AND OVARIAN CANCER. THE EUROPEAN INSTITUTE OF ONCOLOGY (IEO) EXPERIENCE

Irene Frerco, research nurse, Claudia Passoni, research nurse, Monica Banile, Geneticist, Alessandra Rossi, Secretary, Angela Maniscallo, secretary, Bernardo Bonanni, Director.

European Institute of Oncology, Milan, Italy.

The management of subjects at high risk for familial/hereditary predisposition is typically based on a multidisciplinary approach which should be maintained during time with a tailored follow up. The preventive measures should be modulated on each individual’s risk profile, age, health and attitude.
Currently in Italy the role of the nurse involved in the genetic counseling process is not yet established. However, there is a rising need for a professional figure to be included in this new area of clinical oncology. To fully meet all the needs of the patients and their families, in our Division of Cancer Prevention and Genetics at the IEO we use a multidisciplinary approach where all team members have a specific role in the patient’s pre and post counseling care. This team includes a nurse, a geneticist, an oncologist (expert in cancer treatment and prevention), a patient manager and a secretary. The team interacts on a regular basis with many other specialists according to a High Risk Clinic model.

The role of the nurse includes the submission and evaluation of a dedicated questionnaire and the collection of the relevant clinical documentation of the patient and family cancer cases. She starts the pedigree drawing and the risk assessment which is performed through the use of several statistical models (Gail, Claus, Couch, BRCAPRO) then, she discusses with the other members of the team the patient’s eligibility for either genetic or cancer prevention counseling, i.e. very high risk subjects are addressed to counseling with the geneticist and – when indicated – DNA testing, and subjects at intermediate risk to a prevention visit with the oncologist. The nurse has an active role during counselling sessions, including educational issues, psychological items, informed consent discussion, counselling on lifestyle changes (diet and physical activity) and various clinical aspects along follow-up and prevention treatments.

All subjects are offered a tailored surveillance and prevention plan, including: education for breast self examination, suggestion to modify life-style, clinical and instrumental examination (US, MRI, mammography, ducal lavage, transvaginal US), CA125 blood levels, the possibility to participate in clinical prevention trials. From Jan 2000 to May 2009, we evaluated 2,555 questionnaires, offered 1,200 genetic counselling sessions (970 performed) and 1,355 cancer prevention visits, and performed 730 DNA testings (137 BRCA1 and 135 BRCA2 mutations).

O-64 TOTALLY SMOKE FREE: A SUCCESSFUL HOSPITAL BASED MODEL OF SMOKING CESSATION FOR PATIENTS WITH CANCER
Ingrid Plueckhahn, RN. B. Health Sc., Grad Dip Cancer Nurse/PallCare.
Peter MacCallum Cancer Centre, Melbourne, Victoria, Australia.

Smoking is identified as a significant public health problem and the largest preventable cause of morbidity and mortality from a range of cardiovascular, respiratory diseases and multiple cancers amongst Australians. Smoking causes an estimated 16,000 deaths, contributing to 82% of all drug related deaths and over 142,500 hospital separations per annum (1). A review conducted of the literature validated the benefits of quitting smoking for the person with a cancer diagnosis in an acute cancer hospital. This pre-empted the initiative of a comprehensive smoking cessation programme including counselling and pharmacologic support which is extended to patients, staff and family members. To sustain a reduction in the burden of tobacco related disease, including protecting non smokers from environmental tobacco smoke, Peter MacCallum Cancer Centre became the first Melbourne metropolitan hospital to become Totally Smoke Free on World No Tobacco Day, 2007, leading a significant health promotion initiative. The process for this successful health initiative required a comprehensive plan, inclusion of key stakeholders and executive sponsorship.


O-65 CARING BEHAVIOURS IN CANCER NURSES IN ONE CANCER CENTRE
Virginia A. Gumley, MA BSc.
SKMCH & RC, Lahore, Pakistan.

This abstract outlines a small project carried out in one cancer centre with nurses undertaking a 2 year Part-Time Post Registered Diploma in Oncology Nursing (Number = 26) – in both the 1st and 2nd year of the programme during 2009. The aim was to expand their horizons and practice. The Diploma in Oncology Nursing programme, the Hospital Vision, Mission, Core Values and the Nursing Division Philosophy all emphasize the importance of holistic and compassionate care. However, despite this emphasis – feedback from patients and relatives through the hospital’s complaint system highlights that there is a gap and insensitive interactions between nurses, patients and relatives occur.

Education on the subject of caring was instituted and a “focus group” was initiated with the 1st and 2nd year students in an attempt to elicit their understanding of the concept from both a theoretical and practical perspective. The presentation will present the results of the “focus group” and identify the next step for the way forward.

References
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CONCURRENT SESSION B3
“CULTURAL AND SPIRITUAL CARE”
(PEACHTREE BALLROOM B)
CHAIR: CATHY GLENNON

O-66 SPIRITUAL NURSING AND THE MUSLIM TERMINAL PATIENT
Kassim Badarani, RN.
Al-Taj Organization, Arraba, Israel.

Muslims: worldwide every fifth person is a Muslim, a culturally diverse group, regionally dispersed, characterized by various degrees of religiosity. Islam is fast growing with a worldwide distribution and there is a marked increase of the prevalence of cancer in this community.

Islamic Views: The six major beliefs in Islam are: oneness of God; angels; books and prophets of God; Day of Judgment; divine decree and life after death. Muslims are encouraged to “seek treatment, for every illness for which God has made a cure,” and live by the teaching that “your body has a right over you.” Although, death is seen as inevitable, “no person can die except by Allah’s leave at an appointed time.” Muslims should “not wish for death for any harm befalls on him.” The Muslim doctor’s Oath states a doctor’s duty is “To protect human life in all stages and under all circumstances, doing my utmost to rescue it from death, malady, pain and anxiety.” The Islamic Sharia (law) rules are:
1. Obligatory – the five pillars: testimony of faith, prayers, fasting, almsgiving and pilgrimage;
2. Recommended – blood and organ donation, circumcision and human tissue bank;
3. Permitted – DNR order, withdrawal and withheld therapy, autopsy, reconstructive surgery, contraception and reproductive technology;
4. Discouraged – forced feeding, smoking and divorce;

Islam and Palliative Care: the palliative team should be responsive to religion when providing care, to ensure trust and ongoing patient cooperation. Islamic faith greatly alleviates suffering, especially when a patient is dying and, as well, there is community support as Muslims are encouraged to visit the sick and pray for them. The dying patients are expected to seek God’s help with patience and prayers. The Imam (cleric) plays a vital role and provides spiritual guidance during illness; prepares the body for burial; and encourages the grieving family to be calm because “the dead is tortured by the crying of the living.”

The Muslim patient understands that illness and suffering are part of life and death is part of a journey to meet God “every soul shall taste death”. Death is predetermined by God; therefore suicide and active euthanasia are condemned. Treatment is not obligatory when there is no hope of survival (passive euthanasia). When brain death occurs, switching off the life support equipment is permissible, but the patient should be provided with food, drink, and pain relief until death.

Conclusions
Awareness, sensitivity and respect of the Muslim patient’s values and beliefs are vital for effective, end-of-life, spiritual care.
Purpose
Little is available in the literature to address how uninsured, indigent men, specifically, Latinos, may use spirituality to cope with prostate cancer, its treatment and side effects. Therefore, the purpose of this study was to understand the perception of spirituality in dealing with treatment-related side effects among low-income, uninsured Latino men treated for prostate cancer.

Methods
Qualitative methods were used to describe perceptions of and reliance on spirituality among underserved Latino men within the context of treatment for prostate cancer. Sixty Latino men were interviewed about their experience with prostate cancer treatment. Transcripts were translated into English for analysis using grounded theory techniques. Emergent themes were verified and descriptive categories developed.

Results: Spirituality manifests as faith and trust in the men’s stories. The major commonality across transcripts was a process that involved the formation of an alliance of support. This alliance included God, doctors, and self and was preceded by the diagnosis and increased awareness of mortality. From the alliance of support men drew strength to manage the disease and its effects, maintained hope for the future, and found new existential meaning.

Conclusions
By recognizing the potential value of an alliance of support for low-income men with prostate cancer, health care professionals may tap into an empowering resource that is beneficial for some Latino men.

O-68 INFLUENCE OF SPIRITUALITY ON THE QUALITY OF LIFE OF CANCER PATIENTS: INTEGRATIVE LITERATURE REVIEW
Giselle P. Guerrero1, Manoel Antônio Santos, PhD2, Namie Okino Sawada, PhD, Associate Professor1
1University of São Paulo at Ribeirão Preto College of Nursing, Ribeirão Preto - São Paulo, Brazil. 2University of São Paulo at Ribeirão Preto Faculty of Philosophy, Science and Letters, Ribeirão Preto - São Paulo, Brazil.

The relation of spiritual questions with quality of life is more and more present in studies. An appropriate mediator of this domain and a better understanding of the subject by health professionals can facilitate the improvement of health interventions. This integrative literature review aimed to search for and assess the main results found in literature according to the order.

Table of Contents
- Knowledge, Attitude, and Practices of Physicians and Nurses in regard to Do-Not-Resuscitate Orders in the Cancer Institute of a Tertiary Hospital in the Philippines
- The Philippine health sector is abound with problems, from lack of policy and even lack of a medical malpractice law. Approximately 40 years behind, few studies have been conducted in the Philippines on end-of-life care. Yet as expected of a developing country, it has adopted Western practices, even when research has shown that the very meaning of death and dying of Filipino patients remains dissimilar.”

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O-69 A PHENOMENOLOGICAL INVESTIGATION OF THE MEANING OF FEMININITY TO IMMIGRANT LATINA WOMEN AT RISK FOR BREAST CANCER: A COLLABORATIVE CIVIC ENGAGEMENT RESEARCH PARTNERSHIP
Susan M. Neville, PhD, RN, Ellen Gree, PhD, OTR/L, LP.
New York Institute of Technology, Old Westbury, NY, USA.

The diagnosis of Breast Cancer is devastating for many women on many different levels. Women, their significant others and/or spouses are affected. This qualitative study presents the concepts supporting the meaning of femininity to Latina women and provides the foundation for three additional stages of the research, including empowerment workshops, education materials in Spanish, and wellness classes with Service Learning and Train-the-Trainer components. The incidence of Breast Cancer is rising globally and the importance of best practices in health promotion and risk reduction strategies in the early detection of a malignancy is emphasized in the literature. The review of the literature involving theories of culture and translation supports the concern for Latina women’s need for access to health care in relation to breast health and the connections between femininity, body image and mental health. However, the voice of Latina women on their perspective of femininity and how it may affect one’s identity in the face of breast cancer has not been studied. Women diagnosed with Breast Cancer need to have a clear sense of self related to femininity and personal power in order to evaluate options and make the best treatment decisions for themselves irrespective of external sources of influence. Cultural implications and prescribed roles for Latina women are strong influencing variables on how they perceive themselves in relation to spouse, significant other and family. Additionally, the resources for a woman, diagnosed with breast cancer may not be identifiable, available or accessible, especially to immigrant Latina Women. The ability to make the best decision for treatment for self, free from external sources of influence, is the long range outcome goal of this collaborative interdisciplinary initiative. The Brentwood/Bayshore Breast Cancer Coalition and Latina Health Initiative provided an established forum for all Latina Women at risk for having received a diagnosis of breast cancer. This support group helps its members facilitate day-to-day living with the diagnosis and treatment outcome. The findings of this study will contribute to the increasing body of evidenced based practice related to understanding the impact of a threat to body integrity related to breast cancer and the development of culturally based support and empowerment strategies for Latina women.

O-70 KNOWLEDGE, ATTITUDE, AND PRACTICES OF PHYSICIANS AND NURSES IN REGARD TO DO-NOT-RESUSCITATE ORDERS IN THE CANCER INSTITUTE OF A TERTIARY HOSPITAL IN THE PHILIPPINES
Bernard L. M. Karganilla, M.A. Public Administration, Mary Francine Krizia Bacalla Doyla, B.S. Nursing, Mary Francine Krizia Bacalla Doyla, B.S. Nursing, University of the Philippines Manila, Ermita, Manila, Philippines. Standard; Bacalla Daya, B.S.Nursing, Mari Francine Krizia Bacalla Daya, B.S.Nursing.

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O-70 KNOWLEDGE, ATTITUDE, AND PRACTICES OF PHYSICIANS AND NURSES IN REGARD TO DO-NOT-RESUSCITATE ORDERS IN THE CANCER INSTITUTE OF A TERTIARY HOSPITAL IN THE PHILIPPINES
Bernard L. M. Karganilla, M.A. Public Administration, Mary Francine Krizia Bacalla Doyla, B.S. Nursing, Mary Francine Krizia Bacalla Doyla, B.S. Nursing, University of the Philippines Manila, Ermita, Manila, Philippines. Standard; Bacalla Daya, B.S.Nursing, Mari Francine Krizia Bacalla Daya, B.S.Nursing.
TOBACCO use, increasing world-wide, is implicated in 30% of cancer deaths. Involvement in tobacco control is an essential professional obligation for oncology nurses globally. About 40 nurses from 20 different countries attended a pre-conference workshop at the 14th World Conference on Tobacco Or Health (WCTOH) in Mumbai, India, 2008. The purpose of the workshop was to facilitate national, international, and regional collaboration among nurses in order to promote an exchange of knowledge and experiences in tobacco control. A central focus of the workshop included discussion of the essential need for a global nursing and tobacco control network to facilitate communication and capacity building among nurses. Another purpose of the workshop was to increase nursing involvement in the World Health Organization Framework Convention for Tobacco Control (FCTC). Despite the fact that the nursing profession, 13 million strong, is the largest group of healthcare professionals worldwide, they are not adequately represented in policy efforts in tobacco control. This is especially relevant to the implementation of the FCTC. Article 14 where the potential for expanding treatment capacity is enormous, yet underutilized. Several of the workshop recommendations provide a perfect opportunity for the International Society of Nurses in Cancer Care (ISNCC) to provide leadership for the nursing community, especially for the global cancer nursing community.

Workshop discussions resulted in global and country-specific recommendations for ways to encourage nurses to become more involved in tobacco control efforts, strategies to facilitate smoke-free work-places, attempts to disseminate evidence-based smoking cessation methods, core competencies for nursing practice such that delivery tobacco dependence treatment is a standard for good nursing care, and methods to increase collaboration among international nursing and healthcare organizations. As was evident at this meeting, there are many nurses who are making a difference in tobacco control. Further discussions included strategies to reduce barriers to nursing involvement, including assisting nurses to become smoke-free role models, and dissemination of resources, including materials about Tobacco Free Nurses (www.tobaccofreenurses.org). At the next WCTOH we hope to share ISNCC’s tobacco control policy efforts.

Funding support: Global Tobacco Dependence Treatment Partnership, WCTOH we hope to share ISNCC’s tobacco control policy efforts. About Tobacco Free Nurses (www.tobaccofreenurses.org). At the next WCTOH we hope to share ISNCC’s tobacco control policy efforts.

CONCURRENT SESSION B4
“PREVENTION AND SCREENING” (PEACHTREE BALLROOM E)
CHAIR: BARBARA D. POWE

0-71 NURSES AND TOBACCO CONTROL: INTERNATIONAL COLLABORATION
Linda Sarna1, Stella A. Balbous, DPhH1, Marjorie Wells, PhD1.
1UCLA Los Angeles, CA, USA, 2Tobacco Policy International, San Francisco, CA, USA.

Objectives: To explore issues that 30-year old women have raised in focus group discussions (FGDs) as encouraging CCS attendance, with particular focus on aspects that are susceptible to intervention.

Methods
A stratified random sampling technique was used to recruit 30 year old women with varied CCS histories and results, through the population-based CCS registry in Stockholm, Sweden. Nine face-to-face FGDs and 30 internet-based FGDs were conducted with a total of 138 women. Qualitative analysis was inspired by interpretative description, to generate clinically relevant and useful data.

Results
In general, these women, regardless of screening history, expressed positive views about the CCS program as an existing service. They described a wide range of factors encompassing the entire screening trajectory from invitation through follow-up which could motivate young women to participate, and addressed the importance of social marketing. Many suggestions related to individualization of the CCS program, as well as to the need for women to better understand the relationship between human papilloma virus and cervical cancer.

Conclusions
These results are discussed in terms of the inherent tension between population-based public health initiatives and individually-oriented health care provision. Although many suggestions are already incorporated into the screening program, this information appears not to always reach women who need it. New research should test whether systematic information on HPV may provide a missing link in motivating young women to attend screening, and which of the approaches suggested here can serve to increase screening participation.

ORAL ABSTRACTS

O-73 A RANDOMIZED CONTROLLED TRIAL OF CERVICAL CANCER RISK AND HEALTH EDUCATION IN RELATIVES OF COLORECTAL CANCER PATIENTS
Mary Jane Esplen, RN, PhD1, Sarah Harrington, PhD2, Melyssa Aronson, MS, CCC2, Heidi Rothenmund, MS, CCC2, Kana Semotuk, MSc3, Bridget Fernandez, MD, FRCP, FCCM4, Elizabeth Dicks, RN, MS5, Sahil Weng, PhD6, "University Health Network, Toronto, ON, Canada, 2Behavioral Sciences and Health, University Health Network, Toronto, ON, Canada, 3Canada, 4Dr. Zane Cohen Digestive Diseases Clinical Research Centre, Mount Sinai Hospital, Toronto, ON, Canada, 5Memorial University of Newfoundland, St John’s, NL, Canada, 6‘de Souza Institute, Toronto, ON, Canada.

Colorectal cancer (CRC) is a leading cause of cancer death among Canadians. Adherence to screening recommendations is crucial for the prevention and early detection of CRC—ultimately leading to decreased mortality. Unfortunately, relatives of CRC patients often have insufficient knowledge on the CRC risk factors, carry misperceptions about CRC risk and symptoms and do not always engage in recommended screening.

This project examines the effectiveness of in person risk counseling in addressing the information needs of first degree relatives of CRC patients and improving their screening compliance. First degree relatives of CRC patients were recruited from the familial colorectal cancer registry in two Canadian provinces. A randomized controlled method was used comparing in person risk counseling with telephone counseling. Both were then compared with a control arm with written information only. A standardized manual based on clinical risk & genetic counseling practices was developed to ensure consistency in intervention. All participants were assessed at baseline and post intervention for their knowledge, risk comprehension, and intention to participate in CRC screening.

Results
A total of 205 participants were randomized into 1 of the 3 study arms and followed up for 1 year: 60 of them received in-person counseling, 69 telephone counseling, and 76 received written information only. Follow up results indicated that risk comprehension and knowledge improved immediately post intervention in both in-person and telephone counseling in a comparable manner. The control group also improved after receiving individually tailored written information. Despite the improvement, however, participants still overestimated their CRC risk post intervention and during the one year follow up. In terms of cancer worry, the anxiety level was reduced first in the in-person counseling arm, but at one year follow up, participants in telephone counseling and in control arm achieved similar distress reduction. The intention to participate in colorectal screening remained high before and after the intervention, no group difference was observed. Conclusion: In person counseling, telephone counseling and individualized written information are all effective methods, as shown in our study in assisting CRC families and their families living with cancer and cancer risk. The implication of the finding for oncology care such as cancer prevention, treatment and surveillance will be discussed.
Ireland has the highest mortality rate for colorectal cancer (CRC) in Western Europe, with over 900 people dying from the disease each year. Over the past 15 years, the incidence of CRC has increased by 20 percent. By 2020, the incidence of CRC is predicted to increase by another 20 percent. Over fifty percent of patients in Ireland are diagnosed with stage three or four CRC – the most advanced stage of the disease. Less than five percent of patients with stage four CRC survive for longer than five years. Furthermore, in summer 2008 a national cancer charity commissioned a CRC awareness survey of 1,000 adults which showed a stark lack of knowledge of the early signs and symptoms of CRC and the measures which can be taken to prevent this common cancer. For example one in three people cannot name one sign or symptom of CRC, and one in four people do not know factors which might increase their risk of developing the disease.

These alarming statistics highlighted the urgent need to increase the awareness of CRC, early warning signs and symptoms and the absolute necessity for early detection to improve survival. April 2009 was consequently designated Ireland’s first ever Bowel Cancer Awareness Month, and the national cancer charity launched a major, multi-faceted national campaign including an intensive broadcast, press, outdoor and online advertising campaign; free editorial; and the distribution of colorectal cancer awareness leaflets and posters to GPs and pharmacies across the country.

The primary objective of the campaign was to raise awareness of the signs and symptoms of CRC and to encourage people to discuss any concerns in confidence with a specialist cancer nurse by calling the freefone national cancer helpline, which is at the heart of the cancer information service. Throughout the campaign, the specialist cancer nurses received just over 1000 calls relating to CRC through the national cancer helpline. The vast majority of calls (789) were from individuals concerned about specific symptoms possibly indicative of bowel cancer. Following a discussion with the specialist cancer nurse, most of these callers were encouraged to see their GP.

Through the campaign advertising mediums, posters, leaflets and free editorial, the cancer charity also directed people to a dedicated website linked to the awareness campaign. This website received just under 20,000 visits throughout the campaign.

While the above indicators point towards a phenomenally successful awareness drive, the cancer charity has commissioned a follow-up study to the bowel cancer awareness survey carried out in Summer 2008 in order to comprehensively measure the impact and effectiveness of the campaign. Results are expected in mid-August 2009.

O-74 RAISING AWARENESS OF COLORECTAL CANCER:
THE ROLE OF A NURSE-LED CANCER INFORMATION SERVICE
Joan Kelly, RGN, RM, MSc...
Irish Cancer Society, Dublin, Ireland.

Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in Canada and the United States. CRC grows in a slow and predictable manner and is curable when diagnosed at an early stage. Yet, average risk individuals do not adequately participate in CRC screening. Current literature has examined the effect of individual values, beliefs, and attitudes on CRC screening behavior. Some researchers have also studied the effect of socioeconomic position, race and ethnicity on CRC screening. Research on breast cancer screening has established the positive role played by family in promoting screening in women. However, research has not examined the role of family in promoting CRC screening to average risk individuals.

This study explored the perceptions of physicians, patients, and their family members about the role of family in promoting regular fecal occult blood testing (FOBT) by average risk individuals. A convenience sample of primary care physicians (N=6), patients at average risk of CRC (N=10), and family members (N=8) was used to conduct in-depth face-to-face interviews. Data collection and analysis used the work of Van Manen (1990) as a guide, while the work of Thorne et al. (1997) was used to interpret and describe the findings. The analysis revealed seven common themes: a) Unappealing test; b) Fear of discovering cancer; c) Need for large-scale FOBT awareness initiative; d) Annual physical examination as a prerequisite; e) Take some responsibility; f) Acceptance of role of family; and g) Lack of open discussion about FOBT.

The study findings inform nurses and physicians that: a) FOBT is an unappealing test that is not openly discussed in casual conversations among the family members; b) fear of cancer inhibits individuals from FOBT and needs to be addressed while discussing and handing the FOBT kits to the patients; c) large scale public awareness initiatives are needed to create awareness about CRC screening and encourage open discussions about FOBT; d) annual physical examination by individuals and physician taking time to explain CRC and FOBT help patients to adhere to FOBT screening; e) the majority of participants did not see a role for family because FOBT is not a test that is openly discussed; and f) participants saw a role for family only when individuals need help and/or physicians seek help from the family member in order to maintain healthy habits or to sustain FOBT screening behavior.

O-75 FAMILY AS A PARTNER IN PROMOTING PATIENT PARTICIPATION IN COLORECTAL CANCER SCREENING: EXPLORING THE PERCEPTIONS OF PHYSICIANS, PATIENTS, AND FAMILY MEMBERS
Sunita Bapuji, BN.
University of Manitoba, Winnipeg, MB, Canada.

Breast cancer is a very common form of cancer amongst women in Israel. Every year, approximately 4,000 women are tested positive for breast cancer and registered data of cancer in the nation in Israel testify that one in eight Jewish women and one in 22 Arab women are hit with this illness in the course of their lifetime.

In the State of Israel, a system for the detection through mammography operates since 1996, one which systematically examines the general population of women between the ages of 50–74. Despite the program, the response for carrying out the test is relatively low and reaches only 64 percent.

In the year of 2007, a program for the implementation of “Model Stage 3” was executed among primary clinics in the center region – from which the percentage of implementation of the test was significantly lower as compared with the rest of the country. Objective Increasing the rate of women that carry out the mammography test within the age range of 50–74.

The Program for Societal Intervention Identifying and mapping clinics in which the rate of carrying out the examination is lower than the national goal (75%).

Model of Three Stages
Was developed by oncology nurse, composed of three main phases: the doctor, the nurse, and the administrator.

For every stage there is a role in the process: the doctor recommends and explains the examinations, the nurse takes care of obstructions and lowers oppositions that are related to the exam, and the office sets a date according to the preference of the woman. The woman is referred from the doctor to the nurse and from the nurse to the office and every stage raises the chances of the execution of the mammography.

Outcomes at the end of the first year:

Clincs within which the intervention was implemented, a rise of 19 percent was seen as compared with clinics that did not implement the model – where the rise was only 6 percent.

Outcomes at the end of the second year:
The first clinics within which the intervention was implemented, maintained a gain in the second year as well and saw a rise of 17 percent versus 9 percent in the clinics that did not implement the intervention. Another five primary care clinics were brought into the program and at the end of a half a year, all of them saw a nice rise that ranged between 8 and 10 percent.

In the year of 2007, in the beginning of the intervention, the percentage of implementation of the examination in the center region was 56 versus 58 percent in the entire country.

In 2009, the outcomes tipped and the percentage of execution of the mammography in the center region was 67 percent versus 64 percent in the remainder of the country.
O-77 AN INNOVATIVE MODEL OF CARE FOR AMBULATORY ONCOLOGY NURSING

Kendra-Ann I. Seenandan, BN, RN

The current oncology nursing ambulatory care delivery model was reviewed in order to 1) identify an evidence-based model of nursing practice to meet patient needs, and 2) re-organize practice within an interdisciplinary, academic cancer care centre. Using an iterative process of stakeholder engagement, steering committee guidance and consultation, the outcomes identified included a patient-centered oncology nursing delivery model to improve nursing care management, patient outcomes, and patient and family satisfaction.

Phase 1: Stakeholders (oncology nurses, oncologists, educators, radiation therapists, administrators, etc.) interviewed agreed on the following goals of an effective care model: a safe model of nursing care that prevents hospitalizations; education of patients as a priority; professional, reliable assessment for patient care; translation of treatment plans to patients and families; and nurses spending more time with new patients to facilitate the patients’ control, reduce confusion, and increase understanding. Phase 2: While primary nurses were skilled, enthusiastic, dedicated and motivated to make a difference for their patients, the following could be improved to allow them to work to full scope of specialized oncology nursing practice: redundancy, rework, gaps, and duplication in nurses’ work, continuity of care, amount of paperwork, non-nursing work, and interdependent/independent nursing roles.

Recommendations for change were identified for the centre as a whole, the patients, and nurses. Specifically, the recommendations included group chemo teaching, nurse-run assessment clinics, education of patients as a priority; professional, reliable assessment for patient care; translation of treatment plans to patients and families; and nurses spending more time with new patients to facilitate the patients’ control, reduce confusion, and increase understanding.

The Dynamic Nursing Care Model (DNCM) is a conceptual framework which serves as a roadmap to describe nursing practice at Roswell Park Cancer Institute. The overarching framework of the DNCM supports different epistemological views (e.g., objectivism, constructionism, and subjectivism) and subsequent theoretical perspectives in the approach to knowledge acquisition and knowledge application to nursing practice and cancer care.

The Dynamic Nursing Care Model (DNCM) is a conceptual framework which serves as a roadmap to describe nursing practice at Roswell Park Cancer Institute. The overarching framework of the DNCM supports different epistemological views (e.g., objectivism, constructionism, and subjectivism) and subsequent theoretical perspectives in the approach to knowledge acquisition and knowledge application to nursing practice and cancer care. The essential elements of the DNCM framework illustrate the integration of six key values that nursing shares with the organization to support optimum cancer care. Innovation promotes a health care delivery system that curbs and comforts, research that informs the world and education that enlightens and enables future generations. Compassion and respect are enriched by the diverse cultures, needs, and expectations of our coworkers and the communities that we serve. Integrity is the commitment to making each decision whether related to patient care, research, education or administration based on standards that are thoughtful, informed, honest, transparent when appropriate and always respectful of privacy. Commitment is demonstrated in the devotion to achieving extraordinary progress on behalf of those we serve. Teamwork is valuing viewpoints and constructive opinions of all people and disciplines and recognition of all contributions that strengthen the results that we achieve.

The Dynamic Nursing Care Model conceptualizes essential components of patient and family-centered care that is significant to nursing practice and health care delivery. In the continuum of cancer care the application of DNCM together with the nursing care delivery system varies by patient acuity, specialty, staffing, and by inpatient unit and ambulatory center. Nursing practice expertise, evidence-based practice, professional growth and development, workforce/governance, and customer service are key components which influence patient/family/community outcomes, outcome measures, quality indicators, implementation, and evaluation of care.

The Dynamic Nursing Care Model embraces the mission, vision, philosophy, and values of Roswell Park Cancer Institute and nursing practice in a fluid yet dynamic approach to cancer care. This dynamic approach or “roadmap” to excellence in care is designed to meet the specific needs of each individual or groups within each unit/center or community setting. The DNCM empowers nurses to provide expert holistic and ethical care through self-governing nursing practice that is vital to provide reliable, focused, and safe cancer care.

O-80 CONNECT AND BEYOND

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Due to increased prevalence rates of cancer and improved 5 year survival rates an increasing number of cancer patients are living through and beyond a cancer diagnosis. For many the diagnosis treatment and subsequent follow up carry with them significant psychological physical and social sequelae. One avenue for meeting these significant psychosocial needs is through peer support programs. The Cancer Council Connect (CCC) program in NSW Australia has been providing peer support (initially for women with breast cancer) for over 30 years, it now provides peer support for 10 different cancer types. The CCC program has evolved significantly since its inception in response to the changing needs of newly diagnosed patients. Trained volunteers who have had cancer are linked by telephone to newly diagnosed cancer patients. Consideration such as age, gender, marital status and treatment are given careful consideration when matching clients. An Evaluation of the program was conducted on 2008 to examine the clients and volunteer’s experiences of the CCC programme; particularly focusing on satisfaction and to the extent the service met the client’s needs and expectations. The focus for volunteers was satisfaction with training and the interactions with the CCC staff. A total of 86 clients and 65 volunteers completed a Computer Assisted Telephone Interview. Respondents, who during the interview, expressed dissatisfaction with their involvement with the program, were recruited into an in-depth semi-structured telephone interview about their experience. Overall the survey revealed a high degree of client satisfaction with the CCC program reflected in 97% reporting that they would recommend the program to others diagnosed with cancer. Similarly volunteers reported a high degree of client satisfaction with the program.
of satisfaction with their role and reported feeling well supported by CCC staff, however, almost half felt underutilised and keen to have more matches. The recommendations from this evaluation are being used to implement targeted volunteer and client policies and procedures to further enhance service delivery.

O-81 DELIVERING CANCER AND PALLIATIVE CARE BY MEANS OF A COMMUNITY OF PRACTICE
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The Adelaide Tambo School of Nursing Science in Tshwane, South Africa was one of four winners of a grant to improve the health of South Africans through the transformation of nursing scholarship. The School selected a Community of Practice (CoP) model to create unique learning opportunities for both pre-registration and post-registration nursing students through service delivery. A cancer CoP as well as a palliative CoP form part of the greater project. Cervical and breast cancer and Kaposi sarcoma screening as well as palliative care are rendered by means of mobile clinics to a specific community. Members of this impoverished community live in a semi-formal settlement where employment and social problems are rife. The creation of this project with its pain and pleasure, screening methods and the palliative care needs of the community will be discussed.

O-82 ENHANCING ACCESS TO CHEMOTHERAPY PROTOCOLS: DEVELOPMENT, IMPLEMENTATION, AND DEMONSTRATION OF A FREE CHEMOTHERAPY ORDERS MANAGEMENT WEBSITE
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Oncology nurses and other health care providers in community settings across the globe struggle with the ever-increasing complexity of cancer management and the delivery of standardized, evidence-based patient care. Despite a wealth of published guidelines and chemotherapy protocols, there continues to be a great deal of inconsistencies in oncology care delivery. Community practices frequently do not have easy access to the latest chemotherapy protocols. A large private oncology practice in the Southeast United States recognized the need for easier access and sought to enhance the availability of standardized, evidence-based chemotherapy protocols and patient education materials to the oncology community through a no-cost website (“ChemOders.com”). The purpose of this presentation is to describe the development, implementation and maintenance of the website and demonstrate its current utility for oncology nurses throughout the US and internationally.

The speakers are both oncology nurses who assist in the creation and ongoing maintenance of the website. The website allows for the printing of disease specific chemotherapy protocols and order forms, chemotherapy administration flow sheets, informed consents, and patient education materials. All protocols are reviewed and approved by a group of oncologists, pharmacists and oncology nurses. The chemotherapy protocols adhere strictly to published dose, schedule and administration guidelines, with references provided. Currently, oncology practices in all 50 states of the US and 17 countries have accessed protocols, totaling >18,000 protocols. The speakers will conduct an exploration of the website and demonstrate its features. Applicability to nurses will be discussed, with an opportunity for questions.

O-83 LIVING WITH BREAST CANCER, A LEBANESE EXPERIENCE
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Aim
The purpose of this qualitative phenomenological study is to provide in-depth understanding of the experiences of Lebanese women living with breast cancer.

Background
Breast cancer is the most frequently diagnosed cancer in women worldwide. In Lebanon, a country of 4 million people, breast cancer is as well the most widespread type of cancer among Lebanese women. The meaning of cancer diagnosis, the meaning of childbearing and femininity all have cultural bases in Lebanon. The international literature lacks information on how Lebanese women live with breast cancer when compared with women of other cultures.

Method
The study followed purposeful sampling and saturation principles in which 10 participants with a mean age of 51.3 years were chosen based on their actual knowledge of the phenomenon, and their readiness to share that knowledge. Data were collected between December 2007 and May 2008. All interviews were audio taped and transcribed verbatim. Data were analyzed based on the Utrecht School of Phenomenology.

Findings: Four major core themes describing the participants’ lived experience emerged from the interviews: Living with losses; living with guilt feeling; living with fears and uncertainty; Living with the need to know and to share that knowledge.

Conclusion
The experience of Lebanese women with breast cancer revealed distinctive themes not reported by other women from other cultures. The results of this study challenge health care providers and educators to be aware of the difficulties that Lebanese women are facing when they are living with breast cancer.

Keywords
Breast cancer, nursing, qualitative, women, Utrecht School, in depth interviews.

O-84 HOW MUCH BLOOD IS ENOUGH? AN EVIDENCE BASED REVIEW ON THE MINIMUM BLOOD VOLUME REQUIRED FOR LABORATORY TESTS.
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Frequent blood sampling for laboratory testing can be an unnecessary source of blood loss in the critically ill oncology patient. The increased number of analytes measured combined with increased frequency in testing and easier collection with arterial and venous catheters can directly lead to iatrogenic anemia.

As critical care oncology nurses we recognized our role in performing the majority of these tests. We wanted to seek preventive strategies to minimize excessive blood loss and decrease the patient’s risk for anemia.

An evidence based review of the literature was conducted to examine what is the minimum blood volume required to run selected lab tests. A total of 26 articles from CINAHL, PubMed, MEDLINE, Google, COCHRANE REVIEW and Evidence Matters were reviewed. There were a limited number of meta-analysis, randomized experimental design, quasi-experimental and non-experimental studies related to blood conserving mechanisms. Expert opinions and guidelines were evaluated. Committee members from the PACU and ICU ranked the evidence based on the Stetler Model.

Evidence supports using smaller volume vacuum collection tubes for
specified laboratory tests such as troponin and BMP. The committee concluded that blood volume needed for all our chemistry tests in our departments could be reduced by half. In PACU and ICU this lead to the use of the smaller plastic 4ml tubes versus the larger 8ml glass tubes. In addition to the safety benefit, smaller tubes are less likely to cause hemolysis of samples due to less vacuum. Limitations consisted of restriction to critical care areas due to the excessive number of “add on” tests on the inpatient units.

After the implementation of smaller blood tubes, we were interested to see if the changes had any other impact on our patients such as the amount of blood drawn. Volume saved, and evaluated this outcome through laboratory test reviews. Twenty adult patients were randomly chosen from the intensive care unit population. It was determined that a total of 375 tests required a red top tube. Red topped tubes require 10milliliters of blood. The number of tubes was multiplied by the volume of blood collected. The amount of blood drawn from red topped tubes for the twenty patients was 3,750 milliliters for the week. In contrast, the newly implemented gold topped tube held 3.5 milliliters. The number of tubes was multiplied by the volume of the blood collected, 375 times 3.5 is 1,312.5 milliliters. Therefore by converting to the smaller gold topped tubes, a total of 2,437.5 milliliters of blood were saved. The data reflected that using smaller blood tubes had a significant impact.

O-85 PATIENT-CENTERED OUTCOMES IN CANCER: REACHING CONSENSUS ON A CORE SET OF MONITORING CLINICAL CARE QUALITY
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Significant advances have been made in the treatment of cancer with improvement in survival and mortality outcomes. In spite of this progress individuals with cancer report difficulty accessing the information and psychosocial resources they need to minimize the adverse physical and psychosocial consequences of cancer. While tracking survival and mortality rates is fundamental to monitoring the quality of cancer care, there is also a need to monitor whether the clinical care provided by the interdisciplinary team is of high quality and able to improve patient experience of cancer (and their families). Patient-centered outcomes are defined as those that matter to the patient and include physical, emotional, and social health and related dimensions such as effective coping and sexual health. This paper will present the findings of an extensive scoping review of the literature that examined conceptual definitions and psychometric quality of outcome measures that could capture health domains (physical, emotional, social) and related dimensions and could be used to stimulate quality improvement in interdisciplinary cancer care delivery. We used an integrated knowledge translation approach that included survivors in partnership with researchers and leaders of national organizations to reach consensus on a core set of patient-centered domains and outcomes measures using a modified RAND appropriateness methodology. The findings of the consensus process and the endorsed set of core outcome measures for monitoring the quality of clinical cancer care will be presented in this paper.

O-86 ONCOLOGY EDUCATION & PRACTICE COUNCIL: A CREATIVE MODEL FOR MULTI-SYSTEM COLLABORATION AND BEST PRACTICE
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In this era of diminishing healthcare resources, the clinical oncology leadership of one large Midwestern United States healthcare system has developed a successful, cost effective model for delivering quality oncology nursing education and best practice across the enterprise. In response to a need to educate large numbers of oncology nurses across the system in chemotherapy and biotherapy administration, a group of clinical oncology leaders from 9 institutions came together to formulate a strategic plan despite limited financial support. They solicited funding from pharmaceutical companies and partnered with the Oncology Nursing Society to become ONS Chemotherapy/Biotherapy Course trainers through a special instructional offering at a local institution. They then developed a unique system of rotating coordination of the ONS course as well as sharing the teaching responsibilities. To date, the group has educated over 275 clinicians in chemotherapy and biotherapy administration standards, as well as presented an OCN Certification Review course to over 130 participants. As the group evolved into an Oncology Education and Practice Council, it developed a mission statement, goals, strategic plan, and structure with future plans to solidify its administrative foundation. Besides the pooling of expert resources and diverse talents, other outcomes of this collaborative council have included: networking and strengthening ties between community and tertiary centers; mentoring and development of leadership; development of an integrative evidence-based nursing foundation for standardizing oncology practice; establishing oncology nursing competency standards; development of position papers to guide practice with key clinical issues; creating an educational DVD and guide for patients first receiving chemotherapy or biotherapy; and expanding educational opportunities for staff in genetics, end of life care, and oncology basics for Nursing Assistants. The OEC model reinforces the value of oncology nurses collaboratively pooling resources and finding creative, cost-effective solutions to enhance oncology education and practice across a large healthcare system.

O-87 A COMPARISON OF ONCOLOGY PATIENTS’ AND NURSES’ PERCEPTIONS OF CARE
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Caring is a concept adopted in the early 1800s by Florence Nightingale. Since that time, it is generally acknowledged that the concept of caring is central to the practice of nursing. There are differing findings in the literature as to how patients and nurses actually perceive caring. Recent focus on patient-centered care highlights the importance of viewing caring from the patient’s perspective. The Institute of Medicine (IOM), chartered by the United States government as an independent advisor to improve the nation’s health, in its report Crossing the Quality Chasm defined patient-centered care as care in which treatment recommendations and decisions are respectful of and responsive to patients’ preferences, values, and beliefs. Focus on patient-centered care requires adaptation to patient perceptions. True patient-centered care then requires congruency in patients’ and nurses’ perceptions of care. A comparative descriptive cross-sectional study was conducted to determine if there was a difference in oncology patients’ and nurses’ perceptions of caring. The Caring Behaviors Inventory (CBI), based on Watson’s Theory of Human Caring, was administered to 207 patients and 216 nurses on inpatient units of a rural tertiary care hospital. This paper reports on a subset of 19 patients and 15 nurses from the oncology unit. The CBI measures caring words and phrases on a 3-point scale: 1 = rarely; 2 = sometimes; and 3 = often. The non-parametric Mann-Whitney U test was used to compare responses. Both nurses and patients rated nurses fairly high on caring behaviors. There were significant differences between patients’ and nurses’ perceptions on overall caring and on several individual behaviors including knowing how to give treatments, responding quickly to call, checking on a patient, and managing pain. Nurses’ caring was rated high by both groups on being pleasant, protecting privacy, and watching out for safety. Patients and nurses rated nurses’ caring low on concepts considered key in oncology including spirituality, assisting with decision making and appreciating a patient’s life story. Nurses cited time and staffing constraints as impediments to their providing care. Focus on patient-centered care needs to be a consideration in any policy decisions regarding nurse–patient staffing. To truly meet the concept of patient-centered care it is necessary to adapt to the patient’s perception of caring by developing innovative approaches to providing nursing care.

O-88 THE PROJECT TO REDUCE THE INFECTION RATE OF IMPLANTABLE VASCULAR ACCESS DEVICES IN THE ONCOLOGY UNIT OF A MEDICAL CENTER IN THE EASTERN TAIWAN
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Implantable Vascular Access Devices (IVADs) have used for patients with cancer for more than 20 years. Although IVADs are common, they give microorganisms easy entry into the bloodstream infection and cause serious infection. IVAD-related infection is not only a dangerous complication for cancer patients but also a costly one. The purpose of the project was to re-

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In 2008, a group of oncology nurses conducted a project to explore the Afro-Caribbean community's attitudes and behaviors regarding cancer screening. The first stage of the project involved a survey, which used a cross-sectional sample of Afro-Caribbean adults living in Toronto, and focused on cancer screening for four common cancers, breast, prostate, cervical, and colorectal cancers. Analysis of the survey results revealed the following influences that impacted on their utilization of cancer screening. These were identified as: lack of knowledge and awareness, fear and embarrassment, the approach of health care providers, the need for culturally sensitive community-based education, and the role of family physicians and other health care providers in cancer screening.

A second stage qualitative descriptive methodology was used to further examine the survey findings. Focus groups composed of Afro-Caribbeans were formed to seek depth and clarity regarding the initial results. The group shared their unique perspectives related to: current and desired screening practices, strategies for developing culturally sensitive education, and opportunities to forge community bonds with health care providers for the purpose of improving screening for cancer. The study findings will be used to develop culturally sensitive education related to cancer screening opportunities with support and involvement of the Afro-Caribbean community. Further research would then focus on the effectiveness of community-based education and support strategies in enabling the community to take advantage of cancer screening.
O-92 CERVICAL SCREENING IN TSHWANE SOUTH AFRICA: WOMEN’S KNOWLEDGE OF CERVICAL CANCER, ACCEPTANCE OF VIA AND PRACTICAL LESSONS LEARNED

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Cervical cancer is a global health problem and the most common cancer in women living in sub-Saharan Africa. Various barriers to cervical screening have been identified. These include cytology based screening. Cervical screening by means of visual inspection with 3% to 5% acetic acid (VIA) can be implemented in a wide range of settings as no laboratory processing is required. This study was a pilot study to determine the knowledge of women, employed by one institution in Tshwane, regarding cervical cancer, whether VIA screening would be acceptable, what the results of such screening would be as well as the practical lessons that could be learnt to improve the screening process. The research study was an exploratory, descriptive and contextual survey. The sampling method was convenient (n=31). Data were gathered by means of self-report using a structured interview. The results of the screening were documented on a clinical record. The study provides evidence that VIA screening was acceptable to women. However the knowledge of women, despite having a higher level of education, was low. Although one of the participants was VIA positive, none was VIA positive / invasive cancer. Lessons learnt inter alia were that the number of women that could be screened in a given time should not be underestimated and that clinical breast examination should be part of a cervical screening campaigns.

O-93 PERCEIVED BARRIERS TO CERVICAL CANCER SCREENING AMONG WOMEN OF NEWFOUNDLAND & LABRADOR (NL)

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Problem
Despite the known benefits of the Pap smear, self-reports from women in national and provincial surveys suggest that many eligible women are not screened regularly. In NL participation rates are significantly lower than similar rates. Despite widespread screening, a provincial cytology registry and an organized screening program, NL cervical cancer incidence and mortality rates have increased whereas national rates have declined. It is estimated that 25 new cases of cervical cancer will be diagnosed this year in NL and 10 of those women will die from the disease.

Purpose
To improve screening rates among women in NL, it is imperative that health professionals understand women’s reasons for non-adherence. Our research team considered the barriers women of NL were experiencing related to accessing cervical screening. The research is focused on examining reasons associated with failure to avail of regular screening among women who have been diagnosed with invasive cervical cancer. The researchers felt that this population of women could provide a richer appreciation of the importance of screening. Specific education and recruitment strategies can then be designed to appropriately target women’s perceived barriers.

Methodology
A two-phase research study was designed. A qualitative phenomenological approach has been utilized to obtain an in-depth understanding of individual women’s perceptions, beliefs and attitudes associated with cervical screening, reasons for avoiding screening and personal insight of how to improve the experience of screening. A thematic analysis of this data provided the research team with direction and a framework to design a quantitative questionnaire to utilize in phase 2. In phase 2 researchers distributed a questionnaire to all women identified as having a diagnosis of invasive cervical cancer in NL, who meet the studies inclusion criteria and who did not participate in phase 1.

Data Analysis
Data analysis of the qualitative data has revealed six main themes and seven recommendations. Themes include: STI association, sexual connotation, dehumanization & confidentiality, feeling of being rushed, birth control association, and seriousness of Pap smear screening. The seven recommendations include: regular women’s health clinics, health promotion, sexual health, recall system, open discussion in families, increased professionalism in health care workers and a less rushed approach.

Conclusion
Upon completion of phase 2, the researchers anticipate the results will benefit health providers in NL by encouraging them to develop recruitment strategies that may assist in eliminating perceived stigmas, offer more time to women who fear the procedure and reach those who need screening but are most resistant. Conclusion of phase 2 is anticipated in the fall of 2009.

O-94 DEVELOPING AND EVALUATING A CANCER EDUCATION PROGRAMME IN COLLABORATION WITH AND FOR YOUNG PEOPLE

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The consequences of cancer treatment can be reduced substantially by reducing the incidence of cancer (prevention), early detection and in educating the population regarding the impact that cancer can have on the lives of those affected by cancer and their carers.

A project has recently been established by individuals from the local Cancer Centre, Macmillan Cancer Relief and the Healthy Communities Collaborative in collaboration with a local high school, with the aim of developing a cancer focused educational initiative which reflects the needs of local young people. An initial focus group with 7 young people of various ages was used to establish what information they / their peers would like regarding cancer (responses included what is cancer, what causes cancer, what are the signs and symptoms, what is it like to have cancer) and how they would like education session delivered (responses included the requirement for session to be practical and interesting, not lectures, not delivered by teachers, an opportunity to speak to people preferably in their 20’s / 30’s who had had cancer and perhaps with visible signs of their disease / treatment, etc).

This information and ongoing involvement from the focus group / class and teachers is being used to plan and implement a bespoke event which we are proposing to deliver to students (age 15 / 16 yrs) later this year.

Various aspects of the project are being evaluated throughout and the author is proposing to develop a research project to establish if a cancer education initiative developed in collaboration with young people in one school could be applicable to young people across a cancer network AND would such an initiative influence the young person (their families) adoption of healthy living behaviors / actions (short and long term), increase early cancer detection rates (within the local area) and positively influence young peoples perceptions of people who have / have had cancer.

If positively evaluated this could result in the development of a young person’s cancer education resource which could be adopted locally and nationally. Various resources could also be used and developed for other population subgroups e.g. the survivorship element could be developed for us with young carers.

Reference
is to longitudinally examine and identify predictors of the symptom experience in cancer patients undergoing HSCT. METHODS: A prospective, longitudinal design was used in this multi-site study in the United States that is part of a larger randomized controlled trial (evaluating the effects of a behavioral nursing intervention). For this study, we will analyze data from the usual care control group only (n=80). Data were collected at four time points: baseline, 7 days post stem cell infusion, day of discharge, and 45 days post stem cell infusion (approximately one month post hospitalization). The Symptom Experience Scale (Samarel et al.) was administered by trained interviewers. Clinical data were obtained by medical record abstraction. Data collection is nearing completion and analysis will be completed by December 2009. Multiple regression procedures will assess possible predictors (age, cancer diagnosis [lymphoma vs. multiple myeloma], and number of co-morbid health conditions) on cancer-related symptoms (individual symptoms and overall symptom distress) over time. IMPLICATIONS: Findings from this study can inform oncology clinical practice and research. Through the identification of HSCT patients who are most vulnerable and at risk of developing severe symptoms, early interventions and vigilant assessments by nurses may minimize complications and promote quality of life.

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O-96 EXERCISE IN PATIENTS RECEIVING INTENSIVE CANCER THERAPY
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Problem
Patients receiving hematopoietic stem cell transplantation (HSCT) experience considerable reductions in physical activity and deterioration of their health status due to intensive cancer therapy. Strength training has been identified as a potential intervention, although limited information is available to evaluate its use following HSCT. The purpose of this pilot study was to test the effects of strength training compared to usual activity on physical activity, muscle strength, fatigue, health status perceptions, and quality of life following HSCT.

Conceptual Framework
The Revised Wilson and Cleary Conceptual Model of Patient Outcomes guided the study.

Methods
Twenty-two patients scheduled to undergo HSCT agreed to participate in this two-group, randomized controlled study. The strength training intervention included a comprehensive program of progressive resistance to strengthen the upper body, lower body, and abdominal muscles using elastic resistance bands. Usual activity was defined as the standard recommendations for rest, activity, and exercise as advised by the subject’s attending physician. The strength training intervention was introduced in the hospital and continued for six weeks following discharge from the hospital. Dependent variables included physical activity, muscle strength, fatigue, health status perceptions, and quality of life. Variables were measured prior to admission to the hospital for HSCT, day 8 following HSCT, and six weeks following discharge from the hospital. Analysis: Split-plot ANOVAs were used to examine differences between groups, over time, and the interaction effect.

Results
Significant time effects were noted for many variables with anticipated declines in physical activity, muscle strength, fatigue, and health status perceptions immediately after HSCT and subsequent improvements six weeks following hospital discharge. One group effect was noted with subjects in the exercise group reporting less fatigue than subjects in the control group. Although no significant interactions were detected, several variables, such as physical activity, approached significance with the exercise group exhibiting enhanced recovery compared to the usual activity group six weeks following hospital discharge.

Nursing Implications
This pilot study demonstrates that it is feasible for patients receiving HSCT to participate in strength training and a randomized controlled trial testing the effects of strength training on various patient outcomes.

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O-97 THE EFFECTIVENESS OF A HOME CARE NURSING PROGRAMME IN THE SYMPTOM MANAGEMENT OF PATIENTS WITH COLORECTAL AND BREAST CANCER RECEIVING ORAL CHEMOTHERAPY: A RANDOMISED CONTROLLED TRIAL
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The purpose of the study was to assess the effectiveness of a symptom-focused home care programme in cancer patients receiving oral chemotherapy in relation to toxicity levels, anxiety, depression, quality of life and service utilisation costs.

Patients & Methods
A randomised controlled trial was carried out with 164 colorectal and breast cancer patients receiving oral capecitabine. Patients were randomised to receive either a home care programme by a nurse or standard care for 18 weeks (6 cycles of chemotherapy). Toxicity assessments were carried out weekly for the duration of the patients’ participation to the trial, and validated self reports assessed anxiety, depression and quality of life.

Results
Significant improvements were observed in the home care group in relation to the symptoms of oral mucositis, diarrhoea, constipation, nausea, pain, fatigue (first 4 cycles), and insomnia. Anxiety, while it improved in both groups, significantly more improved in the home care group. Unplanned service utilisation was also lower in the home care group, particularly the number of inpatient days (57 vs. 167).

Conclusion
A symptom–focused home care programme was able to assist patients to manage their treatment side effects more effectively than standard care. It is imperative that patients receiving oral chemotherapy are supported with such programmes when they are back at home, improving their treatment and symptom experience.

O-98 PSYCHOSOCIAL BENEFITS OF PERSONAL HEALTH SOCIAL NETWORKS
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Description
The Internet is a powerful tool, connecting 74 percent of American adults. The health care industry has particularly felt the effects of an increasingly Internet savvy society that expects to easily access information at the click of a mouse. In the past decade, the percentage of adults that look online for health information has more than doubled from 25 percent in 2000 to 61 percent in 2009. These “e-patients” and their caregivers have revolutionized the medical industry, demanding a more participatory style of care. Nearly 40 percent of e-patients use social networking websites such as MySpace and Facebook to follow friends’ personal health updates or to write about their own. However, these social networking websites are designed for multiple purposes and are better suited for entertainment and socializing. During a serious health event, e-patients and their caregivers are now turning towards personal health social networks to share their news and receive support.

A social network pioneer since 1997, CaringBridge was the first personal health social network and continues to be the leading force in this industry. Before MySpace and Facebook existed, CaringBridge helped families facing a serious health event communicate quickly, privately and efficiently online. The free websites are private; visitors need to know the exact name to access the site, and all authors can protect their site with a password or a pre-approved guest list. The fastest growing personal health social network, CaringBridge will celebrate one billion website visits in September 2009.

A personalized CaringBridge website improves a patient’s quality of life by building a therapeutic connection that reduces isolation and stress. CaringBridge author Sara Pallen started a site after she gave birth and was diagnosed with leukemia on the same day. The next day, after 120 people visited her site, Sara realized the true benefit of CaringBridge. The ability to communicate with hundreds of people by writing gave her a chance to find self healing. Additionally, the people who visited her site were able to offer messages of love and encouragement, creating a vast network of support. Sara’s online community of care helped her through her treatments and into remission.
Researchers say that personal health social networks have widespread psychosocial benefits and can make a difference when going through health events. Dr. Charles Raison, an assistant professor of psychiatry and behavioral sciences at Emory University of Medicine says that social support helps improve a patient’s quality of life. The support and encouragement that patients receive through CaringBridge “can make the difference in a person’s life between _ surrendering to hopelessness and _ finding the gumption to keep going,” said Raison. The positive experience that CaringBridge has on patients also helps relieve the psychological stress that illnesses place on family members, according to Raison.

E-patients are effectively leveraging personal health social networks during their health journeys. The Internet is a powerful medium, and with the help of CaringBridge and other personal health social networks, the Internet can be harnessed to improve patients and caregivers’ quality of life while they are going through health events.

About CaringBridge

CaringBridge is a 501(c)(3) charitable organization providing free websites that connect family and friends to share information, love and support during a serious health event, care and recovery. Its mission is to bring together a global community of care, powered by the love of family and friends, in an easy, accessible and private way. CaringBridge saves time and energy by centralizing communication and easing the burden of updating everyone during a health event.

Learning Objectives

• Experts say that personal health social networks have numerous psychosocial benefits that can make a difference when going through health events.
• Patients and their caregivers are using personal health social networks to share health updates.
• CaringBridge, the first personal health social network, is effectively improving their authors’ quality of life as they go through serious health events.

O-99 QUALITY OF LIFE OF PATIENTS WITH CANCER UNDERGOING RADIOTHERAPY.
Bruna Sabino, II, Maria Clara Cassuli Matheus, Maria Gaby Rivero Gutiérrez, Universidade Federal de São Paulo, São Paulo, Brazil.

Quality of Life of Patients with Cancer Undergoing Radiotherapy

Introduction: Cancer is a disease that causes enormous distress in the life of patients and their family. Coping with the distress of having cancer goes beyond the physical aspect only to include the emotional, social, and spiritual dimensions. In addition to the emotional distress of having the disease, patients must also deal with cancer treatments such as radiotherapy and chemotherapy. This study focuses on exploring the impact and significance of cancer and the quality of life of patients with cancer undergoing radiotherapy. Objectives: To understand the meanings of having cancer and undergoing radiotherapy and to identify the coping strategies and nursing care expectations held by patients with cancer undergoing radiotherapy. Methods: The symbolic interactionism served as the theoretical framework for this qualitative descriptive study. Morse and Field methodological approach for latent content analysis was used to analyze the data. Following the study ethical approval, interviews were conducted from February to March 2009 with 13 patients with cancer from the radiotherapy department of the “Hospital São Paulo – São Paulo Hospital” in Brazil. Results: Two main categories, consistent with the objectives of the study, emerged from the data. The first category “IMPACT OF LIVING WITH CANCER” consisted of the following sub-categories: living with uncertainty of having cancer, shock of being told to having cancer, adjustment and/or acceptance, being rational, relying on faith, facing self-finitude, looking for/or having support, isolating and recognizing life being limited by the disease. The second category “RENEWING HOPE WITH RADIOTHERAPY” comprised the following sub-categories: living the expectations about the type of cancer treatment, living the discomforts of the radiotherapy, renewing hope about the effect of the radiotherapy in helping patients continue to live, feeling the disease and the treatment are being vulgarized, valuing nursing care and praising radiotherapy department customer service. Conclusions: According to the symbolic interactionism, patients with cancer react to the disease and to the radiotherapy based upon their meanings in patients’ life. Distress regarding the diagnosis of cancer is consistent with other studies. However, the treatment of cancer represents a new marker in terms of meanings and the ways patients face the disease: patients became more optimistic regarding their future, the discomforts from radiotherapy were much less compared to chemotherapy, and there were significant improvements in their quality of life.
1) Meanings of cancer and radiotherapy originate from patients’ interactions with all things they can perceive.

2) Meanings of cancer and radiotherapy are modified through an interpretative process to deal with things that patients can perceive during the trajectory of the disease and its treatment.

CONCURRENT SESSION B9
“PREVENTION AND SCREENING” (ROSWEll I)

O-100 LUNG CANCER SCREENING: AN UPDATE, 2009
Kimberly L. Quinn, BSN, MSN, ANP, ACNP, Union Memorial Hospital, Baltimore, MD, USA.

Based on the American Cancer Society statistics from 2007, it is estimated that 213,000 individuals will be diagnosed with lung cancer and of those, 170,000 will die. Lung cancer is the number one killer in the United States today. About 80 of the lung cancers that are presented are the adenocarcinoma (non–small cell) type and 20 are the squamous cell type. Nationwide, according to the Lung Cancer Alliance (2006), 50 of the new lung cancer cases will be diagnosed with late stage disease, Stage IIIb or IV. Of this group, only 5 will live for 5 years. The relative 5 year survival rate for all lung cancers is only 15. The medical community agrees that a screening tool ought to be employed to capture early staged lung cancer. However, which diagnostic tool is the most reliable continues to be a controversial topic.

In 1999 and then later in 2005, Claudia Henschke a radiologist, designed a study called the Early Lung Cancer Action Plan (ELCAP), that was specifically designed to explore what diagnostic screening tool could be used to detect early staged lung cancer. The goal being early treatment would lead to early cure of lung cancer. The study compared chest x-ray with low dose radiation CT scans of the chest. The early results suggested that low dose radiation could contribute substantially in the detection of early staged lung cancer. Hospitals nationwide set up lung cancer screening programs and offered this tool to the high risk lung cancer group.

In 2007, the U.S. Preventive Services Task Force, released a report that stated screening for lung cancer by way of CT scan, chest x-ray or sputum cytology showed no benefit of screening and given further testing could actually cause harm. It was further suggested that unnecessary procedures, biopsies and surgeries, were costly and anxiety producing. Additionally, the task force went on to say that the people that were screened did not have a lower death rate versus the people who did not get screened. Lastly, it was recommended that more research be done. Hospital screening programs were ceased and the medical community was left once again trying to determine which diagnostic screening tool could be used for this patient population. As the lung cancer rate is projected to increase, more research is being requested for a reliable, beneficial screening tool. The National Cancer Institute is conducting a study with the hope that a solution to this controversial topic will be resolved. Early results are expected sometime this year.


O-101 EFFICACY OF EDUCATIONAL INTERVENTION TO FACILITATE THE STAGES OF READINESS FOR MAMMOGRAPHY USE AMONG KOREAN-AMERICAN WOMEN
Jin H. Kim, Ph.D., R.N., University of Illinois at Chicago College of Nursing, Chicago, IL, USA.

A prospective, repeated-measures, two-group study was conducted to test an efficacy of stage-based educational intervention, specifically designed to facilitate the stage of readiness for mammography use among Korean immigrant women in U.S.

The integration of the transtheoretical model of change (TTM) and the health belief model (HBM) guided the study. A total of 180 KA women participated. The educational program was a 45-minute, stage-based session on breast cancer/early screening knowledge and perceptions for KA women grouped according to stages of readiness for mammography use. Each woman in the intervention group (n=90) completed a baseline survey, attended an educational session arranged by mammography stage at baseline (pre-contemplation, contemplation, and relapse), and completed a follow-up questionnaire.
Prostate cancer is the leading cause of solid cancers in men and the second leading cause of cancer deaths in men. Recommendations for prostate cancer screening include patient participation in the decision to screen with the PSA test. However, men have historically demonstrated poor knowledge of this cancer and may therefore be inadequately prepared to participate in the shared decision making surrounding screening.

While randomized control studies have demonstrated efficacy of prostate education in the form of pamphlets and lengthy videos (longer than twenty minutes), little is known about the value of a brief video intervention.

The purpose of this quasi–experimental study was to examine the efficacy of watching a short informational video on knowledge of screening and level of perceived individual risk of developing prostate cancer in men. A convenience sample of 123 men, ages 45–75 years, was recruited from community settings (community agencies, civic groups, and churches). This one group, pre-test/post-test design included a brief (six minute) digital video intervention presenting information based on the Center for Disease Control guidelines for prostate screening education. In addition to demographic information, instruments included the 10 item PROCASE Knowledge Index (measuring knowledge of prostate cancer screening), and a single item risk assessment of perceived individual risk for prostate cancer prior to and immediately following the video.

The results indicate that men in this study scored significantly higher on a knowledge questionnaire after viewing the video (t = 11.12, p < 0.001). The mean score of 58% correct on the pre-test increased to a mean score of 79% correct on the post-test. In addition, on the posttest men were significantly more likely to rate their personal risk of developing prostate cancer correctly (n = 72) than they rated their risk correctly prior to the video (n = 56) (McNemar \( \chi^2 = 33.91, p = .005 \)). Of the men in this study who changed their risk rating from before to after watching the video, men were nearly 4 times more likely to correctly estimate their individual risk of developing prostate cancer after watching the video (5.8 % to 19% respectively) versus incorrectly estimating their risk.

Personalizing the risk and providing factual information, according to the Transtheoretical Model, may encourage movement beyond passivity to a stage of change where informed men contemplate, prepare, or actually engage their primary care providers in discussion about prostate cancer screening.

O-103 PREVALENCE OF RISK FACTORS OF CERVICAL CANCER AND AWARENESS RELATED TO PAP SMEAR AMONG WOMEN RESIDING IN DHARAN

Abstract
Background- Cervical cancer is the second most common cancer next only to breast cancer throughout the world among women where as in Nepal cervical cancer is the number one cancer among married women aged from 30 to 60.

Aims: To find out the prevalence of risk factors of cervical cancer and awareness related to Pap smear among women.

Settings
Dharan municipality.

Material & methods
A descriptive cross sectional study was adopted. 200 women were included in the study. Samples were chosen by systematic random sampling method. Data was collected by using pre-tested, pre-designed, validated, self developed proforma.

Statistical analysis: Data was analyzed using appropriate descriptive statistics (frequencies, %).

Results
Risk factors which are more prevalent include early marriage (42.5%), early intercourse (42.5%), early child birth (26.5%), multigravida (31.5%), alcohol intake (40%), use of hormonal contraceptives (35%) & not using condom (96.5%). Women were also not aware of Pap test (98%) and they have not undergone Pap test (96.5%).

Conclusion: Measures should be taken by health professionals to create awareness among public about risk factors, control risk factors, detect & treat cervical cancer in early stages.

Key words: Cervical cancer, prevalence of risk factors of cervical cancer.

O-104 ASSESSMENT OF TRASTUZUMAB INDUCED CARDIOTOXICITY IN EARLY HER2 BREAST CANCER
Helen Roe, BSc (Hons). North Cumbria University Hospitals NHS Trust, Carlisle & Whitehaven, United Kingdom.

In 2007 when the National Institute for Clinical Excellence (NICE) issued its guidance regarding the use of Trastuzumab, it stressed the importance of regular cardiac monitoring due to the potential to decrease the left ventricular ejection fraction (LVEF) and the possibility of causing heart failure in this patient group.

This presentation presents the findings of an audit of the potential cardiotoxic effects for patients receiving Trastuzumab for HER2 early breast cancer by monitoring fifty patients’ cardiac function and effect on planned treatment prior to the commencement of the first combined cardiology/oncology clinic and fifty post.

The combined cardiology/oncology clinic was the first developed in the UK in February 2008. It’s aim was to provide patient centred care by providing an echocardiogram performed by the same cardiologist, using the same machine and a patient review by the consultant cancer nurse, who discusses the results of the echocardiogram and any possible consequences for the patients, planned treatment.

We established:

- The timing of cardiac monitoring in comparison with NICE recommendations
- Number of patients who completed Trastuzumab without any complications
- Number of patients who experienced a delay in the planned course of Trastuzumab
- Number of patients who required supportive cardiac medication to enable them to complete their planned course of Trastuzumab
- Number of patients who did not complete the course of Trastuzumab due to decreased cardiac function

O-105 THE IMPORTANCE OF HAND HYGIENE
Virginia A. Gumley, MA BSc. SKMCH & RC, Lahore, Pakistan.

This abstract outlines the Hand Hygiene Programme in one cancer centre. It became evident after many audits on Hand Hygiene that nurses were still failing to comply to “best practice”. 

MARCH 9, 2010 4:30PM – 6:30PM
CONCURRENT SESSION C2
“PATIENT SAFETY” (PEACHTREE BALLROOM D)
CHAIR: KAREN BELANGER
Therefore the Nursing Division spearheaded a concentrated effort and developed a programme to improve the compliance rate and embed “best practices” in hand hygiene.

The programme concentrated on education, training, supervision, monitoring and auditing – and presenting the results of the audits to the nurses to enable them to change their behaviour. In this programme recent developments in the field were presented and the development of newer guidelines emerged. The evidence will be presented.

References
Guideline for Hand Hygiene in Health–Care Settings 2002 National Center for Infectious Diseases
WHO 2005 World Alliance for Patient Safety

O-106 AN EVIDENCED BASED REVIEW: ISOLATION PRACTICES IN AN EMERGENCY ONCOLOGY SETTING
Maryanne Costello, RN, Janine M. Kennedy, RN,MA,OCN, Susan Baeckes RN, Hosana Razon, RN.
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The Urgent Care Center (UCC) of a comprehensive cancer center sees 20,000 patient visits annually in an ER setting. In this setting, patients are often immunocompromised, which leads to an increased risk of acquiring infections. Patients seen in the UCC often need isolation. The large volume of patients needing isolation causes a significant impact on isolation ability and patient flow.

This evidence-based review sought to determine the best patient isolation practice for the UCC. Concerns regarding isolation practices included maintaining patient flow; deciding whom to isolate; and prioritizing patients into isolation. A committee of UCC nurses conducted a comprehensive review of literature, guidelines from the Centers for Disease Control and Prevention (CDC) and professional organizations, and infection control expert opinions. There was minimal published literature on isolation procedures in the emergency room, other than focusing on bioterrorism and SARS. Few professional organizations had published guidelines. Evidence was drawn mainly from CDC guidelines and expert opinions.

From the review of evidence, hand hygiene and respiratory etiquette practices were confirmed. Infection control experts recommended adapting CDC Ambulatory Isolation Guidelines. All patients demonstrating active symptoms of a contagious infectious process should be isolated in the appropriate fashion upon arrival to the UCC. It was recommended to educate staff to direct all patients and visitors to the hand hygiene stations and maintain a 3-foot distance between symptomatic and asymptomatic patients in the waiting room.

The committee also recommended changing the location of the Fast Track area, thus freeing up 3 isolation rooms. In addition, the transision room would be turned into a cohort waiting space if patient isolation warranted it. The emergence of the H1N1 virus this past Spring had lead us to implement most of the recommendations. When patients arrived to the UCC with influenza-like illnesses, we immediately activated our isolation overflow plan, including transforming our transision room into a cohort waiting room, isolating based on symptoms, and freeing up the isolation rooms for these patients. This lead to improved patient care and safety for patients, visitors, and staff. The committee has gained approval from leadership to reconfigure the UCC from a structural standpoint.

Based upon the evidence, the isolation practices of patients within the UCC need to stress the importance of hand hygiene, symptom assessment, and education of staff, patients, and visitors. Oncology nurses need to be diligent in following isolation guidelines in order to provide the safest care. By implementing these recommendations, we hope to see an improvement in isolation practices and its impact on patient care and flow.
2. National confidential enquiry into patient outcomes and death. For better, for worse? These reports were produced in response to serious concerns about quality and safety, for patients receiving day-case chemotherapy and the potential side effects of treatment.

The West chemotherapy nurses group have developed a chemotherapy 24 hour triage, rapid assessment and access tool kit. The pilot of the tool kit is being undertaken within 10 hospital settings.

**Purpose**

The purpose of this pilot study is to determine if the rapid assessment and access tool kit can be used in a variety of settings including emergency departments, emergency admission units and the Haematology/Oncology telephone triage setting. Telephone triage enables the oncology nurse to co-ordinate and have an impact on the standards of care, to reduce the number of unnecessary clinic visits, recognize early or potential emergencies, and provide ongoing emotional support to the family. Many situations arise in Oncology/haematology care that requires patient assessment over the telephone. At present there are no consistent national guidelines in place to support practitioners in helpline patient management.

The tool kit aims to provide:

1. Guidance and support to the practitioner at all three stages of –Contact, –assessment/definition of problem and appropriate intervention/action, 2. a simple but reliable assessment process 3. Safe and understandable advice 4. communication and record keeping 5. Competency based training 6. an audit tool

The level of oncology/chemotherapy knowledge and training required to manage a 24 hour helpline/triage is variable nationally and many practitioners feel unsure and ill equipped to make advanced care decisions. This tool kit will also be an educational tool and will include a competency assessment framework that all disciplines of staff would need to complete prior to handing a helpline facility.

The tool kit consists of:

1. National patient alert card 2. Telephone log sheet 3. Telephone triage pathway which is to be used to guide the user through the triage process 4. Assessment tool based on the WHO/NCRI–CTCAE, common toxicity criteria is also included with individual guidelines 5. Competency assessment package

**Conclusion**

It is hoped with the use of this tool kit, to improve quality of care for cancer patients receiving chemotherapy and provide a framework for staff undertaking telephone triage.
use or modify this curriculum to teach oncology or critical care nurses specific knowledge and skills important for the care of acutely ill cancer patients.

O-113 FAST-TRACK SURGERY FOR WOMEN WITH GYNECOLOGICAL CANCER: IMPLICATIONS FOR NURSING PRACTICE.

Leila Lancaster, Alison Brand, Vennder Sidhu.
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Historically the care of women undergoing open abdominal surgery for gynaecological cancer has included pre-op bowel prep, opioid premedication, prolonged pre- and post-operative fasting, gradual mobilisation, slow re-introduction of oral nutrition, an extended period of post-op opioid analgesia and a protracted convalescence. Post-operative morbidity commonly included nausea and vomiting, ileus, fluid over- or under-load, anorexia, constipation, sleep disturbances, loss of muscle strength, fatigue and general debility.

Fast-track surgery incorporates a multimodal rehabilitation model to minimise physiological and psychological stresses associated with surgery, shorten hospital stay, reduce complications and decrease use of hospital resources. It includes avoiding bowel preparation, sedative premedication, intra-op hypothermia, nasogastric tube and wound drains; a shorter period of pre-op fasting and post-op parenteral analgesia; judicious peri-op IV fluid management; multimodal anesthetic care and early mobilisation and resumption of oral nutrition.

In women with gynaecological cancer, fast-track surgery has decreased complication rates, hospital lengths of stay and readmission rates. However it challenges established nursing practices and patient expectations. It requires intensive pre-operative patient education with a focus on the patient’s active participation in the recovery process. Thorough pre-op psychosocial assessment is imperative to ensure timely referrals to support services in facilitating early discharge. Close liaison with and co-operation from allied health staff is crucial.

The successful implementation of a fast-track surgery program in an oncology setting requires multidisciplinary collaboration with evidence-based protocols and intensive staff education prior to its introduction.

O-114 CLOSING THE CIRCLE OF CARE FOR CHEMOTHERAPY OUTPATIENTS

Heather McKenzie1, Lillian Hayes1, Kate White1, Keith Cox1, Judith Fethney1, Jo Dunn1.
1University of Sydney, Sydney, Australia, 2University of Sydney/Sydney Cancer Centre/Royal Prince Alfred Hospital, Sydney, Australia.

Introduction
This paper presents the findings from a study to determine the nature and magnitude of chemotherapy outpatients’ unplanned presentations to hospital. On average of 125,000 outpatient chemotherapy visits occur each year in the state of New South Wales, Australia, with this number anticipated to increase (Cancer Institute NSW 2006). To date there has been no research that has investigated unplanned presentations for this group in Australia and only two studies internationally. As outpatient cancer treatments increase, there is growing recognition of the need to improve community based services for these patients.

Method
A retrospective audit of hospital records of the chemotherapy outpatient unplanned presentations to a large Sydney metropolitan hospital for a twelve month period (2006–2007). The reason(s) for presentation, cancer diagnosis, chemotherapy regimens, position in the chemotherapy trajectory, the difference in management between those admitted and those not admitted, demographic variables were identified. The antecedents to unplanned presentations were explored through semi-structured interviews with current chemotherapy outpatients making an unplanned visit to hospital.

Findings
363 unplanned cancer presentations were identified, and a substantial proportion of these visits are due to side effects of chemotherapy. Nausea, vomiting (60%) and dehydration (35%), fever, pain and anxiety were among the reasons reported for unplanned presentations to hospital. One third of unplanned presentations occurred within the first 7 days post-treat-
Women with known or suspected gene mutations face a higher lifetime risk of breast cancer. Heightened public awareness has more women seeking information about their own risk profile, resulting in increasing numbers of referrals to the High Risk Assessment Clinic (HRAC). This in turn contributed to lengthy delays for individual clinic appointments with the physician and nurse, as patient demand exceeded clinic capacity. Protracted wait times often caused undue psychological distress for those overestimating their own risk profile. In addition, women at higher risk were not being assessed within a reasonable timeframe or offered appropriate screening recommendations, surveillance, and counselling with regards to options for chemoprevention and prophylactic surgery. This had important implications for the team responsible for service delivery within the program.

A new model of care delivery was developed to increase access to quality care, reduce wait times, and decrease patient anxiety. Redesign focused on process and technological improvements, as well as interprofessional collaboration rather than investment of new resources. Several strategies were used to better align patient demand and clinic capacity. First, referral criteria were redefined and discharge criteria standardized. Second, experts nurses developed and implemented nurse-led education sessions for those women of low to moderate risk, further reducing the wait from referral to initial visit. Nurses provide individual risk profiles, as well as teaching about breast health, strategies for risk reduction, and appropriate screening recommendations. Women with a higher lifetime risk continue to meet individually with the nurse and physician. Lastly, technological improvements included developing a database for monitoring quality performance, which also serves as a patient tracking tool. The new delivery model continues to offer comprehensive preventative cancer care while meeting the stated objectives of reducing wait times, improving access and decreasing patient anxiety. The interprofessional approach has resulted in timely access to education, support and guidance, increased likelihood of early diagnosis, and improved quality of life. Dissemination of the process redesign and evaluation results could serve as a model for high risk assessment clinics in other centres.

Clinical Information Systems (CIS), computerized approaches to managing health records, are often referred to as a catalyst to improve patient care and outcomes within the healthcare setting. In fact, currently hospitals around the globe are dedicating substantial funds to the effort of creating and installing systems with the intent to improve efficiency, and patient safety. Once the design and implementation of such systems is complete the end-users must reorient their practice to the functional design of the system in order to complete their daily work. It is during this period that the core of the system is tested in clinical practice, resulting in the clinicians developing both personal and group strategies for leveraging the system to better practice, or develop workaround strategies to accommodate for system deficiencies. In addition to improving patient safety and efficiency within the oncology setting, a CIS affords the ability to data mine in order to inform research, and better operational performance. Oncology represents a challenge when considering the transformation required to convert to a CIS mainly due to the specialized skill sets required to translate the complex chemotherapy orders, and the extensive workflow requirements inherent within the discipline.

The Foothills Medical Centre (FMC), is a 1000 bed hospital located in Calgary, Alberta, Canada. The FMC had been using the E7000 System since 1988 for electronic order entry and, minimal clinical documentation. In January 2007 the FMC underwent a conversion to a new CIS, Sunrise Clinical Manager. Unit 57, 50 bed Oncology, Hematology, and BMT Unit, successfully implemented computerized physician order entry, medication administration, and aspects of clinical documentation with the aforementioned activation. We were able to leverage the capabilities of the new system to achieve a number of goals including; designing chemotherapy regimens as comprehensive order sets with embedded clinical decision support to ensure clear concise orders translated to nursing staff, as well as introducing nursing real–time computerized documentation to the oncology nursing community.

This presentation will review the impact of introducing a new CIS on the Oncology setting specifically, addressing the time periods immediately post the initial activation, to now, 2 1/2 years later. Over the course of the past 2 1/2 years nurses have developed strategies to enhance and optimize the use of the CIS including; altering the nursing education requirements, utilizing tools within the system to address the varied roles of nurses, and developing ‘work arounds’ to account for system functionality when required.

As oncology settings move further into the world of technology we, as nurses, ultimately need to understand the impact that this movement will have on our specialty of oncology.

O-118 THE ROLE OF NURSES IN AN ONCOLOGY OUTREACH PROGRAM IN WESTERN KENYA REGION

Jennifer M. Smylie, Sandra K. Lowry, BScN.
The Ottawa Hospital, Ottawa, ON, Canada.

To highlight the role of nurses in the provision of comprehensive oncology outreach services in Western Kenya Region. To determine the frequency and pattern of HIV associated malignancy. To evaluate the care outcome of these patients.

Method
Traveling to distant sites, setting up, arranging and administering chemotherapy in 6 Academic Model for Providing Access To Health care(AMPATH) sites in Western Kenya Region-Chulaimbo, Busia, Kitale, Amukura, Webuye and Moi Teaching and Referral Hospital (MTRH).

Results
By 31st December 2007, 60,285 patients had been enrolled in the AMPATH program. 640 were diagnosed with HIV associated malignancies. Diagnosis was mainly clinical as opposed to histology or cytology. Most patients did not have medical insurance cover. Most patient’s had low CD4 counts at diagnosis and improvement in the counts were noted alongside clinical improvement. Most patient’s received ARV’s as well as specific treatment modalities for cancer e.g. chemotherapy, surgery, radiotherapy either single or combination. Responses to the HIV associated malignancies to therapy were varied i.e complete response, partial response,stable disease and no response or worsening. Loss to follow-up was low.

Conclusion
Nurses play a major role in the development of oncology services in developing countries. Use of ante–retroviral therapy together with specific cancer treatment improves patients’ quality of life and outcome. Issues to address affordability, availability and accessibility of health care services to patients have a positive input in reducing cases of loss to follow-up. It is possible to provide quality oncology services in resource limited counties with a nurse–led team.
0-119 QUALITY OF LIFE IN YOUNGER FEMALE SURVIVORS OF CANCER: PILOT STUDY
Alexandra McCarthy, PhD1, Retsy Yates, PhD1, Vanessa Brunelli, BN1, Alexandra Clavaron1, PhD2, Ramon Shahan, MN1, Sarah Winch, PhD2
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Cancer survivorship has not been extensively researched in younger Australian women. In particular, we know little about their quality of life in the context of cancer–treatment related changes to health status, or the factors that may influence their quality of life at this stage of the cancer trajectory. Research has shown, however, that physical symptoms, psychological attitudes and personal characteristics tend to influence an individual’s longer-term quality of life when they experience a chronic disease like cancer.

We undertook a pilot study (n = 86) that investigated the impact of the later effects of treatment in younger female survivors of cancer in Australia. In this paper, we discuss the findings in this study related to quality of life during survivorship. The WHOQOL–25, which is a 25 item survey, measured 5 life domains (quality of life, physiological, psychological, sociocultural and environmental domains). This was supplemented by the 18 items of the Brief Symptom Inventory, which measured symptoms such as somatisation, depression and anxiety, which are also known to influence quality of life. Stable personality traits over time, such as dispositional optimism, which may be further predictive of levels of well-being and physical health in cancer survivorship, were also measured. Twenty five participants undertook a further indepth interview to enhance our deeper understanding of what influenced these quality of life and symptom measures once cancer treatment had ceased.

Data collection will be completed in July, 2009 and data analysis is due to commence in August 2009. This paper presents the questionnaire and interview findings of quality of life aspects of the pilot study.

0-120 LIFE AFTER CANCER: LIVING WITH THE RISK
Krista L. Wilkins, PhD(c), RN, BScN, BSc1, Roberta L. Woodgate, PhD2
1University of New Brunswick, Fredericton, NB, Canada, 2University of Manitoba, Winnipeg, MB, Canada.

Recent research shows that cancer survivors are at greater risk of developing cancer than the general population. Although recommended, many cancer survivors receive no regular follow-up care for early detection of a second cancer. Cancer survivors’ perceptions of their second cancer risk are, in part, suspected to influence their participation in follow-up care. Few studies have sought information on how cancer survivors define and interpret second cancer risk. Thus, an interpretive, descriptive qualitative study was conducted to more fully describe second cancer risk using cancer survivors’ own words. This study is part of a larger project entitled “Mixed Method Study of Second Cancer Risk Among Cancer Survivors”, guided by Kaplan’s social ecological framework.

Twenty-two cancer survivors (mean age = 50, range 19–87) from Atlantic Canada participated in semi-structured, open-ended interviews that explored survivors’ interpretations of cancer risk and how they manage that risk. The overall theme, Life After Care – Living with the Risk, describes survivors’ sense that risk is now a part of their everyday lives. Three sub-themes shape how risk influenced the person’s sense of self and how they lived with the risk: (1) thinking about risk, (2) the risk may be there, but it does not define me and (3) taking care of the risk. Results highlight which risk factors from Kaplan’s framework cancer survivors take into account when interpreting second cancer risk, the importance survivors assign to these risks, which elements of risk are missing from the model, and perceptions of risk acceptability and courses of action.

Study results provide foundational knowledge about the nature of second cancer risk that may be used to develop and refine standards for survivorship care including how second cancer risk can be best managed. Knowledge gleaned from this study may help guide and support the work of health professionals, and may ultimately improve the health of cancer survivors.

0-122 CANCER SURVIVORSHIP: CHANGING FOLLOW UP CARE IN THE 3 COUNTIES CANCER NETWORK
Jon Burford, MSc, MBA, Anne Sullivan, MSc, Peter Davies, Annie Young. 3 counties cancer network, Gloucestershire, United Kingdom.

The National Cancer Survivorship Initiative (NCSI) was launched in September 2008 its initiation has been driven by the United Kingdoms Cancer Reform strategy published in December 2007. It has been further developed by a national think tank event held in March 2008 in a partnership approach between the Department of health and Macmillan Cancer Support. The aim of the initiative is to improve the health and well being of people who are living with and beyond cancer, in that they feel supported, have access back to appropriate services if problems arise and where the appropriate people can be found, provided they are there. The goal is for women be part of every health care visit, so that oncology nurses can eliminate this “black hole” and help women enjoy the lives they have been given back.

ORAL ABSTRACTS
As diagnoses of cancer are made earlier in the course of the disease and treatments become increasingly effective, survival rates from cancer are rising. This leads to an elevation of the importance of issues related to on-going quality of life, including menopausal status and fertility. This presentation reports the findings and recommendations of a qualitative study undertaken to explore the emotional and interpersonal impact of premature menopause and fertility damage.

Interview data was collected from 17 New Zealand women who were pre-menopausal prior to their diagnosis of cancer and primary treatment and identified fertility and menopause effects as important to them in the survivorship phase. Data was analysed using general inductive analysis techniques. The concept of liminality, and Chronic Sorrow Theory were used as aids to the interpretation and explanation of the data. Four fundamental categories were identified that illustrated the participants’ experiences of premature menopause and fertility damage from cancer treatment: Changes in the Balance of Choice and Control, Multiple Losses, Emotional Responses to Multiple Losses, and Changes in Perception of Self. Our understanding of these considerable impacts is crucial to the provision of patient-centered and effective survivorship care.

**O-123 MOSES AND THE RED SEA: THE IMPACT OF PREMATURE MENOPAUSE AND FERTILITY DAMAGE FROM CANCER TREATMENT**

Sarah E. Hunter, RN MNurs(Hons) Doctoral Candidate, University of Auckland, Auckland, New Zealand.

As diagnoses of cancer are made earlier in the course of the disease and treatments become increasingly effective, survival rates from cancer are rising. This leads to an elevation of the importance of issues related to on-going quality of life, including menopausal status and fertility. This presentation reports the findings and recommendations of a qualitative study undertaken to explore the emotional and interpersonal impact of premature menopause and fertility damage.

Interview data was collected from 17 New Zealand women who were pre-menopausal prior to their diagnosis of cancer and primary treatment and identified fertility and menopause effects as important to them in the survivorship phase. Data was analysed using general inductive analysis techniques. The concept of liminality, and Chronic Sorrow Theory were used as aids to the interpretation and explanation of the data. Four fundamental categories were identified that illustrated the participants’ experiences of premature menopause and fertility damage from cancer treatment: Changes in the Balance of Choice and Control, Multiple Losses, Emotional Responses to Multiple Losses, and Changes in Perception of Self. Our understanding of these considerable impacts is crucial to the provision of patient-centered and effective survivorship care.

**O-124 DEVELOPMENT OF THE CONCEPT OF COMMUNICATIVE PARTICIPATION IN PATIENTS WITH HEAD AND NECK CANCER**

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**Purpose**

Communication, an integral component of life, is often compromised for patients with head and neck cancer (HNC), significantly affecting their quality of life (QOL). Communicative participation, a concept emphasizing the day-to-day functional aspects of communication, is relevant for HNC research. Continued concept development is needed prior to using this variable in HNC research. The purpose of this qualitative study was to further develop this concept of communicative participation in patients undergoing treatment for HNC.

**Conceptual Framework**

The World Health Organization (WHO) International Classification of Functioning, Disability, and Health (ICF), was the conceptual framework.

**Subjects:** This was a qualitative study with one time data collection occurring 2-6 months post initial treatment for HNC.

**Methods:** Data collection included a semi-structured interview, observation, and field notes. Data analysis consisted of line by line coding and constant comparison. Codes were organized into conceptual categories.

**Results**

Communicative participation ranged along a continuum. Points along the continuum included those that were: transformed, or those who developed a new appreciation of communication; normalized, those who were back to a full range of activities and communication situations; constrained, those who functioned within rigidly defined limits; and isolated, those who withdrew from normal activities and communication situations.

**Discussion**

Patient responses to these patterns and the effect of patient and family or community interactions are key foci of our continued analysis. This research has implications for better understanding the functioning and QOL of HNC survivors. Of particular importance is the difference between the ability to speak clearly and full communicative participation in life’s valued activities.
Evidence suggests that cancer patients and their families require information and support at various points along their cancer journey. In 2005 an evaluation of the Cancer Council Helpline was conducted where all participants were asked if they would have liked to receive a follow-up call following their initial Helpline contact. One-quarter of participants indicated they would have appreciated a call-back, a third were cancer patients. In order to respond to this need The Cancer Council New South Wales, Australia introduced a Call Back Service into their existing Cancer Helpline. The aim of the service was to train and support volunteers to be able to provide a high quality call back service to enhance referral systems to support programs and provide a safety net for callers who may require further support especially those with advanced disease. Callers to the Helpline are asked if they would like a follow-up call and are contacted two weeks later. Volunteers are trained to provide a listening and empathetic ear to a caller and they have clearly defined boundaries preventing the provision of medical or psychological advice to a caller.

The Cancer Council Helpline employs oncology professionals, primarily nurses, to deliver expert oncology information and emotional support to those affected by cancer throughout the cancer journey. Referrals to the call-back service were initially a challenge as it represented a major change to practice and the philosophy of the Helpline program; from one on one contact to an extended relationship. A preliminary evaluation conducted with the volunteers who provide the service show a high satisfaction rate with the training and their role. Feedback collated from data entry at the time of the call-back indicates a high level of satisfaction from the recipients of the service.

Following these findings volunteers have been undergone enhanced communication skills to take on more complex calls such as palliative care issues. Following these findings volunteers have been undergone enhanced communication skills to take on more complex calls such as palliative care issues. Call-back indicates a high level of satisfaction from the recipients of the service.

The number of referrals have consistently increased since the program commenced and Helpline staff have embraced the philosophy of the call back service.

O-127 THE ROLE OF PATIENT NAVIGATION IN CANCER DIAGNOSIS: WHAT, WHY AND WHO?
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1Cancer Care Ontario, Toronto, ON, Canada, 2University of Toronto, Toronto, ON, Canada, 3Erin Hughes Counselling, Toronto, ON, Canada, 4Cancer Care Ontario (formerly), Toronto, ON, Canada, 5Relieve Consulting Services, Petersham, ON, Canada, 6Ontario Ministry of Health and Long-Term Care, Nursing Secretariat, Toronto, ON, Canada.

Background
The process of diagnosing cancer often involves tests and exams in various settings, with various clinicians, over lengthy periods of time. The diagnostic phase of cancer care often means long waits and delays that may have a negative impact on patient outcomes. Patients have expressed the need for navigational support during the diagnostic process.

Methods: In this work, we examine patient navigation and its role in the diagnostic phase of cancer care, paying specific attention to the role of the nurse. A literature review summarizes the information available on models of patient navigation and determine when navigation requires the skills of a nurse.

Findings
Patient navigation is inconsistently defined in the literature. Common to most definitions is the facilitation of care and assisting patients to overcome barriers. Providing patients with information and support are also central to the navigator’s role. Navigation can be provided by laypersons, clerical staff or healthcare professionals. Nurses specifically add value to navigation largely by virtue of their ability to assess patients, manage complexity, provide supportive care and integrate with other health care professionals.

Navigation during the diagnostic phase of care gives patients access to information and support in decision making. It has a demonstrable effect on reducing patient anxiety and increasing satisfaction. Through navigators, physicians gain access to community resources and benefit when patients are better informed and prepared. The system benefits through improved efficiency, expressed by shorter wait times.

Conclusions
A model of patient navigation during the diagnostic phase of cancer care is described, where the intensity of care during navigation a) depends largely on patients’ physical and psychosocial needs and b) will dictate the type of person who can fulfill the role. Informational navigation, provided either by an individual or through educational material is necessary, at a minimum, and may be sufficient for some patients. Other patients may require personal assistance and/or clinical intervention and benefit from the skills and preparation of a nurse. More complex patients may require nurses with advanced practice skills. Identifying those individuals who require more clinical intervention is essential so that symptoms can be addressed and the diagnostic experience optimized.

More comparative work is needed to understand the utility of different models of patient navigation and determine when navigation requires the skills of a nurse. This work has provided a foundation for understanding how to best utilize our human resources to meet the needs of patients in this most critical – and challenging – part of the cancer journey.

O-128 PROMOTING QUALITY NURSING CARE FOR THE RADIATION ONCOLOGY PATIENT
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People undergoing radiotherapy require nurses who are responsive to their physical, emotional and social concerns during the acute phase of radiotherapy and into the post-radiotherapy phase. The aim of this study was to examine the impact of a new model of care in the radiation treatment setting on patient, team, and service level outcomes. The model of care evaluated was built on the concepts inherent in person-centred care, and operationalised by a Primary Nursing/Collaborative Practice framework. The study involved a case study research design, in which data were collected through surveys and interviews from patients and clinical staff pre- and post-implementation of the model. Data reflected that patients in Cohort 2 (following model implementation) had significantly greater reported side effects of radiotherapy compared to Cohort 1 (prior to model implementation) (p = 0.008). However, Cohort 2 patients’ ratings of the adequacy (p = .001) and helpfulness (p = .002) of information provided was significantly higher than patients in Cohort 1. Interview data revealed generally positive views of the practice model by both nurses and doctors, especially in enhancing nurses’ understanding of their patient’s needs, and in emotional support for patients. Allied Health staff also perceived that the model resulted in patient care being managed in a more timely fashion than before. However, some radiation therapists reported there were continuing gaps in patient education and noted that the nurses’ focus on individual patients sometimes lead to gaps in care provision and detracted from a multidisciplinary team approach. Findings also revealed differing perceptions amongst health professionals about the nurses’ role in implementing the model, and the nature of collaborative practice models.

O-129 CREATING A SHARED CANCER DIAGNOSTIC ASSESSMENT PROGRAM: BUILDING THE FOUNDATIONS THROUGH REGIONAL COMMUNITIES OF PRACTICE
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Variations in cancer wait times, as one aspect of quality care, demonstrate there is a need for central coordination of patient referrals and diagnostic access within in a geographic region in Canada. One of the key initiatives a provincial government has undertaken to help improve the quality of cancer care delivery within the province is the development of Diagnostic Assessment Programs (DAP). The main purpose of the DAP is to provide patients
with timely, coordinated and standardized cancer care. Nurses play a key role through coordination of the cancer assessment process, patient education and the provision of patient centered supportive care. In implementing our DAP while wanting to maximize capacity within our region, a regional cancer assessment program was launched.

Development of the regional program was fostered by the formation of multidisciplinary disease specific “Communities of Practices” (CoP). To delineate and achieve quality standards, it has been valuable to collaborate regionally to address the needs of patients and the health care teams. The disease specific CoPs have provided the platform for the development of innovative care practices and knowledge translation. Nurses in a new role titled “Cancer Care Facilitator” provide the link between administrative and clinical endeavours. They participate in the activities of the CoPs and lead the implementation of CoP recommendations in their own hospitals. Through the work of the CoPs and the multidisciplinary teams in each hospital, cancer patients across the region now have increased access to skilled inter-professional health care teams, multidisciplinary cancer conferences, standardized quality cancer surgery, formalized clinical pathways and regional education programs.

Development of formal DAPs in regional partner hospitals is underway. At each hospital this includes the creation of a central referral mechanism; central disease specific queues to effectively manage wait times to consult and surgery; the development of strong multidisciplinary teams; the incorporation of regional and provincial care standards and the development of coordinated patient-focused care processes. These Cancer Care Facilitators working within each hospital to advance the initiatives of the regional cancer surgery program, have a pivotal role in leading the development of these patient-centered innovations. Next steps include initiatives to maximize the scope of nursing practice to best meet the patients’ needs within the DAPs: to ensure patients are supported throughout the diagnostic process.

O-130 IMPLEMENTING A SHARED GOVERNANCE MODEL OF NURSING IN A MULTINATIONAL ENVIRONMENT

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Fostering a consistent level of quality patient care in a multinational environment of practice requires a clear mission, vision, and structure. Establishing and sustaining a nursing practice model, which provides structure and context to the delivery of care, requires nursing leadership at various levels within the organization. A shared governance model of nursing practice was designed and implemented at a private oncology hospital in Singapore where traditionally hierarchical nursing practice models exist. This shared governance model includes a core nursing leadership team and nursing councils. According to Porter-O’Grady et al., (1997) shared governance is a dynamic structure that is centered on four critical principles: partnership, accountability, equity, and ownership. A fundamental belief behind shared governance is that staff nurses at every level in the organization should govern their practice and be included in decisions that affect the practice. The design and implementation of the nursing councils was initiated through a nursing retreat. All the nursing staffs are members of a council. Each council is led, or co-led, by members of the nursing staff. The nursing councils have identified goals focused on specific areas of nursing including education, practice, quality, work-life balance and environment of care. After the first year of implementation, a second retreat was held whereby councils reported an annual summary of progress and identified goals for the next year. At the second annual retreat, some of the councils were redesigned to avoid redundancy. Nurse led councils offer staff opportunities to develop leadership skills while integrating professional practice as a means of achieving quality care.

Numerous performance improvement projects have been identified and carried out as result of the various nursing council activities. Some of projects include improving the environment within a patient’s room, developing nursing performance indicators, enhancing patient safety standards, e.g. fall prevention program, and improving patient and staff satisfaction.

O-131 COORDINATED CARE TEAM: DESIGN, IMPLEMENTATION AND EVALUATION OF A MODEL OF CARE DELIVERY IN A COMMUNITY HOSPITAL ONCOLOGY SETTING.

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Abstract

Coordinated Care Team: Design, Implementation and Evaluation of a Model of Care Delivery System in a Community Hospital Oncology Setting

The ability to sustain leading edge cancer care is challenged by increases in patient acuity and growing human resource shortages. It is no longer possible for academic health science centers to deliver the majority of cancer care. Community hospitals are now faced with an increased number and complexity of cancer patients. There has been an increase of 3% of new cancer cases each year combined with a greater than 4% growth in cancer prevalence in Ontario.1 This increase is partly attributed to the aging population,1 while at the same time more Ontarians are surviving with many cancers being managed like a chronic condition.2 There is a need to provide high quality care to oncology clients in a community hospital, yet barriers may exist to recruitment and retention of highly trained and specialized staff. Potential solutions include the redesign of care delivery systems to strengthen collaboration within teams.

A proactive approach was implemented and evaluated by a 485 bed community teaching hospital by initiating the Coordinated Care Team Project. This project consists of the design and implementation of an interprofessional model of care. A four month design process was undertaken. Participants from across health disciplines determined the principles, concepts, values, and structure of the new model. Collaborative design sought to clarify roles and responsibilities in the interprofessional (IP) environment. This kind of activity is part of the foundation upon which key IP care activities can be implemented and sustained.3 The new care delivery model is supported by the tools and structures of the Clinical Practice Model framework. Tools include a comprehensive documentation system, clinical practice guidelines, structured professional exchange process and a partnership council network.

The outcome is the development of an interprofessional care delivery model that enables health professionals to practice to their full scope within the context of their specialty. In addition, the structure and processes of the model fosters IPC, coordinated care delivery and a culture of collaboration. This model of care was implemented on one medical oncology unit and two surgical units thus far. Training and education involved team building, emotional intelligence, and high level simulation. Integration of care processes addressing safety, satisfaction and quality provide primary endpoint data which can be benchmarked against provincial and national standards. The Canadian Nurses Association provides the framework for the ongoing evaluation of the model with a focus on patient and nurse sensitive outcome measures.

O-132 UNIQUENESS OF BREAST CANCER AFFECTING ARAB WOMEN IN ISRAEL

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Background

Arab citizens of Israel compromised 20% of Israel’s population with 82.6% being Muslim, 9% Christian and 8.4% Druze. The epidemiological transition of women in the Arab sector over the last 60 years from farming and active lives to house-bound lives caused a major change with high morbidity from chronic diseases, mainly cancer.

Breast Cancer: In the Arab sector, cancer constitutes the second most frequent cause of death (17%) after heart diseases (19%). In the last 30 years, cancer in Arab women increased 123% compare to only 24.4% for Jewish women. During last 50 years, researchers found a rapid increase of over 40% in breast cancer in the Arab women in Galilee compare to an increase of 24% in Jewish counterparts, while at the national level, diagnosis of cancer increased 204% in Arabs and 43% in the Jewish sector.

Causes: delay of marriage age and first birth, fertility reduction (from 9 to 4.2 babies), reduced breastfeeding period. High obesity rate: 41.2% of Arab women with BMI > 30 kg/m2 compared to 22.2% for Jewish women. Change of nutrition to more red meat with less fiber and beans. Lack of physical activity: only 6% of Arab women perform regular physical activi-
Uniqueness of breast cancer in Arab sector affecting younger women (45.7% are under the age of 50 compared to only 23.3% among Jews). Diagnosed at later stage: only 36% are diagnosed at stage 0–1 compared to 53% for Jewish women, while 42% of Arab diagnosed at stage 3–4 compared to 12% of Jews. Late diagnoses usually due to poor mammography screening: 20% of Arab women compared to over 60% for Jews. Breast cancer with higher affinity to HER2: 39% of Arab patients compared to 24% of Jews (25% globally). Arab breast cancer with higher severity type: 28% at severity grade 3 compared to 12% for Jews. Ratio of incidence to mortality of breast cancer is 2.2 for Arabs compared to 3.0 for Jews reflecting advanced stage at diagnoses. Five year survival is 60% for Arab and 70% for Jewish women.

Conclusions

Life style modification has been identified as a major cause for cancer morbidity in general and breast cancer in particular. Early intervention by health promotion experts for prevention and early detection can improve quality of life of women of various cultures with transition in lifestyles.

O-133 THE PSYCHOLOGICAL IMPACT OF BREAST MRI SCREENING IN WOMEN AT HEREDITARY RISK: STATE OF THE SCIENCE

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Background

Women with a hereditary predisposition to breast cancer are recommended to undergo annual breast Magnetic Resonance Imaging (MRI) in addition to annual mammography screening and clinical breast exam. The clinical utility of the breast MRI has been proven as an effective method of breast cancer detection. Though it is clinically useful it has been found to be highly sensitive and poorly specific, often leading to false positive results. Current research demonstrates that screening in this population can cause both short term and long term psychological distress, but has not focused on the experience women have with breast MRI screening.

Purpose

To systematically review the literature pertaining to the psychological impact of breast magnetic resonance imaging (MRI) screening in women at hereditary risk.

Research Design/Methods

The databases searched were CINAHL, Medline, PsycInfo, PubMed, Google Scholar, and Web of Science. The Garrard (2007) method of literature review was used for the analysis. The keywords that guided this study were breast cancer, screening, surveillance, breast MRI, high risk, hereditary breast cancer, genetic risk, BRCA1/2, familial breast cancer, psychological impact, quality of life, anxiety, distress, depression, and experience. Articles were included if they were in the English language, published between the years of 1998–2009, and if they incorporated information about breast MRI screening.

Results/Conclusions

The search yielded 7 results, all quantitative survey design. The review demonstrated that there is a lack of nursing research completed in this area and also a lack of studies originating from the United States. Results show that screening with breast MRI does have a psychological impact. The greatest time period of psychological impact is the time period immediately prior to MRI screening, and the waiting period for results. False positive results from the MRI, or the need for additional diagnostic testing, may also impact the psychological distress level of women undergoing breast MRI screening. Qualitative information regarding the experience and psychological impact of breast MRI screening is missing in the literature reviewed.

Future Implications

Current evidence supports screening with the breast MRI in women at high risk for breast cancer; however there is limited research available to demonstrate how women experience this screening modality. Further research is needed to examine how women experience using screening for risk management, including using the breast MRI. Nursing as a profession, has the unique opportunity to play an important role in evaluating and changing the psychological impact of breast MRI screening in women at hereditary risk.
Recent adverse events such as the death of a patient in Edmonton, Canada, due to an ambulatory infusion pump programming error, have highlighted the risks of outpatient intravenous (IV) chemotherapy. A root cause analysis (RCA) of this event by the Institute for Safe Medication Practices Canada identified 16 causal factors and associated recommendations, including the design of the drug label, the pump, and the physician’s order. Although the RCA report is extremely thorough and provides excellent safety recommendations, its focus was very specific to fluorouracil and the institution where the incident took place. It is likely that many additional systemic safety issues exist in cancer centres in Canada that were not implicated in this specific adverse event. Further, the RCA report was widely disseminated, but its impact on oncology practice in Canada was not known. Thus, the objectives of our research were to:

- determine the response to the root cause analysis report from the fluorouracil incident
- identify current practices for ordering, preparing, labeling, verifying, and administering ambulatory IV chemotherapy in Canada
- identify additional sources of risk in a wide variety of care environments
- recommend strategies to reduce risks

This project involved three phases: (1) a survey, (2) ethnographic field studies and (3) focussed investigation of top safety issues.

**Phase 1: The survey** was distributed widely across Canada and was completed by 331 physicians, pharmacists, pharmacy technicians, nurses and administrators. Results revealed that 95.5% of respondents were aware of the fluorouracil incident and 71% had reviewed the RCA report. Respondents also described 207 adverse events related to ambulatory chemotherapy.

**Phase 2: Week-long ethnographic field studies** were conducted in six cancer centres across Canada. Two human factors engineers shadowed medical oncologists, nurses, pharmacists, pharmacy technicians, clinic nurses, treatment nurses and administrative clerks as they carried out their regular duties. All aspects of chemotherapy administration were documented, and hazards and risks were analyzed across sites.

**Phase 3: Safety issues identified in Phases 1 and 2 were investigated in detail through literature reviews, in depth analysis of observational data, environmental scans and interviews.** Recommendations for improved safety of ambulatory IV chemotherapy were generated and will be widely disseminated.

This presentation will focus on key findings and recommendations from this study, especially those relating to nursing.

**EGFR therapy include infusion reactions, cutaneous and ocular toxicities, as well as electrolyte imbalances.**

In this presentation the focus will be on signs and symptoms, assessment of severity, and strategies available to prevent and manage adverse events associated with cetuximab and panitumumab. Oncology nurses play a key role in the administration of multiagent treatment regimens, especially with respect to the identification and management of toxicities, patient education, and patient support. By reducing the effect of the adverse events associated with anti-EGFR therapy, oncology nurses have the potential to sustain patient adherence to completion of treatment, identify signs and symptoms early, proactively manage adverse events, and provide appropriate treatment interventions, thereby improving patient quality of life.

**O-138 SOCIOECONOMIC FACTOR PREDICT INCREASED INCIDENCE FOR COLORECTAL, LUNG, STOMACH, LIVER, PANCREAS AND ORAL CANCERS FOR THE BRONX VS. NYC 2001-2005**

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**Background**

Research Objective: The purpose of the current study is to assess the difference in the incidence for selected cancers in the Bronx vs. New York City (NYC) and evaluated the impact of the neighborhood levels of individuals at federal poverty level, median household income (MHI) and levels baccalaureate or higher graduates.

Population Studied: The Bronx is one of the five geographic boroughs making up New York City (NYC) and has higher rates of crime, poverty, lower median household income (MHI) and fewer college graduates. Other studies have shown that level of poverty and level of education are predictors overall morbidity and mortality. Few studies have explored the impact of MHI, levels individuals below the federal poverty levels and levels baccalaureate or higher graduates on the incidence for common cancer found in Bronx neighborhoods compared to all of NYC.

**Study Design**

The New York Cancer Registry Cancer Data for NYC Neighborhoods was queried for seven Bronx neighborhoods and NYC totals cancers. The average incidence of cancers in these neighborhoods was entered into a data base as individual cancer by sex. This data were examined for incidence/100,000 for the Bronx neighborhoods in this study and compared to incidence/100,000 for all of NYC. Other associated variables were also examined including economic profile as evidenced by the MHI, rates of college graduates and levels of individuals below the federal poverty level by zip codes for these neighborhoods. Associations were tested using an unadjusted Chi square and logistic regression models. Descriptive statistics were used for other variables.

**Principle Finding**

The overall incidence of cancer in this study is greatest in Bronx neighborhoods with the lowest MHI, lowest level of college graduates and the higher levels of individual living below the federal poverty level (p < .0001). Chi sq) Regression analysis reveals that for Bronx neighborhoods with higher levels of poverty, lower levels of education and certain tumors are independent predictors of increased incidence (p < .0001).

**O-139 HOW WILL I GET THERE? HOW MUCH WILL IT COST?**

Monica A. Tucker, RN Grad Dip Counselling, Anita Tang, Kelly Williams, Victoria Dolphin, Paula Valentien, Gillian Batt. Cancer Council NSW, Sydney, Australia.

**Background**

Radiotherapy service deficiencies have been reported worldwide. Over the past 20 years in Australia many enquiries and reports have highlighted the importance of radiotherapy in cancer treatment and the underfunding that exists in this area. In NSW Australia the major issues of concern are capital cost of established radiotherapy facilities and a radiation workforce shortage. Cancer Council New South Wales (CCNSW) has long standing concerns about poor patient access to radiotherapy and the associated impact on outcomes for cancer patients.
Objectives
To raise awareness and conduct a telephone Call-in encouraging patients to call the Helpline in order to gather information about access and affordability of radiotherapy services through out New South Wales (NSW) using Cancer Council Helpline.

Method
The Call-in ran from beginning March to beginning April 2009. All Helpline callers were asked a standard set of questions and offered advice, assistance and emotional support as required. All information provided by callers was collected and analysed to assist in identifying issues faced by cancer patients requiring radiotherapy.

Results
The Cancer Council Helpline received a total of 2319 calls. Of these calls 271 (12%) were about radiotherapy. Patients comprised of 86% of the calls and were diagnosed in the previous 12 months. Family and carers accounted for 12% and 2% were general public and health professionals. The average age was 60–69 and the majority of the callers were female.

Conclusions
A telephone call-in is a very effective method for gathering information from cancer patients and their carers about their experience within the health care system. This in turn can then be used to advocate for cancer patients and improve access to standard treatments. The results of the Call-in will also further inform Cancer Council recommendations and advice to the NSW government about improvements needed in radiotherapy.

O-140 MULTIPLE PERSPECTIVES OF ADDRESSING NICOTINE DEPENDENCE AND WITHDRAWAL DURING HOSPITALIZATION
Annette S. H. Schultz, PhD, RN1; Barry Finegan, MD2; Candace I. J. Nykiforuk, PhD1; Margaret Kvern, MN, RN4; Julia Oosterveen, MA1
1University of Manitoba, Winnipeg, MB, Canada, 2University of Alberta Hospital, Edmonton, AB, Canada, 3University of Alberta, Edmonton, AB, Canada, 4Winnipeg Regional Health Authority, Winnipeg, MB, Canada.

Understanding how patients’ tobacco use is addressed within acute care hospital settings is essential, as tobacco use and exposure drastically increase the prevalence of cancer and other life-threatening illnesses. In an effort to address this serious public health issue smoke free hospital grounds are becoming a Canadian reality. While these policies acknowledge the importance of supporting patients’ nicotine withdrawal, perceptions of the enacted policy reality are diverse and incongruent. The purpose of this presentation is to discuss policy maker expectations of the enactment of the policy, as well as health care provider and patient challenges addressing nicotine dependence post-implementation of smoke free grounds within two large tertiary hospitals in Western Canada.

This ethnographic study explored the culture of tobacco use and tobacco use management in hospitals that had implemented a policy prohibiting smoking on hospital grounds. At each site, four adult in-patient units participated in the study. Stories of the enacted reality related to addressing nicotine dependence were heard in the 82 interviews with patients (44% smokers; 37% former-smokers), 16 focus groups with health providers (i.e., pamphlets, posters, patient forms, etc.) from the study units were reviewed for relevant evidence present in the workplace context. The interviews, as well as the documents, provide insight into numerous views concerning the challenges to addressing nicotine dependence. Findings suggest that minimal cessation support is provided beyond merely advising patients that they should not smoke during their hospital stay. While health care provider stories reveal the lack of time, knowledge and resources as reasons for limited intervention, patient stories suggest additional barriers that disrupt receiving support to addressing nicotine dependence and withdrawal during hospitalization. Considering the current smoke-free policies, and the importance of reducing tobacco use, the need to address abstinence and nicotine withdrawal within hospital settings is vital.

O-141 AN ETHNOGRAPHIC STUDY OF ADOLESCENTS’ CONCEPTUALIZATION OF CANCER AND CANCER PREVENTION
Robert L. Woodgate, PhD.
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Before we can develop cancer prevention programs that are meaningful and relevant to adolescents, a detailed understanding of adolescents’ perspectives and beliefs of cancer and cancer prevention is necessary. However, to date most health education for adolescents has not been based on what they themselves know, believe or want to know. Missing is a detailed understanding of adolescents’ perceptions of cancer. Also missing is an understanding of the extent to which adolescents believe that some cancers are preventable, and how they see their life–situations impact on them in their ability to affect their own health in terms of cancer prevention. Accordingly, a 3-year ethnographic research study is presently in progress that seeks to extend our limited understanding of how adolescents frame cancer and cancer prevention within the context of their own life–situations.

Using a purposeful sampling technique adolescents are being recruited from both rural and urban school divisions in a Western Canadian province. To date, 60 adolescents (12–18 years of age) have taken part in the study. In addition to traditional ethnographic methods of interviewing (individual and focus group interviews), the innovative approach of photovoice is being utilized.

Data analysis is ongoing involving several levels of analysis including domain, taxonomic, and componential analysis. The social–cultural themes emerging from the data reflect adolescents’ perspectives and beliefs about cancer and cancer prevention. Adolescents also provide their views on what they feel they and others (e.g., governments, health professionals, parents, teachers) could be doing to address the behavioural, environmental, and social–cultural determinants of cancer.

Overall, this work is important and has the high potential to impact future work regarding the population of interest. The potential contribution of this study is fourfold. First, this study will result in foundational knowledge specific to adolescents’ perspectives of cancer. This knowledge may be used by nurses and other professionals who work with adolescents in the areas of health education and counselling. Second, this study gives a voice to those adolescents participating in the study and provides adolescents the opportunity to articulate a broader vision of cancer prevention that may extend beyond individual behaviour change. There is the possibility of the youth as advocates for more enlightened policy. Third, this study provides grounding for future research work that includes developing and testing a meaningful youth cancer prevention program. Fourth, the findings may be used to guide policy and program development focused on cancer prevention in adolescents.

CONCURRENT SESSION C7
"CANCER IN ADOLESCENTS" (INTERNATIONAL H)
CHAIR: CANDY COOLEY

O-142 IDENTIFYING SYMPTOM CLUSTERS IN PAEDIATRIC CANCER PATIENTS USING THE MEMORIAL SYMPTOM ASSESSMENT SCALE
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This descriptive correlational study determined symptom characteristics and distress in a sample of 54 children newly diagnosed with cancer in a paediatric oncology in-patient department and its associated out–patient clinics in Izmir, Turkey. Data were collected using the Memorial Symptom Assessment Scale one, two and three months after diagnosis. Demographic data were collected using a questionnaire developed by the researchers whilst information on respondents’ disease status and treatment regimens was obtained from medical records. Cluster analysis techniques were used to identify symptom clusters in the sample. The study identified a number of symptom clusters affecting children or adolescents (age range 10 to 18 years), although different clusters became apparent at each data collection point. The most common symptoms in newly diagnosed respondents were lack of appetite, nausea, lethargy, hair loss and feelings of sadness. Four symptom clusters were apparent one month after diagnosis, five in the second month, and four in the third month. The study demonstrated...
that respondents experienced a wide range of symptoms in the months immediately following a cancer diagnosis and the start of treatment; findings which can be used to develop clinical guidelines for symptom assessment and management in children and adolescents with cancer.

**O-143 USING NANDA-I DIAGNOSES IN HEMATOLOGICAL DAYCARE - ON PATIENTS TREATED WITH CHEMOTHERAPY**

Carola E. Hellman, Nursing student, Joaofine K. Johansson, Nursing student. Red Cross University College, Stockholm, Sweden.

**Aim**

The aim of this study was to identify nursing diagnoses according to NANDA-I (North American Nursing Diagnoses Association International) in patients treated with chemotherapy at a hematological daycare unit in a Swedish university hospital. BACKGROUND NANDA-I has not yet been implemented in Swedish nursing though this could facilitate the use of nursing diagnoses, serve as a statistical basis as well as increasing patient safety. Patients treated with chemotherapy in a hematological daycare unit often has vast nursing needs and no studies identifying NANDA-I diagnoses has been done in Sweden within this context. METHOD Data was collected from patient records, a symptom questionnaire (C-SAS: Chemotherapy Symptom Assessment Scale) and individual patient interviews. Next the data was analyzed with descriptive statistics. The study includes 23 patients, 11 women and 12 men, aged between 21 and 78 during five days in 2009. RESULTS A total of 196 nursing diagnoses was identified according to NANDA-I with the most common diagnoses being risk for infection, risk for vascular trauma, fatigue, impaired comfort, impaired oral mucous membrane and nausea. In average the patients had 8 (Md) diagnoses each; women had 7 and men 9.5. CONCLUSION Nursing diagnoses according to NANDA-I was identified and the most frequent occurring diagnoses concurred well with recent studies concerning side-effects of chemotherapy. This verifies NANDA-I as a well functioning instrument in the identification of nursing diagnoses in patients treated with chemotherapy at a hematological daycare unit.

**O-144 RECRUITING ADOLESCENTS AND YOUNG ADULTS WITH CANCER INTO A PHASE II BEHAVIORAL INTERVENTION STUDY**

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**Aims**

The purpose of this presentation is to provide a brief overview of issues related to recruitment of adolescents and young adults (AYA) into research studies. Issues will be illustrated by describing a recruitment plan, preliminary recruitment rates, and the reasons for participation and refusal from an ongoing multi-center study entitled “Stories and Music for Adolescent/Young Adult Resilience during Transplant” (SMART) (R01NR008583; U10 CA098543; U10 CA 095861).

**Background**

Meeting sample recruitment goals can be challenging for investigators when planning a sampling plan to recruit this population. Factors and research design issues, should prove useful to other investigators when planning a sampling plan to recruit this population.

**Methods**

We provide: a) an evaluation of our planning, implementing, and monitoring of recruitment rates for the SMART study and b) examples of successful strategies and barriers to recruitment of AYA in this multi-site study conducted within the Children’s Oncology Group.

**Results**

Recruitment processes specific for AYA resulted in an overall recruitment rate of 50% as of 03/10/2009, with 72 AYA enrolled with more males (n=42) than females (n=30).

**Conclusions**

When designing a study, careful consideration must be given to factors that influence recruitment, such as eligibility and exclusion criteria, performance sites, and general recruitment strategies.

**O-145 STRATEGIES TO SUPPORT NURSE PARTICIPATION IN A COOPERATIVE GROUP BEHAVIORAL INTERVENTION STUDY**

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**Background**

Academic and clinical partnerships are essential to plan and implement research studies that are relevant, feasible and ultimately translatable into clinical practice. The National Institutes of Health (NIH) Roadmap encourages the formation of academic and clinical partnerships and has identified nurses as pioneers in fostering interdisciplinary, collaborative relationships among health care professionals and researchers. However, few models for successful academic/clinical partnerships are found in published literature.

**Aims**

This presentation will summarize the process, benefits, and challenges of establishing academic-clinical nurse partnerships for an ongoing multi-site Children’s Oncology Group randomized clinical trial involving a music therapy intervention targeting adolescent/young adult stem cell transplant (SCT) recipients (R01NR008583; U10 CA098543; U10 CA095861).

**Methods**

The Stories and Music for Adolescent Resilience During Transplant (SMART) study is complex due to several key features: funding from 2 separate institutes within the NIH, 6 participating sites and 8 hospitals, targeted patients—adolescent/young adults with cancer currently undergoing SCT, multiple measurement times, on-line remote data entry by participants and study personnel, and a behavioral intervention that includes 6 intervention sessions delivered over 3 weeks for both study arms. To implement and sustain the research project a multifaceted approach was used to foster strong, collaborative academic-clinical nurse partnerships. Specific strategies included: 1) networking to identify key personnel; 2) defining roles and unique contributions; 3) establishing frequent and varied forms of communication; 4) team building activities; 5) dissemination opportunities for both clinicians and academics. Nurses involved across sites in both academic and clinical settings experienced several benefits: 1) professional role fulfillment, 2) hospital-wide advantages, such as hospital recognition and professional growth/advancement, 3) learning opportunities, 4) clinical practice improvement, and 5) professional networking. The most significant barrier experienced by nurse clinicians was role conflict, in terms of balancing research and patient care responsibilities.

**Implications**

Essential to the success of multi-site studies is dedication to establishing strong academic and clinical partnerships that will ultimately result in win-win relationships between key stake holders in the participating health care organizations and universities. Funding Agencies: The project described is supported by National Institutes of Health – National Institute of Nursing Research RO1NR008583; and by the National Cancer Institute U10 CA098543 and U10 CA 095861.
O-146 SOMETIMES IT'S CANCER: RAISING AWARENESS OF TEENAGE AND YOUNG ADULT CANCER THROUGH SCHOOLS
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The ‘Christie Crew’ are a group of young people aged 16–26 who have all been treated for cancer at a specialist Teenage and Young Adult (TYA) Centre in Manchester. Facilitated by the Nurse Consultant and Youth Support Coordinator, the group are a research and consultation group and carry out various projects to improve TYA cancer services.

Cancer is the most common cause of death in teenagers and young adults after accidents. TYA’s are often delayed in receiving a cancer diagnosis and this is an issue that needs addressing. Part of the delay is attributed to the lack of recognition and reporting of worrying symptoms by young people themselves. At the present time, there is no specific education about cancer in this age group in schools. The Christie Crew wanted to empower others with the knowledge that TYA’s do get cancer and also to educate young people in what the signs and symptoms are that need to be recognised and reported to health care professionals when they have ongoing symptoms. In order to address this, the Christie Crew have produced a 20 minute DVD and education pack to be used in schools and youth services in the North West. The DVD is age appropriate for those aged 11–18 and highlights individual’s stories and the signs and symptoms they experienced. So far the DVD has been sent out to 200+ institutions and will continue to be distributed regionally, with the eventual aim to have the project rolled out nationally as part of the health awareness (Healthy Schools) initiative.

In conjunction with the DVD the young people also worked on a poster campaign highlighting the same issue. This campaign is currently being run at participating schools and youth services and at the Manchester Evening News Arena. The Christie Crew intend the poster campaign will also be rolled out to Manchester Airport in order to maximise publicity within public places and portray the message to young people. By highlighting that young people can and do get cancer more young people will hopefully recognise the signs and symptoms and be empowered to go to their GP if they have persistent problems.

O-147 TRANSITIONAL ISSUES OF ADOLESCENTS WITH CANCER: THE ANALYSIS OF 22 CASES FROM THE RESULTS OF THE QUESTIONNAIRE SURVEY FOR NURSES IN JAPAN
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Introduction/Background
Although the life expectancy of chronic pediatric disease has been increased, chronically-ill adolescents including adolescents and young adults with childhood cancer (AYACC) tend to remain at the pediatric-oriented hospital. Several studies conducted by physicians revealed that various factors medical/health care system for patients with childhood cancer, but transitional issues are still unknown especially for AYACC.

Purpose
The purpose of this study to clear the followings; 1) the behavioral/emotional independence of AYACC and 2) nurses’ perceptions of the facilitating/disturbing factors related to transition from pediatric- to adult-centered care for AYACC.

Method
We sent the questionnaire for nurses randomly selected 478 hospitals in all over Japan, and asked each hospital to distribute the questionnaires to the pediatric unit, pediatric outpatient unit, and the adult unit. The questionnaire was developed based on the literature review and three focus group discussions of nurses who worked for patients with chronic disease.

Results
Of 1334 questionnaire, 249 questionnaire were returned (return rates 18.6%). Among 249 cases, 22 were reported as AYACC. The ages of AYACC were ranged from 12 to 30 years old.

1) The behavioral/emotional independence of AYACC: AYACC could explain their treatments and discussed about their health condition with pediatrician. But, nurses reported that half of AYACC relied on parents and pediatrician. In addition, half of them didn’t talk with pediatrician about developmentally appropriate issues such as smoking.

2) Nurses’ perceptions of the facilitating/disturbing factors related to transition from pediatric to adult centered care for AYACC. The facilitating factors were reported as AYACC’s psychological/social maturation, changes in school/work status, and medical condition that pediatrician couldn’t correspond to treat. The disturbing factors were that pediatrician were not positive for transition and the long-time relations with pediatrician.

Discussion
AYACC had a few opportunities to discuss about the developmentally appropriate issues with pediatrician. AYACC tended to rely on parents and pediatrician in terms of decision-making about transition which was much affected by pediatrician. In the future transition program, nurses need to focus on adolescents’ psychological/social development because such development is the basis of the whole program for AYACC.

O-148 COMPUTERIZED SYMPTOM AND QUALITY OF LIFE ASSESSMENT FOR ADOLESCENT PATIENTS WITH CANCER: A FEASIBILITY STUDY
Wei-Wen Wu, PhD, RN, Donna L. Berry, PhD, AOCN®, FAAN.
University of Washington, Seattle, WA, USA.

Background
Computerized symptom and quality of life (QoL) assessment with web-based, touch-screen notebooks is technically feasible and has been used in a few outpatient settings for adult patients with cancer, but has not been used in pediatric settings in the United States. The purpose of this pilot study was to revise and test the feasibility of an innovative, computerized symptom and QoL assessment for adolescent patients who were treated with cancer.

Method: A convenience sample of forty consecutive adolescent patients who were between 13 and 20 years old and were being treated for cancer, could communicate in English, and were competent to understand the study information and give informed consent and assent, were invited to participate. Each participant answered the Electronic Self Report Assessment—Cancer Adolescent Form (ESRA—CAF) on a wireless, touch screen computer just prior to an on–treatment clinic visit. Descriptive frequencies and central tendency were used to describe sample characteristics and the feasibility measures. Multiple regression analyses were conducted to determine whether resilience mediated the relationship between cancer symptom distress and QoL. Results: The computerized assessment was feasible for use of adolescent patients with cancer in ambulatory settings with regard to data completeness (MMQL—AF 99.4%, SDS 99.3%, RS 99.9% and AES 100%), acceptability (high), time to complete (mode 12 minutes), and amount of assistance required to complete (none). It was confirmed that resilience was a mediating factor between cancer symptom distress and QoL. Implications: Screening of symptoms and QoL may be feasibly integrated into check-in procedures as a routine assessment for adolescent cancer patients in ambulatory settings.

O-149 USE OF EDUCATIONAL CAMPAIGN TO IMPROVE EVIDENCE-BASED PRACTICE KNOWLEDGE, ATTITUDES AND BEHAVIORS: LESSONS LEARNED FROM A PILOT STUDY
Sarah Threlfall, RN, MS, AOCNS®, CHPN, Alice Boyington, RN, PhD, Sheila Ferrall, RN, MS, AOCN®, Brenda Howard, RN, BSN, MA, OCN®. Moffitt Cancer Center, Tampa, FL, USA.

Evidence-based practice (EBP) is the integration of the best available evidence, nursing expertise, and patient values and is the cornerstone of quality patient care. EBP is fundamental to the mission of the International Society of Nurses in Cancer Care to promote and coordinate delivery of care, education and research in cancer nursing.

The scope of EBP among oncology nurses and the elements for successful EBP education are not known. Barriers to EBP may be related to attitudes or deficits in knowledge and/or skills. A pilot study to measure knowledge, attitudes, and behaviors of oncology nurses regarding EBP and to evaluate effectiveness and feasibility of an educational campaign was undertaken. The study was approved by the institution’s Scientific Review Committee and Institutional Review Board.

The design was a pre-test–post-test one–group quasi experimental descriptive study. A convenience sample of 115 registered nurses was recruited from two inpatient units and one outpatient clinic at a U.S. National Cancer Institute–designated Comprehensive Cancer Center. The Upton & Upton (2006) questionnaire, Clinical Effectiveness and Evidence-Based Practice Questionnaire, was administered pre- and post-in-
Concurrent Session CB

"Quality Care" (International E)
Chair: Olivia Hill

O-150 The Development of Information of Holistic Service in Cancer Asian, Thailand.
Viriyasuebphong Phatmanee, Ph.D.
Boromarajonani College of Nursing Sappasitiprasong, Ubonratchathani, Thailand.

The action research was aimed to study the process of searching for and developing information as regards taking care of the patients. The research methodologies were: analyzing the real situation, and evaluating the result. The sample groups were divided into two groups: the 25 service recipients and the 25 service providers. The research instruments were personal notebook, in-depth interviews, questionnaire, and information development project. Content analysis, researcher position analysis and thematic analysis were carried out. The research findings were as follows: regarding the circumstance analysis, it was found that the hospital did not yet the systematic information. It did not have the clear information on documents, and other media. Those seeking health services wanted to have information on ways of preventing and controlling the site effect of treatment. In the step of implementing, new knowledge was established and holistic innovation was developed in the following: 1) information on patients who received chemotherapy; 2) information on the patients who were terminally ill; 3) information on the patients who were exposed to radiation; 4) information on the patients who underwent operation. In addition, information was developed to meet the demands on how to prevent the site effect of treatment. With regard to evaluation, it was found that the majority of the patients were satisfied with the information from the health care team. The health personnel were also satisfied with the improved information development.

Recommendations
It was recommended that the holistic information model should be used in the process of taking care of the patients. The personal should be taken into account. Family members should be involved in taking care of the patients. Information should be systematized from the beginning to the time of treatment and discharge. Moreover, it was found that information was related to knowledge management. Systematized knowledge and information would be easily accessible and greatly beneficial. That would increase working effectiveness. The information would be more effective and up-to-date.

O-151 A Retrospective Activity Analysis of a Novel Nurse Led Chemotherapy Telephone Helpline Service Over a 12 Month Period.
Joanne Reid, PhD, MSc, BSc, Samuel Porter, PhD, BSc, Queen’s University Belfast, Belfast, United Kingdom.

Purpose
The complex and continually changing nature of the health care system means that telephone delivered health information is becoming increasingly important. The Regional Cancer Centre, Northern Ireland, established a nurse led chemotherapy telephone helpline service in 2005 to facilitate direct and immediate access to specialist advice and support.

Objective
To conduct a retrospective activity analysis of the Chemotherapy Telephone Helpline service over a 12 month period.

Methods
All calls made to the Chemotherapy Telephone Helpline are recorded on standardised departmental forms. The information on calls made between 01/01/2007 – 31/12/2007 was collated. Each call was given a serial number and data were sorted under the following headings: source of call; reason for call; patient’s diagnosis; age; sex; geographical location; subsequent action recommended; and additional comments. All data were entered and analysed using the Statistical Package for Social Sciences.

Discussion
Results from this study show the number of calls received by the telephone helpline over a 12 month period. Additionally they establish the characteristics of callers using the helpline service and determine the profile of cancer patients who callers are contacting the helpline about. Most importantly, they ascertain the reason callers are using the telephone helpline service and identify common concerns of this client group. This study is distinctive in that it provides an in-depth understanding of the activity of a novel chemotherapy telephone helpline service. Investigating this service provides nurses with insights into callers’ profiles and their concerns. Findings from this study have the potential to contribute to the development of practice and delivery of the best possible standards of care that are anticipatory and supportive of the needs of this client group.

O-152 The Effects of a Patient Orientation Program (The POP Trial) Conducted by a Multi-disciplinary Team on Anxiety and Self-efficacy in Newly Registered Cancer Patients.
Raymond Chan, BN, MApSc (Research); Sally Jones, BN, Grad Cert (Cancer); Ann-Marie Butler, BN, Michael Bishop, BN, Alana Fraser, BSpPath, Joan Webster, BA, SRN, SRM, Linda Bennett, BAppSc, BN, Alanna Geary, BN, MHlthSc, Royal Brisbane and Women’s Hospital, Herston, Australia.

The first visit of patients with cancer and their families to an outpatient cancer centre often causes intense anxiety and negative emotions. Several small-scale randomised controlled trials have demonstrated the benefits of orientation programs for newly registered cancer patients. However, these programs were conducted by one nurse, rather than a multidisciplinary team. A recent nursing initiative in Cancer Care Services (CCS) at the Royal Brisbane and Women’s Hospital (RBWH) was a multidisciplinary orientation program for newly registered patients and their families/caregivers. The 90 minute face-to-face orientation program was conducted by a multi-disciplinary team for groups of up to six patients. The team included a nurse, a dietitian, a social worker, an occupational therapist, a physiotherapist, a psychologist, a speech pathologist, a discharge nurse facilitator, and cancer care coordinators. The programme included practical information about the cancer care facilities, potential treatment related side effects and self-care strategies, services available from the multi-disciplinary team members and a virtual tour of the clinical environment.

This pilot study was a randomised controlled trial with the aim of evaluating the effects of the multi-disciplinary orientation program on the levels of self-efficacy, anxiety, mood state and information awareness. The intervention group received the orientation program before receiving treatment specific education from a nurse, whereas the control group only received usual care which was treatment specific education given by a nurse. Methodology and results will be discussed in this presentation.
0-153 CHEMOTHERAPY FOR NONCANCEROUS CONDITIONS: NURSING IMPLICATIONS
Lisa Harthop/F Smith, RN, MS, AOCN, CNS.
Riverside Methodist Hospital, Columbus, OH, USA.

Chemotherapy and biotherapies are increasingly being used for noncancerous conditions, including many autoimmune disorders such as Rheumatoid Arthritis and Lupus. Examples of agents used for noncancerous conditions include Rituximab, Cyclophosphamide, Methotrexate, and 6-Thioguanine. These agents still have the same potential toxicities and implications for safe handling precautions despite their indications for use. The purpose of this presentation/poster is to 1) Describe indications and potential side effects of chemotherapeutic and biologic agents used to treat noncancerous conditions, 2) Discuss controversial issues related to educational preparation for RNs who administer these agents, and 3) Describe strategies to help prevent life-threatening errors when these agents are administered in non-oncology settings.

0-154 “QUALITY OF LIFE IN FEMALE PATIENTS WITH BREAST CANCER IN FIRST-LINE THERAPY: EVALUATION FROM NURSING”
Michael Andrés Neira Figueroa, Sr., PhD. Student, Nursing Practitioner1-2, Carolina Mené Navarrete, Nursing Practitioner1, Maria Elisa San Martín Nuñez, Nursing Practitioner1.
1Universidad Andrés Bello. Facultad de Enfermería. Escuela de Enfermería, Santiago, Chile, 2Instituto Oncológico Fundacion Arturo López Pérez. Capítulo Chileno de Enfermería Oncológica, Santiago, Chile.

Abstract
Defining “Quality of Life” (CV) is not an easy task for it in this paper is determined as “subjective assessment of normal life activity compared to activity after starting treatment. Because in Chile there studies analyzing the CV in Women with Breast Cancer (CM), born assess motivation from Nursing, how it affects the passivity CV and analyze the role of professional nursing in the task right to provide care appropriate to the needs of the person. This research was made descriptive, assessing the various factors expressed by people in their perception of CV; these relate to: physical functioning (FF), emotional functioning (EF), symptoms associated with your treatment (SATRA) and social functioning (SF). It was used for general evaluation instrument EORTC QLQ-30 and BR-23. The study sample is 40 women who met the following inclusion criteria: women aged 25 to 50 years with recent diagnosis of CM, with first-line therapy in chemotherapy (QMT), radiotherapy (RT) and surgical (TQ). We excluded women with preexisting CM. Because this is an ongoing study, the results are analyzed. However, according to the results of international research, a sought similarity in the description and assessment of the CV from the perspective of the person with CM and also analyze the role of professional nursing in the area in Chile. It highlights the role of the professional educator, which makes most imperative delivering not only information but also strengthen their self-care, the family and/or primary caregiver.

0-155 SURVIVING HEMATOLOGICAL MALIGNANCY: THE LIVED EXPERIENCE OF UNCERTAIN REPRODUCTION AND MOTHERHOOD
Lesley E. Halliday, Psychology BSc (Hons), Associate Professor Maureen A. Boughton, RN RM PhD.
University of Sydney, Sydney, Australia.

Introduction
Fertility and future motherhood have been identified as important issues for cancer survivors (Schower 1999). However, it is often difficult to provide an accurate prediction of whether or not a woman’s reproductive potential will be impaired by the cancer treatment she receives because of the many treatment and individual patient factors that need to be considered (Lee et al. 2006). As a consequence, many young women who are treated for haematological malignancy live with uncertainty about whether they will be able to have another child in the future. Uncertainty is associated with higher levels of emotional distress, poor psychosocial outcomes and reduced quality of life in cancer survivors (Shaha et al. 2008) and is linked to negative psychosocial outcomes in individuals experiencing reproductive challenges (Cina 2007; Giurgescu et al. 2006).

As no previous research has been identified that specifically addresses un-
O-157 HELPING CANCER PATIENTS PREPARE FOR HOSPICE
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People with life-limiting cancer will make decisions about their end-of-life care at some point during their illness. Hospice is an option of care aimed at providing optimal quality of life at the end of life. Nursing plays a major role in helping people transition from curative treatments or treatment that control the disease to end-of-life care. Choosing hospice is difficult for many people with cancer. Furthermore, health care providers also face challenges in discussing end-of-life care. The purpose of this presentation is to discuss issues associated with engaging patients in conversations regarding end-of-life care and to offer strategies that can be implemented by nurses to help people with cancer prepare for hospice care.

Topics to be addressed include uncertainty of prognosis, initiating end-of-life discussions, timing discussions, determining eligibility, multiple cancer treatment options, possible patient reactions, and the role of family and caregivers. Strategies for nursing will be presented in an algorithm format. First, nurses begin with examining personal beliefs and developing a thorough understanding of hospice and end-of-life care. Nurses can then identify appropriate patients, observe for opportunities to engage, assess patient needs, and provide information to patients/caregivers. Through the use of communication techniques and developing an interdisciplinary team approach, patients will be better prepared to transition to hospice care.

CONCURRENT SESSION C9
“PALLIATIVE CARE” (ROSWELL I)
CHAIR: ELIZABETH AGUNWAH

O-158 INTEGRATION OF PALLIATIVE CARE SERVICES INTO A TERTIARY ACUTE CARE PRIVATE HOSPITAL: THE CHALLENGES AHEAD...
Karen Gower, Graduate Diploma Nursing (Cancer).
The Wesley Hospital, Brisbane QLD, Australia.

The Wesley Hospital is one of Queensland’s largest private hospital offering a complete oncology service. Patient numbers have continued to grow each year since cancer became one of the hospital’s key service areas. The hospital has been at the forefront of innovation and development in cancer care both statewide and nationally. From these humble beginnings the services have continued to grow. The radiation centre has three linear accelerators treating over 100 patients per day as well as offering high dose rate brachotherapy treatment. The haematology/oncology day care unit now treats 60 patients per day and admits around 1,100 patients each year to the hospital as well as providing a range of ambulatory care and day procedures.

In 1996 the Wesley open a nine-bed transplant unit. This unit is the only private facility offering both autologous and allogeneic stem cell transplants in Australia. Since its opening it has performed 350 transplants (85+ per year) and treats patients from all areas of Queensland as well as from northern New South Wales and the Pacific region. In 2002 a review of palliative care within the organisation was completed to determine the key guiding principles and core components of service model were identified. The guiding principles included: Patient and Family Centred Care; Enhanced Community Provision; and Supported by Specialist & Hospital Provision. The core components of the model were themed under six main headings: Timely identification of palliative care needs; Holistic Assessment; Integration of services; Co-ordination of care; End of Life & Bereavement Care; and Public and Professional Awareness.

Findings:
Following the review of the data obtained from all the strands of work undertaken the key guiding principles and core components of service model were identified. The guiding principles included: Patient and Family Centred Care; Enhanced Community Provision; and Supported by Specialist & Hospital Provision. The core components of the model were themed under six main headings: Timely identification of palliative care needs; Holistic Assessment; Integration of services; Co-ordination of care; End of Life & Bereavement Care; and Public and Professional Awareness.

Table of Contents:

Conclusion
The proposed model provides a framework around which palliative care services in Northern Ireland can be made more accessible and effective to the growing numbers of people who will require them. However this project is the first stage of a process that requires more development in terms of implementation for practice.

O-159 DEVELOPING A REGIONAL MODEL FOR PALLIATIVE CARE PROVISION FOR NORTHERN IRELAND
Sonja McIlfatrick, Donna Fitzsimons.
University of Ulster, Newtownabbey, United Kingdom.

Aim
To develop a regional model of palliative care provision for Northern Ireland.

Background
Palliative care patients present a great challenge to professional service providers, linked with complex physical needs but also the emotional context in which care is provided. The definition of palliative care was care delivered to any adult in the last 12 months of life.

Methods
In order to achieve the aim five main work strands were developed:
1. A comprehensive review of the literature
2. A regional need assessment
3. Professional Consultation achieved by a variety of different activities, such as email discussions (n=145 delegates), focus groups and interviews (n=87 participants included GPs, District Nurses, Palliative Care Specialists)
4. User consultation comprised of evidence from studies undertaken in the local context. Through the efforts of these studies the views of approximately 82 patients, 91 carers (both active and bereaved) and 123 professionals have been sought.
5. District Nursing Shadowing Exercise
6. Consultation Workshop (n=60 participants)

Findings
Following the review of the data obtained from all the strands of work undertaken the key guiding principles and core components of service model were identified. The guiding principles included: Patient and Family Centred Care; Enhanced Community Provision; and Supported by Specialist & Hospital Provision. The core components of the model were themed under six main headings: Timely identification of palliative care needs; Holistic Assessment; Integration of services; Co-ordination of care; End of Life & Bereavement Care; and Public and Professional Awareness.

O-160 NEEDS ASSESSMENT OF CANCER PATIENTS AND THE OUTCOME MEASURES OF A STANDARDIZED PALLIATIVE CARE PLAN: THE EGYPTIAN EXPERIENCE
Nawar Elkalbey, DNS, Soaad Hashem, B Sc. N, Mona Elshater, B Sc. N.
National Cancer Institute, Cairo University, Cairo, Egypt.

Palliative care is a concept of care which provides coordinated physical, emotional & spiritual support not only for patients who have advanced and incurable disease, but also those who need symptom relief during complications from which they will recover. It is a proactive care seeks to maximize quality of life for patients and families. Perception and level of experience of health care professional may affect the continuity of care. Nurses needs educational support and written guidelines to enhance their experience of health care professional may affect the continuity of care. Nurses needs educational support and written guidelines to enhance their performance and provide quality palliative care.

The purpose of this study is to develop a standardized care plan based on assessment of palliative care needs of cancer patients, and evaluate the impact of the implemented care plan on the quality of care provided and patients satisfaction.

Methods
A convenient sample of adults and pediatric cancer patients As well as nurses assigned to perform the care were recruited from the palliative care unit. Both patients and nurses assessed before and after implementation of the care plan. Setting: National Cancer Institute, Cairo University, Egypt.

Tools: 1- Questionnaire completed by patients and structured interview completed by the researchers if patients are illiterate. 2- Palliative Performance Scale (PPSv2). 3- Problems assessment tools. 4- Checklist for recording activities performed by assigned nurses. 5- nursing guidelines and patients self-care instructions.
The presentation will describe the results and analysis of patients response before and after implementation of the care plan. Also the significant differences in nursing performance in spite of the shortage of staff and workload . Implications for practice: Palliative care is important specialty, nurses play important roles in supporting patients during the various stages of illness. Educational and training programs should be revised and adapted to the needs of local setting.

O-161 IMPROVING END OF LIFE CARE IN THE ACUTE CARE SETTING.
Lisa Wayment, Christina Fabbruzzo-Cota.
Mount Sinai Hospital, Toronto, ON, Canada.

Cancer remains the second leading cause of death in Ontario (Cancer Care Ontario, 2004). As a result in the acute care setting we are seeing an increase in the number of patients receiving or requiring end of life care. Mount Sinai Hospital’s focus on the delivery of patient/family centered care aligns with the recognition that there is a knowledge gap in the provision of end of life care in the acute care setting. It is well appreciated that clinical staff nurses physically and psychologically support the patient and family through their end of life experience. These nurses voiced emotional distress and lack of confidence and knowledge when caring for dying patients and their families. A chart review also identified that many standard end of life care orders were frequently missing or were not addressed. The review of the literature supported that these gaps do exist and can be addressed through a variety of strategies. There is clearly an opportunity to address these concerns and propose solutions to improve overall end of life care within our organization. (McKechnie & MacLeod 2007) comment that whether one has a “good death” or not is determined not only by the progression and management of the disease process by health professionals but also by the way in which one is perceived by self and others. Further discussion and transfer of knowledge with nursing and the interdisciplinary team will aid in the ongoing development of best practice initiatives, consistent and enhanced patient and family management specific to end of life care.

O-162 CANCER PATIENTS’ PAIN SEVERITY, SATISFACTION WITH PAIN MANAGEMENT AND PATIENT-RELATED BARRIERS TO PAIN MANAGEMENT IN A TEACHING HOSPITAL’S ONCOLOGY UNITS IN ISRAEL.
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Background
Pain among cancer patients is a national and international problem. For this reason, the oncology nursing division at a major tertiary institution in Israel is conducting a quality assurance program to improve the control of cancer patients’ pain. Among the projects implemented to achieve this goal was a survey study that examined not only their pain severity, but their pain management satisfaction and pain management barriers in order to identify areas of possible weakness within its pain palliation program.

Purpose
To examine cancer patients’ pain severity, satisfaction with pain management and patient-related barriers to pain management in oncology units at a teaching hospital in Israel.

Design: A descriptive, cross-sectional, correlational design was employed. The study sample consisted of a nonprobability convenience sample of ambulatory (n=76) and hospitalized (n=68) patients experiencing pain in the last 24 hours. The patients were drawn from the oncology, hematology, and bone marrow transplant departments and the oncology day care and radiation units.

Method
Patients who had experienced pain in the last 24 hours completed three questionnaires: The Revised American Pain Society Questionnaire, The Barriers Questionnaire – Short Form and the Personal Profile Questionnaire. Data was analyzed using descriptive statistics to describe the sample and the study’s key variables, bivariate correlations to examine relationship between the key variables, and t-test to detect differences.

Results
Although over 60% of the patients reported moderate to severe present pain levels and 85% reported experiencing severe pain levels in the last 24 hours, patients were very satisfied with nurses’ and physicians’ treatment of pain. There was a significant relationship between patients’ pain severity and their expectation of possible pain relief (present pain: r=0.27, p=0.002; worse pain: r=0.26, p=0.002; lowest pain level after medication: r=0.51, p=0.000). The demographic item that demonstrated the greatest significance was education. The less educated patients had significantly higher pain severity scores. The greatest barriers to pain control were “fear of addiction” and “medication should be saved in case the pain gets worse”. Nursing Implications: Because of the relationship of cancer patients’ pain severity and their expectations regarding pain control, patient education will play an important nursing role in improving pain control.

O-163 SCREENING FOR DISTRESS, THE 6TH VITAL SIGN: A CANADIAN STRATEGY FOR INFLUENCING PERSON-CENTERED CARE.
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Funding has been made available for five years to implement the Canadian Strategy on Cancer Control, through the auspices of the Canadian Partnership Against Cancer. The Cancer Journey Action Group is one of the eight action groups charged with specific mandates. Its mandate is to provide leadership to change the focus of the cancer system so that patient, survivor and family member needs are better served.

One of the strategies identified in achieving the vision of a person-centered system is Screening for Distress (the 6th Vital Sign). Screening for distress is a proactive, rapid identification of selected indicators that allow clinicians to determine if further assessment and/or referral is necessary. Ideally there needs to be better access to psychosocial services, information and support, and navigation across the system if the quality of life of those living through a cancer experience is to be improved. Research on the effectiveness of developing national strategies on patient care is required. This work presents an excellent opportunity to rebalance the focus of cancer care and access to psychosocial services.

O-164 MEASURING SLEEP: CORRELATIONS BETWEEN OBJECTIVE AND SUBJECTIVE MEASUREMENT IN A SAMPLE OF LUNG CANCER PATIENTS.
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Purpose
Sleep problems in patients with lung cancer are under-recognized and under-treated. While much of the previous research has focused on self-reported sleep measures, now objective measures are adding more information to understanding the issues. The purpose of this paper is to evaluate the correlations between both subjective and objective measures of sleep.

Methods
Participants were referred by oncologists and nurse practitioners from the Philadelphia and Buffalo VA Medical Centers and asked to participate following one cycle of platinum-based chemotherapy. Participants were asked to complete the following: Pittsburgh Sleep Quality Index (PSQI), a sleep diary for 7-days and wear the motionlogger actigraph (Ambulatory Monitoring, Inc.) for 7-days. Descriptive, correlational analyses were used.

Results: Among 50 participants, mean age was 64.2 years (SD=9.9, Range=47–74), with 98% male, and 50% African American. The majority of patients were diagnosed with NonSmall Cell Lung Cancer (73.6%) and 100% received platinum-based chemotherapy. PSQI results revealed mean sleep latency 36.5 (SD=31.2), mean sleep duration 6.3 (sd=1.6) hours, and mean sleep efficiency 74.5% (sd=19.9). Motionlogger actigraphy results revealed mean sleep latency 75.7 (sd=83.2), mean sleep duration 5.2 (sd=2.2), and mean sleep efficiency 66.8% (sd=16.4). The PSQI mean global sleep quality was 9.0 (sd=4.0) with 77% of the sample scoring above the clinically significant cutoff score of five. We divided the sample into good sleepers (PSQI < 5) (n=11) and poor sleepers (PSQI ≥ 5) (n=37). Significant correlations in poor sleepers were found between subjective and objective measures of sleep duration (r = 0.44), and sleep efficiency (r = 0.38). A significant negative cor-
O-165 A CASE REPORT: THE DESIGN, IMPLEMENTATION AND EVALUATION OF THE CANCER CARE NURSE RESEARCHER PROJECT (CCNRP)
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Cancer nurses are well placed to make an impact in improving health outcomes of patients by providing evidence based nursing care. There is a robust body of literature documenting the barriers to undertaking and utilising research amongst nurses. Positions such as professorial chairs, research fellows and directors of nursing research are best placed to combat these barriers by supporting nurses at an organisational level. However, these positions are not designed to support a specialised team of nurses at a service level. Although the literature has documented the role of nurse researchers supporting nurses at a service level and in the clinical setting, there is little information in relation to the design, implementation and evaluation of such role.

The “Cancer Care Nurse Researcher Project” (CCNRP) was a joint-initiative of Cancer Care Services (CCS) and Centre for Clinical Nursing (CCN) at the Royal Brisbane and Women’s Hospital (RBWH). This project was implemented over a 12 month period from July 2008 to June 2009. The project included (i) designing the role description of the nurse researcher (ii) creating a model of support system for the role and (iii) evaluating the outcomes and deliverables of the role over a 12 month period.

Findings from the evaluation demonstrate a success in implementing the role of a nurse researcher at CCS, RBWH. Within the first year of appointment, primary research and systematic review activities have been initiated and funding achieved through competitive research grant processes. The model may serve as a reference when designing a structure for nursing research in cancer care settings.

O-166 ENHANCING THE CLINICAL LEARNING ENVIRONMENT FOR ONCOLOGY NURSING STUDENTS
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Nursing students are our future generation of oncology nurses. Undergraduate educators are challenged to provide a comprehensive and rewarding introduction to oncology nursing but are frequently limited to teaching clinical concepts to students as part of a general medical-surgical nursing course. At our institution, nurse educators and clinicians on the inpatient oncology unit actively collaborate to ensure that the unit provides the optimal clinical learning environment to facilitate positive student learning during clinical rotations. Educators utilize a number of teaching strategies so that students gain a comprehensive introduction to the diversity of oncology nursing, including a patient assignment rubric, evidence-based practice resources, and opportunities to discuss professional and personal issues unique to oncology nursing. Focus groups held with past undergraduate oncology nursing students revealed that students especially appreciated opportunities to partner with staff, have continuity with assignments, and learn in an environment where students feel trusted and autonomous. Because staff-student relationships are critical to the learning environment, unit inservices were held to recognize how staff can engage and support students in optimal learning opportunities. The effectiveness of teaching strategies will be evaluated with the Clinical Learning Environment Scale (Dunn & Burnett, 1995) and additional surveys will evaluate clinical outcomes with oncology unit staff. Effective undergraduate teaching in the oncology clinical setting may have an important influence on students’ future career preferences. Nurse educators need to partner with clinical nursing staff to describe and create the optimal clinical learning environment for undergraduate oncology nursing students.

O-167 THE DEVELOPMENT AND VALIDATION OF CLINICAL SKILL COMPETENCY ASSESSMENT TOOLS
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Competency has an important place within nursing education as a means of promoting quality care to patients (Pirie & Gray, 2007). A range of indicators exist for the assessment of competence (Evans, 2008). Within the realm of direct observation, interest in tools or checklists to assess discrete clinical skills remains prominent. Employer demand and the provision of compatible information for promotion and recognition serve as reasons for the need for quantifiable data and further support the use of clinical skill competency assessment tools (Andre, 2000).

The Australian Government’s Strengthening Cancer Care Initiative, National Cancer Nursing Education Project (EdCan) provides a way forward for the development of the cancer nursing workforce in Australia through the provision of a framework, a set of capabilities outlining role expectations for nurses working in cancer control, and resource materials aimed at supporting nurses to acquire these capabilities. One further aim of the project is to deliver a suite of tools to support the assessment of the broad range of attributes and capabilities that comprise nursing practice. The project developed tools to assess four clinical competencies, identified as core areas of practice and important to ensuring the safety and quality of patient care. An evidence and best practice review was conducted to guide the structure, content and rating system of these tools. With ethics approval, content and face validity of tools was established using expert panels via an anonymous web-based platform. A minimum of nine panelists for each tool provided comments and a rating for the ease of assessment, structure of the tools and relevance of the performance criteria and rubrics. Analysis indicated overall agreement that the tools defined the essential elements of Specialist Cancer Nurse performance in the related tasks and that the rubrics describe levels of performance across the development continuum.

Pilot testing of the tools is underway in a number of Australian states, with a view to establish national consistency in competence assessment.

O-168 WORKING CONDITIONS AND PROFESSIONAL EDUCATION IN ONCOLOGY NURSING IN COUNTRIES OF CENTRAL AND SOUTH AMERICA
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The constant scientific and technological development in the area of oncology, in addition to phenomena such as globalization of the economy, changes in communication and working systems, pose major challenges to nurses working in areas of oncology in countries Central and South America to meet increasing educational and work demands that day by day are generated in specialized units and services in this area.
International organizations including WHO, have worked in the professional regulation of nursing, the ICN has proposed guidelines for practice universal basic and specialized in order to help resolve issues of authority, definition, boundaries, scope of practice and standards training for the specialties of nursing. As the importance of international trade agreements, minimum standards should be established within regions, so that professionals can practice their profession when they move from one country to another. In many countries an important dynamic aspect of regulation is related to the employment of staff of health without academic title, as a result of restructuring initiatives and cost reduction.

It is necessary to recognize the common problem in professional practice and specialized care for people with cancer and to identify whether all countries in the region has achieved a level of specialized training within this field of nursing. With the information obtained from different countries of Latin America, this study aims to develop a joint proposal to the development of the specialty of oncology nursing in the region, through cooperative mechanisms to facilitate information and manage policies, programs and projects specialized vocational training and improving working conditions in a field that posed permanent occupational risk to workers.

O-169 DEVELOPMENT AND EXCELLENCE IN ONCOLOGY NURSING PERSPECTIVE OF A NATIONAL ASSOCIATION
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The strengthening of collaborative work in academic and nursing associations and searching alternatives to solve the most significant problems of development of the profession is recognized by some authors as a challenge, especially in environments where financial resources and the time nurses are limited to meet the responsibilities and commitments related to an Association.

Within the team work concept, is described the process of works and projects of the Colombian Association of Oncology Nursing (AEOC) for 20 years, which was created to represent the oncology nurses and to promote scientific development and excellence in this specialty in the country. Results that increasingly geared towards a more prominent position in the field of professional health and nursing in the country and in Latin America are presented.

The persistence and leadership of three of its founding members in achieving the original objectives now permit spell out in detail the advances and achievements in recent years in response to the concerns and needs of more than 80 partners, including mention of the Website and their updating online courses, the recognition from national and international cancer societies, regional and national academic conferences, position statements, guidelines for safe practice care, academic endorsements, links to associations and societies of cancer, promotion of cancer nursing research and review of regulations in cancer.

O-170 APPLYING THE PRINCIPLES OF MAGNET RECOGNITION EXCELLENCE TO THE ONCOLOGY NURSING WORK CULTURE
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Since 1994, the American Nurses Credentialing Center (ANCC) has recognized health care organizations that characterize exemplary nursing excellence. Currently, only 334 of the over 5,000 health care facilities in the U.S. have Magnet status. While the Magnet recognition program is based in the U.S., 2 hospitals in Australia and 1 in New Zealand have received Magnet recognition and other international facilities are in varying phases of application preparation.

The Magnet Program is a standards-oriented, evidence-based quality-driven recognition given to facilities that personify a work environment that supports excellence in nursing practice. Criteria indicative of Magnet status were initially identified through research completed in 1983. The original 14 Forces of MagnetismTM were delineated as core characteristics of health care facilities that attracted high quality nursing staff which resulted in enhanced patient outcomes. In 2007, ANCC commissioned an analysis of the existing Magnet framework which resulted in the formulation of a new Magnet Model. The Forces of Magnetism and their associated sources of evidence are now collapsed in an alternative framework within 4 major domains: transformational leadership, structural empowerment, exemplary professional practice, and new knowledge, innovations and improvements. The current model emphasizes and requires reporting of empirical patient, nurse and organizational outcomes. Additionally, the Magnet recognition provides consumers with benchmarking capability in determining the quality of care they can expect to receive. When the annual U.S. News and World Report delineation of “America’s Best Hospitals” is published, being a nurse Magnet facility now contributes to the total institutional score for high quality inpatient care.

Currently, three of the thirty-nine U.S. National Cancer Institute—designated Comprehensive Cancer Centers hold Magnet recognition. However, the majority of cancer patients in the U.S. receive care in community cancer programs. Many of the current 334 Magnet institutions have oncology programs whose outcomes have contributed to a successful Magnet designation. Additionally, facilities currently considering or who are in the process of applying for Magnet recognition employ oncology nurse leaders whose exemplary practices can be chronicled within evidence submission. This presentation will describe oncology nursing exemplars of excellence within the 4 domains of the Magnet model. By delineating these exemplars, audience participants will be able to benchmark their oncology nursing culture of excellence and appraise their institution’s readiness for Magnet application.

O-171 WHAT CAN WE LEARN FROM CANCER PATIENTS’ REFLECTIONS ON LIFE AS THEY APPROACH DEATH? QUALITATIVE FINDINGS FROM AN ANALYSIS OF DIGNITY THERAPY TRANSCRIPTS
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One of the most perplexing challenges facing end of life providers is how to help patients achieve a sense of dignity as death draws near. Over the past decade our research team has delved into the cancer patient experience of dignity as death approaches. Out of these empirical research efforts, a conceptual framework of patient dignity was developed, followed by the creation of a dignity therapy intervention. Dignity therapy is a novel, manualized, therapeutic approach designed to decrease suffering, enhance quality of life and bolster a sense of dignity for patients approaching death. In our earlier work, the benefits of dignity psychotherapy were documented in a sample of 100 dying cancer patients (50 from Winnipeg, Manitoba, Canada, and 50 from Perth, Australia). All patients were over the age of eighteen and had a life expectancy of less than six months. In this qualitative study, a random sample of 50 of the 100 dignity therapy transcripts was analyzed according to the qualitative method of interpretive description. All 50 transcripts were independently coded by three coders. Meetings were held regularly after each successive 5 transcripts had been coded, so that the coding categories could be discussed and refined. The findings revealed that dignity therapy served to provide a safe, therapeutic environment for patients to review the most meaningful aspects of their lives in such a manner that their core values were apparent. Core values are defining and permeating features of a patient’s whole life. The most common values expressed by our sample included “Family”, “A Sense of Accomplishment”, “True Friendship”, “Pleasure”, “Rich Experience”, and “Caring”. Exemplars of each of these values illustrate the defining role of values in our lives. These exemplars will be shared with the audience, and the findings will be discussed in terms of values theory, our conceptual framework of dignity, and the practical ways that nurses and other health care providers can enhance the dignity of dying cancer patients for whom they care.
O-172 PATTERN OF PALLIATIVE CARE AT HOME OF THE CAREGIVER
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Generally, all people want to die, or live in the final moments of our lives in the midst of love and understanding of those we love. Only then, will palliative patients feel warmth and happiness. Therefore, family members play an important role in providing palliative care to the patient who the family members respect, love, and have done so much for them. This research is a qualitative applied research study of palliative care at the home of the caregiver, conducted as a Participatory Action Research. Data were collected from 7 subjects consisting of the primary caregivers of the palliative patients who provide palliative care at least 5 days per week, and live in the same home. In-depth interviews and focus group discussions were utilized for data collection.

Analyses revealed that the primary caregivers are wives for 5 of the subjects, 1 is a daughter, and 1 is a younger sibling. Of all the caregivers, 6 are female and only 1 is a male. The subjects gave care with love, sympathy, gratefulness, and genuineness. Providing palliative care is considered the final chance to give to the loved one. Palliative care at home is about providing physical needs, such as bathing, comfort of the patient, cooking and feeding, sometimes through nasogastric tube feeding, medication administering, sometimes involving insulin injections, and wound dressing. It also entails satisfying emotional and social needs, by caring with love, sympathy, and encouragement; by reassuring the patient that he or she is not a burden to the family. Turning on Buddhist preaching to soothe the mind and to boost spirituality is also important.

The results suggest that the community needs support in providing equipment, advising and consulting, and reinforcing the workforce to boost the confidence and feeling of security for the palliative caregivers.

O-173 THE IMPACT OF PALLIATIVE CARE ON CANCER PATIENT’S MANAGEMENT IN RADIOTHERAPY DEPARTMENT OF THE UNIVERSITY COLLEGE HOSPITAL, IBADAN, NIGERIA.
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Background
Cancer specialists all over the world are still struggling with the challenge of finding a cure for cancer. As a result, more patients are living with cancer. These large numbers of patients facing the challenges of living with cancer or dying from it, face major challenges which affect their quality of life. Palliative care was established to support patients and their families throughout their illness through the relief of suffering and improvement of quality of life.

Learning objectives
This study was aimed at identifying the benefits patients derived from palliative care. Participants will learn about: (1) the need to use holistic approach to care for dying patients and their families. (2) How palliative care helps to improve quality of life of the cancer patients during course of their disease.

Methods
Two Questionnaires were administered to cancer patients. One at the initial stage and second 4 months later.

Findings
A total of 105 patients agreed to the interview. All the 105 patients completed the interview at the initial stage and 90(85.7%) at the final stage, 15(14.2%) patients died during the duration of the study. At presentation fifty-nine (56.2%) had pain, 8(7.6%) loss of appetite, 11(10.5%) nausea and vomiting, 15(14.3%) had tender wound, 12(11.4) had weakness and fatigue. Many had combination of these symptoms. Seventy patients (66.7%) were visited at home by the palliative care team. The remaining 33.3% were not visited by the team but were only seen in the hospice and palliative day-care center of the hospital. The patients enjoyed pain and symptom control, psychosocial, spiritual and emotional support. Also, bereavement counseling, and assessment for will writing was advocated. Proper Wound management which improved patient’s quality of life, promoted comfort, improved confidence and prevented isolation. And they had easy access to analgesics (oral morphine) as one of the modalities of palliation. At the end of 4 months all the symptoms were drastically reduced as follows, pain 25(27.8%), loss of appetite 5(5.6%), nausea and vomiting 9(10.0%), healed wound 12(13.3%), weakness and fatigue 8(8.9%) and 31(34.4%) were symptom free.

Conclusion
The result suggests that palliative care service has played a role in improving quality of life of cancer patients.

O-174 NUMBER OF EMERGENCY ROOM VISITS BY ONCOLOGY PATIENTS AT THE END OF LIFE: DOES THIS DEFINE QUALITY PALLIATIVE CARE?
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Objectives
• To determine the pattern, rationale and appropriateness of visits to the emergency room by palliative oncology patients in the last two weeks of life.
• To ascertain patient outcomes related to emergency room visits in the last two weeks of life.

Background
Given the overburdened status of our health care system, specifically hospitals, a lot of recent attention has been placed on the use of emergency rooms (ER) to access care. Our provincial cancer care agency has established a Quality Index on their public website to monitor quality of cancer services across the care continuum from screening, through diagnosis and treatment, to palliation. One palliative care indicator currently tracked is the number of ER visits by oncology patients within two weeks of death. Literature supports that avoidable end of life ER visits can indicate poor quality care since most patients indicate their desire to be cared for and to die at home. However, the numerical data reported on the quality index only provide raw visit numbers by oncology patients. Therefore, it is not possible to conduct any analysis of the rationale, appropriateness or outcome of the ER visit by these palliative patients. However, this information is critical in determining whether the ER visit was the most effective and efficient way to access care for this group of patients.

Methods
Our Palliative Care Consult Team conducted a retrospective chart review of 100 oncology patients who had a documented ER visit at our tertiary level hospital within the last two weeks of life. The audit spanned a 9 month period. Audit indicators included patient demographics, type and stage of cancer, current treatments, co-morbidities, existence of advanced directives or discussion of goals of care, current community supports, previous involvement of Palliative Care professionals, reason for the ER visit, source of the referral to ER, ER interventions, ER disposition, hospitalization course, hospital length of stay, date and location of death.

Outcomes
Findings indicate that numerous factors may prompt an ER visit in this patient population. However, raw visit numbers alone are not an indicator of poor quality palliative care. Further investigation shows that the ER is often the most appropriate place to access care or the only viable alternative for palliative oncology patients. This may be due to issues including symptom complexity, treatment regimens, lack of community supports, lack of access to a primary care physician, lack of adequate advanced care planning and failure to discuss and/or determine the patient’s goals of care.

Conclusions
Indicators are key components in identifying and trending quality palliative care, but it is essential that those chosen actually measure quality and are not just selected for ease of reporting.
O-175 PROMOTING QUALITY CARE FOR ONCOLOGY PATIENTS WITH MALIGNANT PLEURAL EFFUSIONS: RESULTS OF A RETROSPECTIVE AUDIT OF A REGIONAL OUTPATIENT PROGRAM
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Malignant pleural effusions (MPE) are common complications for patients diagnosed with advanced cancers of the lung, breast and lymphoma as well as other cancers. This complication causes distressing symptoms, reduced quality of life, and increased morbidity and mortality for patients with an average life expectancy of less than 6 months. Standard inpatient management of malignant pleural effusions via chest tube insertion and talc pleurodesis often results in only temporary symptom relief as well as an extended hospitalization. Our Malignant Effusion clinic has successfully established outpatient management of this complication via the insertion of a tunneled catheter (PleurX®) as our regional standard of care. Evaluation of our initial pilot program data for 104 patients indicated that symptom management improved, complications were minimal and patients were successfully maintained in the community. However, as we completed the third year of our program we decided to comprehensively evaluate the program’s outcomes via a retrospective chart review of all patients treated in our program over the previous three years. We wanted to ensure that we were providing quality care for this group of complex palliative oncology patients and not simply shifting care to the outpatient setting. Audit indicators included: patient demographics; cancer diagnosis; symptom burden and response (as measured by the Edmonton Symptom Assessment Scale); functional status (as measured by the Palliative Performance Scale); types and frequencies of complications; length of time of catheter in situ, numbers of clinic visits, hospitalizations including rationale, reinsertion rate, mean time to patient death, and spontaneous pleurodesis rate. In addition we evaluated both program costs and savings across the various health care system sectors. This presentation will highlight the overall audit results focusing on quality, safety and patient outcomes. In addition, we will discuss overall health care system implications, costs and benefits.

O-176 PALLIATIVE CARE IN A HOME CARE SETTING
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Background
With a burgeoning elderly population and a shortage of health care personnel, palliative care is increasingly occurring in the home. This will place an expectation upon informal caregivers to manage the palliative care of their family members. This qualitative, grounded theory study was conducted to understand how the family dyad copes in these potentially stressful circumstances.

Method
Purposeful and theoretical sampling was used to select participants. Five individuals who were dying of cancer, three informal caregivers, and nine bereaved caregivers whose family members had died at least three months previously were interviewed. Data were collected and analyzed simultaneously using a constant comparison approach.

Findings
Results indicate that caregivers who try to fulfill their dying family member’s wishes often do so at the expense of their own health or financial circumstances. The core category ‘covering’ captures how the caregiver enables their family member to die in the place of his or her choosing. The basic social process, ‘dancing on the stairs’, chronicled the stages of the patient-caregiver relationship as they navigated through their final moments together. The basic social process occurs only in the context of a relationship; requiring that one is willing to engage through a series of events with another person until the situation has been resolved.

Discussion
Family caregivers reported that it was an ‘honour’ to accompany their family member during this final transition. They indicated however, that they could not do so alone and needed the support of an extensive network of health care personnel, family, friends, and volunteers. To maintain the dying family member in the home it is therefore important that health care personnel are available to the family dyad and are able to provide consistent support and guidance. It is recommended that future research be conducted regarding the utility of the basic social process in assisting health care personnel in this endeavour to support the family.

O-177 RETENTION STRATEGIES FOR AN ENDANGERED SPECIE: ONCOLOGY NURSES
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City of Hope, Duarte, CA, USA.

Focus Area: Workforce Planning

Significance and Background
There is a dwindling supply and an increasing demand for nurses as evidenced by the latest projections from the U.S. Bureau of Labor Statistics (2004) indicate that more than one million new and replacement nurses will be needed by 2012. Today, fully 75% of all hospital vacancies are for nurses. The nursing shortage is expected to intensify as baby boomers age and the need for health care grows. There is a dire need to find measures to retain our current human capital.

Purpose
The purpose of the study is to identify factors that may significantly influence the retention of oncology and nurses’ self perception of their performance in their workplace.

Conceptual Framework: Valuation quotient is the degree one feels valued and important. Valuation may come from intrinsic, and extrinsic sources. Nurses who feel valued and experience job satisfaction bring about better patient outcomes and patient satisfaction. Organizations should examine the factors that may contribute to increasing the “valuation quotient” and develop them further.

Methods and Analysis
The study is an exploratory quantitative research through a paper and pencil survey called “Survey on Retention Strategies for City of Hope Nurses” Factors such as Work Fitness, Work Environment; Human Resource Practices; Collegial Support at the Workplace; Education and Learning Opportunities; were included in the survey. The findings include the self reporting of nurses performance and perceptions of factors that may influence their decision to continue employment in facilities that provide care to patients with patients with chronic illnesses. A multiple regression analysis was used to report the results.

Findings and Implications
The knowledge and insight about City of Hope nurses who specialize in oncology care will be valuable in development and implementation of incorporating policies and strategies relating to work environment, collegial support, human resource practices, educational support and other factors that may impact the decision of senior nurses to stay or leave the workplaces. There are numerous implications to research, practice, education and policy making.

O-178 DEVELOPMENT OF AN INSTRUMENT FOR PERFORMANCE EVALUATION OF NURSES IN A PEER REVIEW PROCESS
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Purpose
The purpose of this project was to develop an instrument for a peer review process for registered nurses in a community hospital.

Background
Peer reviewers for staff nurses are other practicing clinical nurses who are in a position to observe and evaluate their performance in relation to established criteria. An evaluation instrument lists the standards of expected performance and serves as a guide for peer review as well as a means for documenting ratings. Defined performance standards must be clear to everyone in order for the peer review process to be effective. This presentation describes the process used by a group of direct-care nurses to define nursing practice at Reston Hospital Center and develop an instrument to guide and document peer review.

Methods
The Synergy Model provided the theoretical basis for the instrument. The process began with interviews of key administrators and continued with multiple discussions that culminated in consensus on the general desired for-
mat. Items were generated through small group work and open discussions. Reference materials included published standards of practice, codes of ethics, and professional literature related to performance evaluation and instrument development. The first draft was reviewed and discussed with the administrative team and minor changes were made. Psychometric testing was conducted and classes for peer reviewers were held to familiarize them with the instrument. A pilot test was conducted on two units.

**Results**
The instrument was found to be valid and reliable, and was well-received by staff nurses during pilot testing. Psychometric results were: content validity index .93, internal consistency .86, test-retest reliability .94, and inter-rater reliability .85. Each of the eight competencies of the Synergy Model was scored separately on a 3-point scale. Criteria were listed for each of the four levels of the clinical ladder. Pilot testing revealed that reviewers wanted more structure for individualized feedback and minor changes were made in the format of the tool.

**Conclusions**
This project has provided a unique opportunity for staff nurses from a variety of clinical settings to work together to define their hospital’s standards of performance for nurses and resulted in a valid and consistent peer review instrument to support professional development.

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**O-179 PROFILE OF AN INTERNATIONAL ONCOLOGY NURSING EDUCATION PARTNERSHIP**
**Carolyn Ingram, RN, DNSc, CON(C), Olive Wahoush, RN, PhD.**
**McMaster University, Hamilton, ON, Canada.**

The unprecedented oncology nursing shortage in North America is echoed across the globe, and is particularly difficult to address in developing countries that wish to build their capacity in cancer care. In the early 1990s the government of Trinidad and Tobago (T&T) initiated a program of Health Sector Reform in which capacity building in cancer care was a key element. Based on a previously successful relationship with the government of T&T, a baccalaureate nursing program in Ontario, Canada, in partnership with the government and a post-diploma baccalaureate nursing program in T&T, embarked on a 4-year collaboration with the goal of increasing formal oncology nursing education in T&T. At a previously established Ontario-based, degree-linked oncology nursing program is now offered as the major component of an oncology-focused stream within the baccalaureate nursing curriculum in T&T. In this program, which was launched in September 2008, selected 2nd year nursing students located in T&T complete 6 oncology-focused courses over 2 academic semesters including: 2 problem-based, small group, oncology-focused “theory” courses; critical appraisal of research; therapeutic communications; oncology-focused health assessment; and clinical oncology practice. These courses are supplemented by elective oncology and generally required courses developed and implemented by the university in T&T. The Ontario-based oncology courses are delivered through a blend of face-to-face and distance modalities (i.e., webconferencing and an electronic learning management system), with emphasis on the distance component. Early indications are that the program is successful in achieving positive changes in graduates' practice, attitudes and problem-solving skills. This presentation focuses on the major strengths and challenges encountered by the two universities in establishing and maintaining the necessary links between systems to support the program, and the progress that has been made in achieving the desired outcomes.

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**O-181 ENHANCING KNOWLEDGE, PROMOTING QUALITY BY EVALUATING THE IMPLEMENTATION OF ONCOLOGY ADVANCED PRACTICE NURSING ROLES**
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Expansion of advanced practice nursing (APN) roles is critical to meet increasing demand for cancer care. However, research indicates that building capacity and long-term sustainability of APN roles requires strategic planning and implementation. This presentation will describe how the PEPPA Framework, a systematic, participatory, evidence-based, patient-centred process was used to develop and implement APN roles for under-serviced populations in two cancer programs in Ontario, Canada. A major component of the project included evaluating how the PEPPA Framework influenced organizational and healthcare team planning and decision-making.

A case study design was used to examine how the use of an APN Role Implementation Toolkit, the role of a facilitator and the PEPPA Framework influenced the development and implementation of an oncology APN role. Facilitators, experienced in the introduction of APN roles mentored a healthcare team in each setting to establish the new APN role. The cases included a southern and a northern cancer setting. A variety of methods for data collection were used including document analysis, self-report questionnaires and interviews and focus groups with participating health care teams and facilitators.

Findings indicate that at both sites, using Toolkit resources and following the step-by-step PEPPA process allowed healthcare teams to examine their current models of care, identify care gaps, assess the need for an APN role related to a specific population of cancer patients, and to develop an APN role description. The use of project facilitators was perceived to be instrumental in helping teams interpret the Toolkit, identify goals and outcomes and navigate through the process. Several differences were noted between sites with respect to stakeholder involvement, team dynamics and communication, structure of facilitation, and perceived organizational support and presence. Thus, the multi-site design provided the opportunity to gain insight about the application of the PEPPA Framework, interprofessional collaboration and organizational support around APN role development and implementation across oncology settings.

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**O-182 BUILDING A HEALTHY WORK ENVIRONMENT: A COLLABORATIVE PARTNERSHIP BETWEEN INPATIENT AND OUTPATIENT ONCOLOGY UNITS**
**Janet M. Forge.**
**The University of Kansas Cancer Center, Kansas City, KS, USA.**

Collaboration and communication are essential components facilitating seamless, exceptional patient care between the inpatient and outpatient oncology clinical settings. Patients flow constantly between the two settings while receiving care. There is a disconnect that exists between our...
inpatient and outpatient facilities, which does not foster a healthy working environment or collaborative partnership between nursing staff. Analysis of this issue includes commonly identified problems in both settings which compromise exceptional patient care. These mutual problems include inadequate patient education which is evidenced by lack of nursing documentation and lower patient satisfaction scores, increased number of infections identified in our oncology patient population, and inconsistencies in utilizing mutual standards of oncology nursing practice, for example. Because of the lack of communication and collaboration between nursing staff at both in-patient and outpatient settings, there is also a void in addressing and resolving these issues as a team. A collaborative partnership was formed between both settings that include project management committees with specific goals and outcomes identified for each. Quality improvement data gathered within each committee indicates positive outcomes based on measurable goals established by the committee team members. The American Association of Critical-Care Nurses’ Standards for Healthy Work Environments serves as the guide to promote supporting and engaging our oncology nurses to foster a healthy work environment and collaborative partnership between inpatient and outpatient settings. The outcome of our collaborative partnership is exceptional, seamless patient care as evidenced by positive patient satisfaction scores, lowered infection rates, and standardization of nursing practice and care found in both inpatient and outpatient settings.

O-183 THE ECONOMIC COST OF PARTICIPATING IN RESEARCH: HOW MUCH DO PARTICIPANTS REALLY PAY?
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Background
Ovarian cancer is the fifth leading cause of cancer death in women and the most deadly of the gynecologic cancers. In the USA, 20,000 women are diagnosed annually and more than 15,000 die within five years of diagnosis. The purpose of the overarching study was to explore the thoughts and feelings of women diagnosed with ovarian cancer regarding participation in drug trials. The majority of the women in the study made reference to the real or perceived financial burden of participating in research. With greater understanding of the economic conditions and requirements surrounding study participation, the researcher is better able to design rigorous yet humanitarian and feasible protocols.

Methods
A phenomenological approach employing online surveys was designed to elicit qualitative data to address the following overarching research questions:
• What has your experience been with research protocols since being diagnosed with ovarian cancer?
• What do the phrases “inclusion criteria” and “exclusion criteria” mean to you?

Premilinary Results
• Women with ovarian cancer who survive the initial, oftentimes late diagnosis, are led down a road of multiple, serial drug trials to keep them alive.
• Women with this diagnosis express anger, frustration, and feelings of abandonment when exclusion criteria deny them the opportunity to participate in promising clinical trials or when the expenses associated with the study are too burdensome.
• The concepts of study inclusion and exclusion are poorly understood in the general population and lead to feelings that they are “not good enough” or that they are being denied a last opportunity for survival.
• The economic costs of research participation may be hidden and unanticipated to both the researcher and the participant.
• Anticipated costs of research may prohibit participation in some situations.

Conclusions and Recommendations for Practice
There is a need to educate healthcare providers about the stress (including economic stress) of living from drug trial to drug trial in an effort to stay alive. Women and their families also need more information about the research experience and additional support when excluded from studies, especially for those with financial limitations to accessing care. Policy change to enable women to access experimental cancer drugs with minimal cost should also be investigated.

O-184 BRINGING TOGETHER KNOWLEDGE AND PRACTICE IN CLINICAL TRIALS: A STUDY OF CANCER CLINICAL RESEARCH NURSES IN AUSTRALIA
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Introduction
The importance of clinical trials in the development of new approaches to treatment and to optimise recovery from cancer is widely recognised. In recent years, peak bodies within Australia have increased funding for infrastructure support, including additional Clinical Research Nurse (CRN) positions. Surprisingly little is known about this rapidly growing workforce, their knowledge and skills requirements and potential career pathways. As background to the development of a new postgraduate program in clinical trials, the Faculty of Nursing and Midwifery, University of Sydney (Graduate Diploma and Master in Clinical Trials Practice to be introduced in 2010), the perspectives of CRNs were identified as integral to the development of the new curriculum. A pilot survey of CRNs employed in clinical trial positions in cancer was conducted across the state of New South Wales. Following this pilot stage, a survey of CRNs across Australia is underway.

Method: Pilot Survey: A survey comprising 34 questions focussing on knowledge, skills and training in clinical trials was developed and pilot tested. The survey was administered through the website interface “SurveyMonkey”. Invitations to participate in the survey were distributed by the Cancer Institute of NSW (CINSW) to all CRNs based at CINSW supported cancer units (50 in total). Snowball sampling was also undertaken to maximise the response rate. Demographic information was also captured. 41 cancer CRNs in NSW completed the pilot survey. Survey data was downloaded and analysed using descriptive statistics in SPSS. Survey results highlighted variation in the knowledge and skills of the respondents. Areas were identified where CRNs felt knowledgeable and skilled e.g. informed consent, patient recruitment. Areas were identified where CRNs felt less confident in their knowledge and skills e.g. Case Report Form (CRF) design and statistical considerations. Information collected is currently being used for development of the new curriculum.

National Survey
The survey will be distributed across Australia and is the first of its kind to investigate the growing role of the CRN. As there is no single professional group or organization that provides direct access to CRNs, recruitment is being undertaken through peak professional bodies, research centres, and snowball sampling. A number of strategies are being implemented to maximise the response rate and to identify CRNs in as many locations as possible.

Conclusion
The results of this national survey will be presented and implications for this growing workforce explored. The paper will also focus on education preparation and development of the career path for nurses in this important area of cancer clinical research and practice.

O-185 DESIGNING A NURSE-FOCUSED WEB-BASED EDUCATIONAL PROGRAM FOR GOOD CLINICAL RESEARCH PRACTICE
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There are a number of programs available to educate nurses and other clinical research professionals about clinical trials. However, most of the entry level programs offer general preparation that is designed to address the needs of a wide variety of clinical trial personnel. They often do not take into account the knowledge and experience nurses bring with them or address the unique issues that arise in oncology clinical trials. Recognizing this gap, a professional nursing organization began a process to create a program that was nursing specific and reflected the unique contributions of research nurses to oncology clinical trials. A four member project team was selected which included experienced and novice clinical trials nurses from academia, the community, and the pharmaceutical industry.
During initial discussions, the project team worked through the challenge of differentiating between the content that should be included in an introductory course and that which would be considered more advanced. Once essential content was identified, a course outline including 12 interactive modules was developed. The modules focus on the elements of good clinical research practices with an emphasis on the clinical trials nurse role. The course starts with general information about research and good clinical research practice, then is organized around the major sections of a research protocol. Since the team wanted the learner to walk away with skills that could be applied in practice, multiple interactive activities were designed including a protocol analysis exercise.

By the end of the course, it is expected that the clinical trials nurse will be able to successfully operationalize a clinical research protocol. The course teaches novice clinical trials nurses about: the science, components, process and requirements of clinical research studies; regulations related to clinical trials; key components of the research nurse role such as advocacy, patient and staff education, and protection of patients and protocol integrity; and, key resources available to aid in implementation and maintenance of clinical trials.

Three main challenges were encountered in developing the course. The first was determining how to make the course comprehensive but not overwhelming to the learners. The second was identifying how the course can address the wide variety of ways clinical trials nurses operationalize their roles. Finally, the team wanted to make sure that the unique role of clinical trials nurse was emphasized. These challenges continue to be addressed as the first learners are enrolled in the webcourse.

O-186 BUT IT’S THEIR RIGHT TO SMOKE: CRITICALLY REFLECTING ON THE RIGHTS OF SMOKERS
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In this presentation, the rights of smokers, as expressed by hospitalized patients, health care providers, and health care policy makers, provides the premise for a critical reflection of rights-based arguments within the context of tobacco control. In the recent past, when there were fewer non-smokers and smoking restrictions in developed countries, a prominent expression of rights focused on non-smokers and clean air. In today’s climate of increasing smoking restrictions and decline using of tobacco, the prominent expression is more likely to reflect the smoker’s right to choose to smoke. While this shift makes sense given the diminishing numbers of smokers and the current climate in developed countries, consideration of the premise of rights-based positions reveals deeper issues of interest to tobacco reduction strategies.

An ethnographic study explored the culture of tobacco use and tobacco use management at two large Western Canadian tertiary hospitals that had implemented a policy that prohibited smoking on hospital grounds. At each site, four adult in-patient units participated in the study. Rights-based arguments were noted in the 82 patient interviews (44% smokers; 37% former-smokers), 16 health provider focus groups (n=81; 16% smokers; 17% former smokers; 67% registered nurses), and 23 key informant interviews (60% with policy makers; 40% with support staff; 13% smokers; 39% former smokers) conducted at the two study hospital sites. Statements about smokers’ right to smoke commonly reflected sentiments of people not wanting to impose their beliefs even if the behavior contributes to an individual’s ill health. These statements typically arose when talking about the smoke free grounds policy. Health care provider and policy maker comments included statements about not being able to force people to quit smoking. If patients do not listen to advice, little else can be done because they have the right to smoke. In each of these cases, the use of a rights-based argument appears to be absorbing the speaker of responsibility to influence tobacco use, regardless if the perceived responsibility is realistic or not. In a free world, individuals do have the right to choose to smoke. However, is the only right afforded individuals who use tobacco the right to choose to smoke? Alternate rights of individuals who use tobacco are identified and discussed.

O-187 OFFICE OF GLOBAL NURSING: A MODEL TO SUPPORT ONCOLOGY NURSING OUTREACH
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Oncology nurses at our NCI–designated comprehensive cancer center are able to participate in opportunities to network and share their expertise with colleagues from around the world. Five years ago, in response to increasing requests for international collaboration and consultation, a task force appointed by the nursing leaders of the medical center and school of nursing developed a proposal for an office of global nursing (OGN) to support such activities. The OGN was created in 2006 to help coordinate nursing’s contributions to academic and clinical practice international initiatives. As a large academic medical center, the institution receives many requests from health care facilities and schools around the world. Requests for nursing most often ask for help with leadership development and specialized clinical advice, particularly in the fields of critical care and oncology. Oncology nursing activities have included providing on–site consultation and education at four international sites, and hosting nurse visitors from over a dozen countries. Nurses at all levels from staff nurses to clinical nurse specialists and managers have contributed. Such participation has many benefits for professional development, personal growth, and enhanced cultural competency. Mutual respect and recognition of the common values of oncology nurses worldwide provide a strong foundation for shared learning and collaboration. The OGN facilitates these activities by responding to visitor requests and coordinating visits, identifying opportunities for collaboration, working with others in the institution to support larger projects, and developing proposals for consultation. Most activities produce revenue that helps to support the effort and is used for continuing nursing education activities such as conference attendance. The most significant challenges include managing limited resources, competing priorities, and individual nurses’ availability to travel. The OGN works closely with the requesting visitor or institution and oncology nursing to ensure that requests are carefully managed and prioritized, allowing a “win–win” for all involved.

O-188 CUSTOMIZATION OF AN ELECTRONIC HEALTH RECORD TO OPTIMIZE THE CLINICAL RESEARCH PROCESS
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In April 2004 Executive Order 13335 was signed by President Bush, creating a National Coordinator for Health Information Technology whose job was to develop “a nationwide interoperable health information technology infrastructure.” Simply put, the medical field was encouraged to move to electronic health records, and each facility was allowed to purchase and adapt the system of its choice. One of our chief needs was customization for Clinical Research utilization.

We ceded a Research Coordinator to IT to become our IT Clinical Analyst, identified our most common problems, and prioritized them based on need; a way to identify research patients to caregivers was critical. Via in–interface, we posted the study number and researcher contact info in the patient header in the EHR. This alerted all healthcare team members to the patient’s research involvement.

As we continued to identify needs we formed interdisciplinary teams to develop EHR solutions, resulting in greater acceptance of changes made. Orders specific to research included Pathology and Interventional Radiology requests for tissue specimens, Patient Access and Case Management requests to communicate patient financial and home care needs, and Diagnostic Radiology requests for tumor measurements. We’ve begun to create study–specific order sets to simplify CPOE, enhance patient care, and ensure research procedures are ordered as required. In addition, we customized standard electronic nursing assessments to enable staff to document research–required data points along with those for standard care. Other documentation is planned, with the goal of one coherent place for all patient information.

These initiatives have streamlined processes, enhanced communication among care providers, improved protocol compliance, and made auditing by our external sponsors easier. EHR customization has been incorporated into SOP’s for staff use, and our EHR IT Analyst maintains electronic EHR “how–to” guides for staff reference.
We have learned much about customizing an EHR to complement and enhance research efforts. Initially, we expected staff input into the customization process, however soon realized staff needed time to acclimate to the EHR itself. Having electronic functionality mimic the paper process in the beginning enhanced staff comfort with, and therefore acceptance of, the EHR. All personnel utilizing the EHR are encouraged to suggest improvements and are invited to participate in multidisciplinary committees focused on specific functionalities. Over time, they have begun to ask for and embrace improvements that alter their processes and make them more efficient. We now realize that the project expected to take 1-2 years, will never be “completed” because needs change as technology and health care change, but we’re definitely on our way!

O-189 NURSES AS INFORMATION GATHERERS & POLICY WONKS IN PALLIATIVE CARE IN BOTSWANA
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There is an emerging body of research aimed at understanding the determinants of place of death, as where people die may influence the quality of their death. However, little is known about place of death for people of southern Africa. This study described place of death (home or hospital) in Botswana, southern Africa. The evaluable sample consisted of 18,869 death records, all adult deaths not from trauma or pregnancy from years 2005 and 2006. Home deaths accounted for 36% of all deaths, and were predominantly listed with “Unknown” cause (82.3%), which was significant (p<0.001). This finding impeded the ability of the study to determine whether cause of death influenced dying at home. However, living in rural areas is associated with home deaths (OR=1.3). Nurses are the primary face of health care in Botswana, especially in rural Botswana, and so, they could be educated to conduct verbal autopsies, which are open-ended histories of final illnesses in order to determine cause of death. Thus nurses would gather epidemiological data available to the Ministry of Health, to end-of-life researchers, and to themselves, aiding them in providing appropriate palliative and supportive care to those who die at home.

O-190 CARING FOR CANCER PATIENTS AND CARING FOR FRAIL OLDER PEOPLE - PERSPECTIVES FROM A HOME CARE SETTING
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Introduction
The primary caregiver is a key person in the home health care setting when a patient is in need of practical help and support. The consequences of the caregiver function are to be assessed systematically in order to reveal caregiver burden.

Aim
To compare gender differences and scorings of the questionnaire The Caregiver Reaction Assessment among caregivers of frail older people and caregivers of cancer patients in the palliative phase.

Methods: Caregiver burden was measured by means of the Caregiver Reaction Assessment. A convenience sample of 224 caregivers of frail older people, and 85 caregivers of cancer patients in the palliative phase was recruited between 2002 and 2005.

Results
Female caregivers of frail older people experience significantly higher level of burden than male caregivers for eight of 24 items of the Caregiver Reaction Assessment. Female caregivers of cancer patients in the palliative phase experience significantly higher burden in only two items compared to male caregivers. Caregivers of frail older people experience significantly higher burden in four out of five dimensions of the Caregiver Reaction Assessment compared with caregivers of cancer patients in the palliative phase. Suggestions to explain these differences are presented.

Conclusion
Caring for frail older people at home is more burdensome than caring for patients with cancer in the palliative phase. Nurses should be concerned about female caregivers’ way of dealing with the caregiver function.

O-191 OPCARE9: INTERNATIONAL INTERDISCIPLINARY COLLABORATION TO IMPROVE END-OF-LIFE CANCER CARE
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OPCARE9 is an EU 7th framework coordination & support action project, with the aim of improving care in the last days of life by systematizing existing knowledge and identifying knowledge gaps. OPCARE9 provides a dynamic interface for health care providers, educators and researchers in palliative care to meet and exchange views.

The multinational project group is interdisciplinary, with representatives from nursing and other clinical professions (including medicine, pharmacy, psychology, physiotherapy and social work), and other sciences, i.e. epidemiology, sociology, health research, ethics and law. In addition to the participating European countries—Germany, Italy, the Netherlands, Slovenia, Switzerland and the UK—other regions are represented by Argentina and New Zealand.

This presentation highlights some challenges encountered in the initial phase of the OPCARE9 collaborative. Issues which engaged the group as a whole in active discussion include:
- questioning of established definitions and assumptions about the nature of expertise and relevant knowledge;
- the timing, role and effects of translation from local languages to English, and how language influences the knowledge obtained;
- how to include neglected perspectives in this process of development, especially those which do not figure in the scientific literature; and
- how to include the wide variety of cultures between and within countries, and utilize both consensus and diversity when systematizing knowledge.

These sometimes abstract issues inspire lively discussion and engagement in the collaborative group, but also present concrete challenges that need to be overcome in the development of specific strategies for systematic reviews of knowledge and Delphi investigations. These issues and strategies for dealing with them in OPCARE9 are of relevance for international, cross-cultural and/or interdisciplinary collaborative endeavours in nursing and palliative care and will be discussed here.

O-192 TESTING OF THE “SURVIVAL PREDICTION SCORE” IN MEN WITH HORMONE-REFRACTORY PROSTATE CANCER
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Purpose
To test use of the Survival Prediction Score (SPS) in a population of men with hormone-refractory prostate cancer (HRPC).

Design: A retrospective cohort study at a university affiliated cancer center.

Methods and Materials
Chow et al (2002) analyzed sixteen factors potentially predicting mortality in a mixed population of 395 cancer patients receiving palliative radiotherapy. They found that a combination score (SPS) derived from three Edmonton Symptom Assessment Scale (ESAS) domains (fatigue, lack of appetite, and shortness of breath) and cancer site, site of metatases and Karnofsky performance status reliably grouped patients into three survival cohorts with “higher”, “moderate” and “lower” survival. We identified consecutive men with
HRPC who completed the ESAS. For each eligible patient ESAS scores for fatigue, shortness of breath, and appetite; sites of metastases; Karnofsky performance status; and survival data were extracted and a SPS was generated. Patients were grouped by total SPS, and number of SPS risk factors. Kaplan-Meier survival curves were constructed and the survival was compared between SPS groups using the log rank test. Overall survival for this study sample was also compared with the results of Chow et al.

**Findings**

Eighty-three eligible men with HRPC met eligibility for this study. The median survival time for the total sample was 71 weeks. The total sample was categorized into the following SPS groups: “higher” (median = 83.4 weeks; range = 0.1–190.4 weeks), “moderate” (median = 33.6 weeks; range = 5.6–139.7 weeks), and “lower” (median = 14.4 weeks; range = 4.8–26.1 weeks), respectively (log rank p<0.001). Median survivals by SPS number of risk factor categories were: “higher” (< 3 number of risk factors) 82.9 weeks (range, 0.1–188.6 weeks), and “lower/moderate” (4–6 number of risk factors) 24.3 weeks (range, 4.9–106.4 weeks) (log rank p<0.001).

**Conclusion**

The SPS discriminated prognostic groups in a sample of men with HRPC. Implications for Nursing: HRPC patients can be quickly and easily classified by SPS prognostic group using information readily available in the patient record. Such information is of potential value to nurses for assisting clients with end-of-life planning, informed decision-making and counseling.

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**O-193 NURSING PRESENCE FOR PATIENTS AT END-OF-LIFE IN ONE CANCER CENTRE**

**Virginia A. Gumley, MA BSc.**

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This abstract outlines a small project which was prompted by a random review of the Mortality data in the early part of 2009. The results prompted further study from June – December 2009. Death is reported and documented in a number of ways in the hospital – one way is the completion of the Death Reporting Form by the primary nurse which is submitted every 24 hours to the Nursing Division Office. The Death Reporting Forms were reviewed for the following:

- Place of Death (Department)
- Length of stay in the hospital
- Bio details – age, gender, next of kin (and if present of not)
- The End–of–life Care Strategy was recently introduced and emphasis placed on the care of the dying person in the last 24 hours of life. Although it may be too early to ascertain its impact.
- The Palliative Care Nursing Team has been operational across the hospital since 2002 with a specific task to act as a Rapid Response Team in end of life situations with patients and their families. The team can be called by any primary nurse for a palliative care nursing consult.
- The presentation will present the results of this review and identify nursing presence and the quality of that presence at the end-of-life for patients and their families.

**Reference**

Palliative Care Tool (2008) – Improving care from the grass roots up in resource–limited settings

The Worldwide Palliative Care Alliance/Help the Hospices

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**O-194 KNOWLEDGE, ATTITUDES AND PRACTICE BEHAVIORS OF CLINICAL ONCOLOGY ADVANCE PRACTICE NURSES REGARDING ADVANCE CARE PLANNING FOR CANCER PATIENTS**

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**Background & Significance**

Advance Care Planning (ACP) is a patient-centered communication process between clinicians and patients regarding patients’ goals and wishes for end-of-life (EOL) care. To date, little is known about oncology advance practice nurses’ (APNs) knowledge, attitudes and practice behaviors (KAP) regarding ACP.

**Purpose/Objectives:** (1) To obtain preliminary understanding of oncology APNs’ KAP regarding ACP. (2) To determine oncology APNs’ perceived barriers to ACP practice. (3) To establish initial reliability and validity of a web–based KAP survey.

**Design**

Descriptive, cross-sectional, pilot survey study.

Sample & Setting: Sample of 300 oncology APNs from eastern USA.

**Methods:** Guided by the Theory of Planned Behaviors, a KAP survey was developed based on literature reviews. A panel of five palliative care experts reviewed the survey for content validity. The initial survey was distributed to 300 APNs through emails with a internet link (SurveyMonkey). One month later, the survey was resent to 90 APNs who had responded to the initial survey. Exploratory factor analysis was used to examine the construct validity and test/retest reliability of the attitudinal and practice behavioral portions of the survey.

Results: Eighty nine (89) APNs responded to the initial survey, and 53 completed the resent survey. Exploratory factor analysis yielded a five-factor solution, with internal consistency calculated using Cronbach’s alpha as follows: Factor 1 (Practice Behaviors, 5 items, r = .83); Factor 2 (Comfort Level, 4 items, r = .84); Factor 3 (Professional Responsibility, 4 items, r = .76); Factor 4 (Religion); Factor 5 (Other Needs, 4 items, r = .72); and Factor 5 (Other Attitudes, 4 items, r = .56).

**Conclusion**

The attitudinal and practice behavioral portions of KAP survey demonstrated preliminary construct validity and test/retest reliability. The oncology APN respondents were somewhat knowledgeable regarding ACP, and they had positive attitudes towards ACP, but their practice of ACP was not routine. Due to a small sample, the survey results need to be further tested and validated through a larger sample of clinical oncology APNs nationwide.

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**O-195 SLEEPING WITH ONE EYE OPEN: THE SLEEP EXPERIENCE OF FAMILY CAREGIVERS OF COMMUNITY-DWELLING ADVANCED CANCER PATIENTS**

**Brenda Purchase, RN, MN, CHPCNC(C)1, Susan McMclain, RN, PhD, CHPCNC(C)2, Diana E. McMillan, RN, PhD2, Mike Harlos, MD, CCFP, FFCP1.**

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The experience of caring for a terminally ill loved one at home is reported to be stressful and exhausting. The issue of disrupted sleep, resulting from providing round-the–clock care to a family member with advanced cancer, is an important yet neglected area of research in palliative care. The purpose of this study was to examine and describe the experience of sleep disturbance in family caregivers (N=13) of advanced cancer patients living in urban and rural Manitoba. Mixed methodology included face–to–face family interviews, Epworth Sleepiness Scale (ESS); Pittsburgh Sleep Quality Index (PSQI); and actigraphy measurement to answer the following research questions: How do family caregivers of community–dwelling advanced cancer patients describe their experience of sleep disturbance? What factors do family caregivers identify as contributing to sleep disturbance? What consequences do family caregivers identify that sleep disturbance has on their ability to carry out their caregiving role? What consequences do family caregivers identify that sleep disturbance has on their own health and well-being? What do family caregivers Qualitative data analysis utilized constant comparative content techniques. Actiware® for the actigraphy data and the Statistical Package for the Social Sciences – 15 (SPSS–15) generated descriptive and correlation statistics. Identify as being helpful to them in managing the sleep disturbances that they experience? The overarching theme ‘sleeping with one eye open’ captures the vigilant nature of caregivers’ sleep experiences. Five of the family caregivers (38.5%) had an ESS score ≥ 11 indica-
tive of excessive daytime sleepiness, and all caregivers had a PSQI total sleep score ≥ 5 indicative of moderate to severe sleep problems. All caregivers’ actigraphy scores fell beyond ‘normal’ values documented in the literature. These findings inform future program development, palliative care service provision, and intervention research directed at family caregivers to promote their sleep, health and well-being, and ultimately the quality of care they provide to others. Impeccable nursing assessment of the patient’s and family’s sleep status, sleep education and intervention strategies, and the provision of high quality respite services are critical in community–based palliative care.

**O-196 DISSEMINATION OF THE MASCC TEACHING TOOL FOR PATIENTS RECEIVING ORAL AGENTS FOR CANCER**

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**Background**

Oral agents for cancer treatment commonly are prescribed throughout the world. Since oral agents usually are self-administered or administered by lay caregivers, patient education is vital to ensure that the oral agents are being stored, handled, and taken correctly. When oral agents are taken as prescribed and patients are well-informed about signs and symptoms to report, patient outcomes are optimized. Patient education varies globally; consequently, there is a need for a consistent and comprehensive approach to educate patients about oral cancer treatment.

**Objectives**

Multinational Association for Supportive Care in Cancer (MASCC) Education Study Group developed a tool (MOATT; MASCC Oral Agents Teaching Tool) to assist healthcare providers in teaching patients who receive oral cancer agents. The aim of this project is to disseminate the tool in different countries and then assess the effectiveness of the tool in a variety of settings.

**Methods**

Seventeen nurses and one pharmacist from 15 countries participated in a train the trainer program which was held in conjunction with the 2008 MASCC Symposium. Each coordinator was expected to: use back translation if needed; hold workshops for at least 40 nurses; select 6 nurses to use the MOATT in practice; and complete score/sheet logs for ten weeks. Logs and data collection of side effects and their symptom experience (Foster et al 2008). With the increased use of chemotherapy in the last few years as a curative treatment, resulting in improved survival rates, the management of the side effects of these regimes has become a priority for nurses in ambulatory care settings. Management of side effects such as nausea during chemotherapy can lead to a better functional status and quality of life for the patients (Kearney et al 2008).

The use of patient self-assessment tools best capture the patient’s perception of side effects and their symptom experience (Foster et al 2008). With no patient self-reporting tool in use in the Peter Mac Chemotherapy Day Unit (CDU) suitable to chemotherapy side effects, a need was identified due to inconsistency of side effect reporting and actions of nursing staff. A project was undertaken to discover and implement the most appropriate tool. It is anticipated that systematic data collection via use of a tool will allow nurses to better plan and respond to patient care needs and facilitate better patient education and referral to other health professionals.

A literature search to identify the most appropriate tool was carried out using the Medline, Cochrane, Embase, PubMed and PsycINFO databases. Clinicians Health Channel and Google Scholar were also examined. Eighteen articles were retrieved, 12 of which were excluded because they assessed specific symptoms such as nausea and vomiting, fatigue or anaemia (n=5); assessed quality of life only (n=3) or utilised electronic methods for data collection (n=6) in disparity to the general side effect data required in the Chemotherapy Day Unit. Following the critical appraisal of six articles, 17 patient self-assessment tools were identified as potentially appropriate. However some tools again were limited in range of side effects assessed while others reported poor psychometric qualities. The Chemotherapy Symptom Assessment Scale (C-SAS) was identified as the most appropriate tool to trial having been previously validated in an ambulatory chemotherapy setting, is completed by the patient and compliments nursing and physician assessments and can improve communication between team members.

Once permission to use the tool is established the implementation phase will commence. The C-SAS will be trialled with a small group of patients (n=20) with a range of cancers when they commence chemotherapy. Feedback on appropriateness, useability and outcomes will be assessed before the tool is rolled out to a larger patient sample.

**O-198 ENHANCING KNOWLEDGE AND PROMOTING QUALITY SUPPORT AND UNDERSTANDING FOR PEOPLE Affected by Pancreatic CANCER**

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**Background**

Research into health information seeking behaviours of people faced with a cancer diagnosis demonstrates that people access information multi-modally; Internet, print, audio-visual, phone and face-to-face[1]. People faced with a diagnosis of pancreatic cancer, (ninety-five percent of whom die within twelve months) have urgent unmet needs for information and support.

Pancreatic cancer patients recorded the highest mean T-scores for anxiety and depression, in a study of fourteen cancers assessed for prevalence of psychological distress by cancer site (Zabora, 2001[2]). This was contributed to by “the relative ineffectiveness of cancer therapies” and the perception of “a stronger message of doom from all sources, including family and members of the health care team”. This paper presents a multimedia supportive care intervention which was developed in response to research identifying the information and supportive care needs of this group of patients. This in-
O-199 ENHANCING SUPPORTIVE-EDUCATIVE NURSING SYSTEMS TO REDUCE RISK OF POST-BREAST CANCER LYMPHEDEMA
Bob R. Stewart, EdD, Connie Brooks, PhD, Robin R. Shook, Jane M. Armer, PhD, RN. University of Missouri, Columbia, MO, USA.

Introduction
This study describes the use of participant feedback from a parent intervention study to plan an educational program for nurses to improve their supportive-educative nursing system when working with breast cancer survivors. Based upon feedback the, research team recognized that participants were not following the intervention protocol. In order for nurses to help patients develop self-care agency (Orem, 2001) to engage in actions to address self-care requisites associated with post-breast cancer surgery, these nurses needed to refine their intervention skills.

Methods
An interview guide was developed based on Orem’s (2001) power components. This guide consisted of open-ended questions to explore the essential capabilities of participants to engage in self-care actions. Questionnaires were mailed to 27 participants and telephone interviews were conducted for those who did not return the survey by mail.

Results
Data for 14 participants found a mean age of 60 who were 13 months beyond breast cancer surgery. Data were analyzed and categorized using Crabtree and Miller’s (1999) template analysis guidelines; categorizing data as related to the power components described by Orem. The focus was to explore the state of power related to self-care agency. Since our goal was to elicit information for developing the educational program to enhance the supportive educational nursing intervention, data were not analyzed in the aggregate.

The data revealed that participants were experiencing the most difficulty in four power components (Orem, 2001, p. 265): 1) ability to maintain attention and exercise requisite vigilance with respect to self as self-care agent, internal and external conditions, and factors significant for self-care; 2) ability to reason within a self-care frame of reference; 3) motivation; and 4) ability to consistently perform self-care operations, integrating them with relevant aspects of personal, family, and community living. Data from these power component categories (Orem, 2001, p. 265) were further refined and example statements included in the training materials.

Conclusion
Motivational interviewing (Miller & Rollnick, 2002) and solution-focused therapy (Berg & DeJong, 1996) were incorporated in the educational training for the research nurse team to strengthen nursing agency and improve supportive-educative nursing systems.
Methodology
This research is focused on collecting data through personal interviews of cancer patients at CWM Hospital and relatives who care for them. We also would use statistics available to us from the Fiji Ministry of Health research unit and hospital library and would send out questionnaires to cancer nurses who work in the other two divisional hospitals palliative care nurses who also work in cancer wards.

Main findings
Fiji’s main referral hospital, (Colonial War Memorial Hospital), has an average admission rate of 27.3% patients per month in 2008. Out of the total of 329 admissions in the same year, 39% were gynaecology cases, 35% surgical cases, 24% medical and 2% urology cases. There was also recorded death of 123 (37%) cancer patients in 2008 and 67% of which were females and 33 males. The survival rate for 2008 is around 63% patients. The finding also identifies that of the 206 surviving patients, 74% are females and 48% are gynaecology cases.

Conclusions
Palliative care is one of the essential nursing services provided by registered nurses in Fiji despite patients not having access to hospice care facilities. The key purpose of having palliative care at CWM Hospital is to prepare the cancer patients to the various methods of treatment that may be needed including the length of treatment depending on the patient’s responsiveness. The work of nurses provide that essential service in caring and preparing a patient accept the ultimate end of a life’s journey.

O-202 NON-PHARMACOLOGICAL CARE-GIVING ACTIVITIES: AN INTERNATIONAL INVENTORY OF WHAT IS DONE IN THE LAST DAYS OF A PATIENT’S LIFE
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O-203 CLOCK TIME AND EMBODIED TIME EXPERIENCED BY PATIENTS WITH INOPERABLE LUNG CANCER
Malin Lövgren, RN, PhD, Katarina Hamberg, MD, Associate Professor, Carol Tishelman, RN, Professor

In this study we explore how patients with inoperable lung cancer (LC) discuss their experiences of time, based on content analysis of open interviews with 35 patients one year post-diagnosis, using Davies’ distinction between “clock time” and “embodied time” as sensitizing concepts. Two interrelated themes were derived: 1. Aspects related to the health care system (HCS), with three subthemes: Waiting times in the HCS; Limited time for patient-professional contact, and Limited time for coordination of services; and 2. Existential aspects, with sub-themes: The future with LC, and Managing an uncertain and finite life with LC.

Time could be experienced as problematic for these patients, when limited, lacking, or through long periods of waiting, especially when these periods occurred without adequate preparation or information. This contributed to exacerbation of these patients’ existing sense of uncertainty, their perception of care as impersonal and insecure, and their need to remain alert and act on their own behalf. Awareness of the seriousness of their disease and the prospect of a limited lifetime was described as increasing uncertainty about dying and fear of certain death. People also described efforts to constructively deal with their situation by reprioritizing their remaining time, increased appreciation of some aspects of daily life, and living consciously in the present. This analysis suggests a collision between clock time which steers the health care system, and embodied time, as experienced by individuals. Greater attention to psychosocial needs is suggested as one means of positively affecting patients’ experiences of time and uncertainty.

O-204 THE LIVED EXPERIENCE OF COMMUNITY NURSES CARING FOR PATIENTS WITH ADVANCED CANCER AT THE END OF LIFE
Caroline M. Huff, BSc, Hons, MSc

Patients with cancer spend 90% of their last year of life at home, many with the support of community nurses. A majority of people with cancer would prefer to die at home, yet only 25% do so, reflecting that the patient’s wishes are often not achieved, with lower levels of satisfaction with care at a higher cost to the health economy. There is a paucity of research which explores in-depth the ‘lived experience’ of community nurses caring for patients with advanced cancer at the end of their life. In-depth interviews were carried out with six community nurses to explore those experiences in detail. The results found that there were three main themes which contributed; those community nurses coping with caring for patients with advanced cancer at the end of life, which were: the structure and support provided by the organisation, key relationships and their skills and experience. The conclusions were that the vital components to coping included: access to a full range of flexible support services, clarity about roles and improvements in relationships between health care professionals, improved communication between services, early referral, full implementation of proactive tools for the end of life such as the ‘Gold Standards Framework’, a positive relationship with the patient and their family, training around holistic care and support through managerial and clinical supervision. Further research is needed on the impact of personal loss and bereavement on nurses’ ability to cope, with managers being trained to detect the early signs of stress. Although there were many challenges identified, it was also clear that caring for patients at the end of life gave the community nurses great job satisfaction and was a valued part of their role.
O-206 DEPRESSIVE SYMPTOMS, GRIEF, AND COMPLICATED GRIEF AMONG BEREAVED FAMILY CAREGIVERS OF ADVANCED CANCER PATIENTS

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Purpose
To examine depressive symptoms, grief, and complicated grief for bereaved family caregivers, and to provide the results of a secondary analysis of the correlations between their scores on depression, grief, and pathological grief scales. The study objectives were: 1) to identify the levels of depressive symptoms, grief, and pathological grief, 2) to explore the correlations between grief and pathological grief, and 3) to identify the significant relationships between depressive symptoms, and grief.

Design
Secondary analysis of preliminary data collected from 2005 to 2008 from a study to determine the effect on patient and caregiver outcomes of providing systematic feedback from standardized assessment tools for improving hospice outcomes. The data being analyzed represents the 3 month bereavement data from the family caregivers.

Setting: Two large hospices in West Central Florida offering comprehensive services from an interdisciplinary team, including bereavement counselors.

Sample: 280 family caregivers of advanced cancer patients, bereaved 3 months.

Methods
A secondary analysis.

Main Research Variables: Depressive symptoms (CES-D), Grief (TRIG Present Feelings Inventory) and Complicated Grief (ICG).

Findings: Family caregivers ranged in age from 29 to 91 years, with a mean of 66 years. 76% were female. At 3 months bereavement, 33.5% of the caregivers had clinically meaningful scores for depressive symptoms with an overall mean score of 3.33 (SD 2.45) on the CES-D. The mean level of grief was 38.77 (SD 9.45) on the 13 item TRIG Present Feelings Inventory, and 24.2% had scores greater than 25 on the Inventory of Complicated Grief (Mean = 18) (SD=11.6). The scores of depressive symptoms, present feelings inventory, and complicated grief were significantly correlated. The correlation between the CES-D and the Present Feelings Inventory was moderately strong (r=0.597; p<0.001); the correlation between the grief inventory and the CES-D was also moderately strong (r=0.515; p<0.001). Correlation between present feelings inventory and the grief inventory was strong (r=-0.788; p<0.001). Scores on the grief inventory and the CES-D correlated identified as clinically significant were weakly correlated (r=0.391; p<0.001).

Conclusions
Assessment of bereaved caregivers at 3 months reveals significant levels of depressive symptoms and complicated grief. Depressive symptoms correlated with symptoms of grief, as clinically meaningful assessment data.

Implications
Caring for a family member with cancer at the end of life may affect the outcomes of bereavement. Assessing for depressive symptoms would provide an opportunity to target scarce resources towards those bereaved caregivers most in need of intervention.
Sexuality being a sensitive issue patients desire that nurses initiate sexuality discussion to assist them come out of their shell and feel free during the discussion. We conclude that patients with cancer have continued need for stable sexual health and nurses are expected to meet this need.

WAY FORWARD

Education for nurses has been identified from the study as an important factor that will equip and instill confidence in nurses for effective assessment of patient’s sexuality. Many challenges facing their sexuality can be avoided by simply letting patients know that they can discuss sexuality with their healthcare providers.

O-208 QUALITY OF LIFE AND SEXUAL FUNCTION OF JORDANIAN WOMEN DIAGNOSED WITH BREAST CANCER

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Breast cancer is the most common cancer among women in the world today. There is a growing evidence that women treated for breast cancer with surgery, chemotherapy, radiotherapy and hormonal therapy commonly experience disturbance in quality of life and sexual function related to changes in body image, fertility, physical, psychological, and social functions. A descriptive cross-sectional design was used to collect data from 135 Jordanian women diagnosed with breast cancer from two hospitals in Amman city, using a self-administered questionnaire including Functional Assessment of Cancer Therapy-Breast (FACT-B) and Female Sexual Function Index (FSFI).

The mean age of the sample was 50.2. Results revealed a positive moderate correlation between quality of life and sexual function. Result indicated that quality of life and sexual function were affected by several sociodemographic and clinical variables. Stepwise regression analysis indicated that sexual function, education, husband acceptance of disease, presence of relatives with breast cancer and fear of disease recurrence explained 49.5% of the variance in quality of life. The percentage of women who had sexual dysfunction was 75%. Stepwise regression analysis indicated that vaginal dryness, age, husband acceptance of treatment, chemotherapy, discussion of sexual relationship between couples, and the perceived value of breast as a symbol of femininity and attraction explained 66.6% of the variance in sexual function.

Sexual dysfunction is a highly prevalent and neglected problem among breast cancer survivors. The study has many implications for practice, education and research. Health care providers need to play a more visible and instrumental role in continuously assessing and improving quality of life and sexual function of women diagnosed with breast cancer.

O-209 OCCURRENCE OF LYMPHEDEMA CONTINUES TO INCREASE TWELVE TO THIRTY MONTHS AFTER BREAST CANCER TREATMENT

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Introduction

Breast cancer (BC) survivors are at lifetime risk for developing lymphedema (LE), the accumulation of protein-rich fluid in the interstitial spaces of the affected body part due to a blockage or malfunction in the lymph system. Of those affected by breast cancer, up to 40% will develop LE, potentially comprising 1 to 5 million survivors. However, all breast cancer survivors are considered at risk for the condition (American Cancer Society, 2007).

While numerous studies have reported LE incidence during the first 12 months following breast cancer treatment, little is known regarding long-term LE diagnosis. Very few studies have examined LE incidence past 1 year post-treatment, and many that have are retrospective or cross-sectional, not prospective, in nature.

Methods

Participants were enrolled following diagnosis of BC but before treatment and followed every 3 months for 12 months, then every 6 months until 2.5 years post-surgery. Limb volume changes (LVC) were measured using: (a) circumferences via tape measure at 4 cm intervals, (b) infra-red laser perometry, and (c) symptom experience (SS) via interview. Four diagnostic criteria for LE were used: (i) 2 cm circumferential change; (ii) 200 mL perometry LVC; (iii) 10% perometry LVC; and (iv) report of limb heaviness/swelling, ‘now’ or ‘in the past year’.

Standard survival analysis methods were applied to identify when the LE criteria were met.

Results:

At 30 months post-treatment, LE incidence using the four criteria ranged from 41%–91% and had continued to increase over time, with 2 cm being the highest estimation method and SS the lowest.

Conclusions

These preliminary findings provide additional evidence that BC survivors continue to be at risk for developing LE beyond the first year following treatment. LE identification, regardless of the criteria used, continued to increase past the initial 12 months post-treatment. From month 12 to month 30, LE identification increased by an additional 10–27%, depending on the criteria used. While identification of LE via symptom experience in the initial 12 months occurred in 31% of participants, only an additional 10% met the criteria in the following months, by far the lowest incidence rate among all criteria. Overall, this analysis finds 2 cm criteria as the most liberal definition of LE (91%), while self-report of heaviness and swelling, along with 10% LVC, represent the most conservative definitions (41% and 45%, respectively).

O-210 BRIDGING GAPS, EXPANDING OUTREACH - METASTATIC BREAST CANCER PATIENT SURVEY

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EVALUATING THE NEEDS OF WOMEN LIVING WITH METASTATIC BREAST CANCER: A GLOBAL SURVEY

Musa Mayer1, Adrian Hunis2, Ruth Oratz1, Cathy Clemmon1, Pat Spencer1, Elyse Caplan1, Lesley Fallowfield1

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Goals

Globally, >1 million new cases of breast cancer (BC) are diagnosed each year (yr), and >400,000 women die from the disease. In developed countries, ~30% of women with primary BC have a metastatic recurrence. Life expectancy after metastatic BC (MBC) diagnosis is ~2-3 yrs, although advances in treatments may mean that some pts live longer. Over 60% of BC deaths occur in the developing world, despite a lower incidence, as most pts are diagnosed at later stages, with fewer treatment options available. In the US alone, which accounts for 10% of global BC deaths, ~155,000 women are thought to be living with MBC. Clearly, the global burden of MBC should also be measured by the experiences of women living with advanced disease. Resources/support networks for MBC pts are limited compared with those available to primary BC pts. Additionally, MBC pts may have a lack of understanding of resources, and access to clinical trials. The goal of this survey is to evaluate the unmet needs of women living with MBC in the US, Europe, Latin America and Africa.

Methods

A Committee comprising 3 thought leaders, 4 pt advocates, and a global public health organization, was set up to develop a survey with the support of Harris Interactive and Pfizer Oncology. There were 5 sections: resources/information/knowledge; support; attention from society; impact on self/lifestyle; clinical trials. The 23-min questionnaire comprised 34 questions and a set of country-specific questions. The survey was conducted in the USA, UK, France, Spain, Poland, Belgium, Argentina, Mexico and Egypt. Globally, 900 women with Stage IV/metastatic disease were interviewed. Survey methods included telephone, mail, and in-person interviews. Topics included MBC resources, support networks, attention given to MBC relative to primary BC and personal impact of the disease.

Results

The results will be discussed that lead to improved collaboration across the MBC community and raise awareness of country-specific issues and global discrepancies relating to information resources. Current character count: 2130.
O-211 THE USE OF BLACK WOMEN BREAST CANCER SURVIVORS’ TO INCREASE SELF ESTEEM IN URBAN TEENAGE GIRLS.

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Because You are My Sister is a community based research project that is aimed at increasing self esteem in urban teenage girls between the ages of 13 to 17, by pairing them with black women breast cancer survivors as mentors. There are currently a number of programs that are designed to increase self esteem, but there is insufficient literature that provides data on the effect of one on one mentoring within this population of urban teenage girls. The purpose of this study is to determine whether pairing the teens with breast cancer survivors will have an effect on their self esteem and promote a positive change to their lifestyles. The project chose breast cancer survivors as the mentors based on a recent research project entitled, “The Black Women Breast Cancer Survivors Project: Long Term Quality of Life in Black Women Breast Cancer Survivors,” where researchers found that the participants stories of survival expressed life in a different way then what these girls may be accustomed to seeing and doing. Their testimonies were powerful and could provide hope for these teenage girls. The specific aims of the Because You are My Sister project is to 1) Increase self esteem by helping girls to make the right choices when faced with drugs/alcohol, physical and verbal abuse, gang activity, and poverty, 2) To educate the girls about healthy sexuality and body image and 3) Introduce the teenage girls to self love. Analysis of the project will be planned for both the participants and the project to determine its impact. The information that will be shared between the teenage girls and the breast cancer survivors will help them to learn from one another along with building the confidence levels of both groups. By allowing the survivors to share their journey through breast cancer and relating it back to how they had to rebuild their own levels of self esteem, not only will it have a positive impact on the teenage girls but also on other breast cancer patients that are fighting to survive a life altering disease.

O-212 CHANGES IN BODY COMPOSITION AND METABOLISM AMONG PREMENOPAUSAL BREAST CANCER SURVIVORS RECEIVING DOSE DENSE ADJUVANT CHEMOTHERAPY

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Dose Dense chemotherapy (DDC) is an approach to adjuvant breast cancer treatment in which standard chemotherapy drugs and doses are administered more frequently than in conventional treatment. Recurrence-free survival rates are improved by reducing the rest periods between treatments. Development of sarcopenic overweight/obesity, in which individuals gain fat while losing lean body mass, is common during and after conventional adjuvant chemotherapy. This weight gain is associated with increased risk of cancer recurrence and may also lead to several chronic diseases that are linked to the Metabolic Syndrome including type II diabetes and cardiovascular (CV) disease. However, DDC has not been studied for its effects on body weight, body composition and changes in the biomarkers for Metabolic Syndrome. The purpose of this longitudinal study was to measure and describe the body weight and composition, cardiovascular (CV) fitness and biomarkers for Metabolic Syndrome of pre-menopausal breast cancer survivors receiving DDC. The study objectives were to: 1) describe the intra- and post- treatment body weight and composition, CV fitness, exercise capacity, blood lipid profiles, and insulin and glucose levels of pre-menopausal women receiving DDC for breast cancer, and 2) describe associated patterns of fatigue and quality of life. 20 women who were beginning DDC were assessed at the start and completion of DDC and 6-months post-DDC. Measures included: weight in kg, waist:hip ratio; body composition via dual-energy x-ray absorptiometry (DXA); fasting serum lipid profiles, insulin and glucose levels; glycated hemoglobin; CV fitness testing; and self-reported fatigue and quality of life. Results indicate that, while small changes in body weight occur during DDC, adverse changes in body composition and the biomarkers for Metabolic Syndrome take place during and after treatment. It is important to reverse the apparent legacy of adverse changes in body weight and fat and the related disturbances in metabolism brought on by DDC. This is especially true for pre-menopausal women, who tend to present with fewer pre-existing chronic disease risk factors and are less likely to be overweight at baseline than postmenopausal women. Our findings will establish the groundwork for development and testing of a tailored lifestyle intervention to help women effectively manage weight-associated risk factors for cancer recurrence and subsequent chronic disease.

O-213 BREAST CANCER SURVIVORS OFTEN MEET MULTIPLE CRITERIA FOR IDENTIFICATION OF LYMPHEDEMA

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Introduction

Assessment and diagnosis of lymphedema (LE) has been problematic, in part due to the fact that various measurement approaches and criteria have been applied. This analysis examines four different criteria for diagnosing lymphedema among breast cancer survivors. Recent scientific literature reports that anywhere from 6 to 30 percent or 6 to 62.5 percent of the breast cancer population has LE. The discrepancies among the reported percentages stem from difficulties in measurement, diagnosis, and follow-up (Petrek and Heelan, 1998; Passik, 1998; Rockson, 1998; Meek, 1998, Armer and Stewart, 2005, Hayes et al., 2008). Traditionally, finding >2cm difference in limb girth between the affected and non-affected limbs warranted clinical diagnosis of LE. Measuring a 200 ml limb volume change or a 10 percent limb volume change (LVC) from baseline and/or between limbs as well as self-reported signs and symptoms are also documented methods of LE diagnosis.

Methods

Participants were enrolled post-breast cancer diagnosis but pre-surgery, and followed every 3 months for 12 months, then every 6 months until 2.5 years post-surgery. Limb volume changes (LVC) were measured using: (a) circumferences via tape measure at 4 cm intervals, (b) infra-red laser perimetry, and (c) symptom experience (SS) via interview. Four diagnostic criteria for LE were used: (i) 2 cm circumferential change; (ii) 200 ml perimetry LVC; (iii) 10% perimetry LVC; and (iv) self-report of limb heaviness/swelling.

Results

In this cohort, 84% met at least one criterion to identify lymphedema by 2.5 years post-treatment. The most common single criterion met was 2-cm circumferential change (25%). When examining meeting multiple criteria, 13% of participants met the combination of 200ml LVC, 10% LVC, and 2cm change. In addition, 11% of participants met all four lymphedema criteria by 2.5 years post treatment.

Conclusions

This analysis demonstrates breast cancer survivors who develop lymphedema often meet multiple criteria for the condition. We found 62% of those with lymphedema met two or more criteria used in this analysis, and 31% met three or more criteria. The most common criterion to identify lymphedema, either alone or associated with one or more criteria, was 2 cm circumference change (77%), while 10% LVC was least likely to be met (26%).

O-214 DO MORAL JUDGMENTS, BLAME, AND ANGER AFFECT THE EMPATHIC UNDERSTANDING BY FAMILY CAREGIVERS ON SYMPTOMS EXPERIENCED BY A LOVED ONE WHO HAS LUNG CANCER?

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Title

Do moral judgments, blame, and anger affect the empathic understanding by family caregivers on symptoms experienced by a loved one who has lung cancer?

Background: In our risk-oriented society in Canada, lung cancer is viewed as a stigmatized disease where the patient is often blamed for smoking cigarettes. Although not openly talked about, it is possible that these reactions by family caregivers may impact their empathic understanding of patient symptoms, leading to mismanagement of patient symptoms, resulting in emergency room visits, in-patient hospital stays, and increased health care costs.

Methods

Weiner’s (1995, 2006) theory of social motivation guided testing of associations among smoking cessation, judgments of responsibility, anger, pride, caregiver empathic thoughts and behaviors, and perceptual understanding of patients’ symptoms. Latent-variable structural equation mod-
O-215 EFFECT OF NURSE CASE MANAGEMENT DISCHARGE PLANNER ON SYMPTOM CONTROL AND QUALITY OF LIFE OF PATIENT WITH RADICAL PROSTATECTOMY
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Introduction
Radical prostatectomy is one of the treatment for early-stage prostate cancer has side effects with which men must cope. Men being treated for prostate cancer may be affected by incontinence, impotence, a decline in libido, bowel dysfunction, fatigue and emotional distress. Having information to form realistic outcome and efficacy expectations can provide a sense of control (Maliski et al., 2001). Knowing how to manage these symptoms and receiving encouragement to perform activities that minimize disruption before discharge from the hospital can empower men to resume life activities sooner (Maliski et al., 2001). In addition, being able to interpret physiologic sensations can empower men to feel more confident in their progress through treatment.

Aims
To investigate the impact of Nurse Case Manager Discharge Plan on symptom control and quality of life of patient with radical prostatectomy.

Materials and Methods
Patient sample consisted of 40 patients (Controls: 20 patients and Study Group:20 patients) who were admitted to the acute care setting. A routine clinic patient care was administered in the control group whilst a discharge program in the study group. As data collection instruments patient data collection form related to early-stage prostate cancer. Prostate Cancer Index, Fatigue Scale, Emotional Distress Scale and EORTC QLQ C30 were used. Self-selection form related to early-stage prostate cancer, Prostate Cancer Index, was found to be similar between the groups. A statistically significant differences was detected between the scores of urinary dysfunction, sexual dysfunction, bowel dysfunction, fatigue, emotional distress, effect of disease on activities, mean symptom burden, role function, social function and global quality of life in the repeated measures of the patients of study group and control group (p< .05)

Results
The results supported Weiner's theory, where significant linkages were found among patient smoking, caregiver judgments of responsibility,anger, and pride held by caregivers, empathic responding by caregivers, symptom assessment of pain, fatigue, and shortness of breath.

Conclusions
The study results lay groundwork for developing a profile of family caregivers at risk for limited empathic helping behavior and perceptual understanding of patients' symptoms. Findings suggested that the impact of smoking behaviors by patients on empathic responding by caregivers is mediated by the cognitio-act link as postulated by Weiner. Caregivers who blame patients for smoking and are angry with them are at risk for providing sub-optimal empathy and understanding of patient symptoms. Clinicians should assess the caregiver's feelings toward the patient, particularly when either or both is still smoking. Clinicians can teach patients and family caregivers empathic communication that can mitigate feelings of anger and blame and enhance sensitive, patient-oriented responses to illness experiences such as symptoms.

Acknowledgment of Funding: This study was funded by the Canadian Cancer Society and a Manitoba Health Research Council Establishment grant.

O-216 FEELING STATES’ THERAPEUTIC TOOL: A NEW AND INNOVATIVE APPROACH TO HELPING CHILDREN EXPERIENCING CANCER
Roberta L. Woodgate.
University of Manitoba, Winnipeg, MB, Canada.

Within the last three decades there have been many advances made in the treatment of childhood cancer. Survival into adulthood is possible for many children since the initiation of multimodal therapy. Therapy, however, can be quite intense and difficult to endure, resulting in short- and long-term symptoms that in turn, can escalate child and familial suffering. In recognition of the suffering experienced by children with cancer, a research program is underway that seeks to help children with cancer communicate and cope with their symptoms and other challenging events related to cancer. The program is guided by the ‘feeling state’ model. A key underpinning of this model is that when symptoms and other challenging cancer-related events are conceptualized as overall feeling states based on assigned personal meaning, children will have more control, incentive or reason to assess and manage them.

The research program involves a series of studies that are based on a participatory design and iterative development approach. The focus of this presentation is on the development of an interactive computer therapeutic tool stage of the research program. The therapeutic tool consists of an online interactive virtual environment offering self-assessment, creative activities and games that are focused on the feeling states of children. The features and purpose of the tool reinforce that the tool is unique and different from any off-the-shelf program and is much more than Face maker. The environment of the tool is developed to enhance the concept of feeling states and will allow children the opportunity to assess and express their feeling states as well as carry out therapeutic actions to deal with their feeling states. Children will learn to cope with their feelings via experiential learning. In addition to developing the tool a series of studies testing the effectiveness of tool are planned. This includes pilot-testing the tool in children with cancer with a focus on evaluating its effectiveness on the children’s quality of life and other psychosocial dimensions.

It is hypothesized that the therapeutic tool will have the potential to benefit children experiencing cancer by: 1) Giving children the opportunity to express with their different ways of feelings through a “user-friendly’ medium. 2) Educating children and helping them understand the things that are contributing to their feeling states. 3) Helping children engage in reappraisal processes through feedback from the environment which may lead to more effective coping. 4) Helping health professionals and families better understand what children are experiencing which in turn may help them to devise more effective, complete, and sensitive care plans.

O-217 DOING SENSITIVE RESEARCH: THE IMPORTANCE OF LISTENING TO THE VOICE OF THOSE AFFECTED BY PANCREATIC CANCER
Helen M. Gooden1, A John Friedsam2, Monica Robotin1, Andrew V. Biankin3, Kate J. White4, Gillian M. Batt2.
1Cancer Council NSW, University of Sydney, Woolloomooloo, Australia, 2Cancer Council NSW, Woolloomooloo, Australia, “Garvan Institute of Medical Research, Darlinghurst, Australia, 4University of Sydney, Camperdown, Australia.

Background
Unlike in many cancers, there are significant gaps in knowledge to improve outcomes for those diagnosed with pancreatic cancer. This lack of research limits the potential for developing tailored supportive care and symptom control interventions for individuals and their families living with this illness. Attempts to involve consumers (patients and carers) in research prioritization presents significant challenges in pancreatic cancer, as advanced stage at diagnosis, rapid disease progression and disabling symptoms, preclude the use of traditional methods of consumer consultation.

CONCURRENT SESSION E2
“SUPPORTIVE CARE” (PEACHTREE BALLROOM D)
CHAIR: PONGPAK PITTYAYAPAN

O-217 DOING SENSITIVE RESEARCH: THE IMPORTANCE OF LISTENING TO THE VOICE OF THOSE AFFECTED BY Pancreatic CANCER
Helen M. Gooden1, A John Friedsam2, Monica Robotin1, Andrew V. Biankin3, Kate J. White4, Gillian M. Batt2.
1Cancer Council NSW, University of Sydney, Woolloomooloo, Australia, 2Cancer Council NSW, Woolloomooloo, Australia, “Garvan Institute of Medical Research, Darlinghurst, Australia, 4University of Sydney, Camperdown, Australia.

Background
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Roberta L. Woodgate.
University of Manitoba, Winnipeg, MB, Canada.

Within the last three decades there have been many advances made in the treatment of childhood cancer. Survival into adulthood is possible for many children since the initiation of multimodal therapy. Therapy, however, can be quite intense and difficult to endure, resulting in short- and long-term symptoms that in turn, can escalate child and familial suffering. In recognition of the suffering experienced by children with cancer, a research program is underway that seeks to help children with cancer communicate and cope with their symptoms and other challenging events related to cancer. The program is guided by the ‘feeling state’ model. A key underpinning of this model is that when symptoms and other challenging cancer-related events are conceptualized as overall feeling states based on assigned personal meaning, children will have more control, incentive or reason to assess and manage them.

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Methods
This study developed an innovative approach to facilitating participation of consumers who are often perceived as unable to contribute to research. The project team developed a self-selected telephone focused discussion group approach. Information was obtained from distinct carer and patient groups after adequate controls, such as the ‘safe space’ technique, were implemented to protect participants from undue distress. Participants were patients and current or bereaved carers of people diagnosed with pancreatic cancer.

Results
There was great concordance between the patient and carer group as to their views of the priorities for future research directions in pancreatic cancer. Five themes emerged overall. Consensual areas of discussion were: earlier detection, clinician communication and awareness advocacy. An additional key theme for patient group centred on improving the quality of pancreatic cancer care and finding ways to shift the medical profession’s negative attitudes towards pancreatic cancer. For the carers group, it was to develop more treatment options. All participants expressed appreciation at being able to participate in setting research priorities, they felt valued that their voice was heard and that it was a positive experience.

Conclusion
Knowledge gained from this study firmly supports the benefits of engaging those affected by life threatening conditions in exploratory research. It illustrates that a telephone discussion group approach offers an effective mean of involving pancreatic cancer patients and carers, when suitably planned. Engaging with people who suffer from this highly lethal, time limited disease is challenging, but by modifying existing research methodologies and using highly trained moderators, consumers affected by cancers with very poor prognosis can contribute to shaping the cancer research agenda.

O-218 END OF TREATMENT WORKSHOP A SELF MANAGEMENT PROGRAMME
Caroline Misell.
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In July 2008, we developed a patient workshop, as it was apparent following treatment there is a significant gap in support. This became evident in the nurse led clinic many of ladies were struggling with menopausal symptoms, fertility issues, and problems with body image sexuality and with an ongoing fear of recurrence of the disease. We wanted to
- Provide an opportunity for ladies to attend a group session following treatment and to give them the tools and knowledge to enable them to face the future with confidence rather than fear.
- Explore and identify psychological needs using the distress thermometer and to action and signpost patients to the most appropriate avenue of support.
- To establish additional self-management workshops 6months to a year following treatment.

The service has now been utilised by over hundred patients and has evaluated extremely well. Due to patient demand we have developed a ‘moving on workshop’, ‘reconstruction workshop’ and a ‘chemotherapy and Herceptin drop in session’.

It is a mechanism to help survivors take greater control of their lives, many of sessions are driven by patients experiences and others take comfort in the fact they are not alone removing the feeling of isolation and abandonment. The workshops focus on health promotion and self management leading to improvement in patients anxiety and can be proactive problems rather than reactive to issues such as lymphoedema or post menopausal bleeds that can lead to better management when caught at an early stage.

The use of the distress thermometer has led to a more accurate assessment of psychological needs prompting referral for additional counselling or to psychologist to action when needed. It is also useful tool for other professionals involved in the patients care as it gives them a better understanding of the psychological and physical needs.

We constantly evolving and trying to identify any forgotten avenues of care, currently we are in the embryonic stages of developing a workshop for partners and husbands, as often they have to form of support and share the same anxieties of the patients. We also focusing on the education of professionals involved in breast care such as physios, mammographers, dieticians, ward staff often they are unaware of the problems women face on daily basis following treatment. The professionals also have the opportunity to share their knowledge with patients hence reducing potential appointments with GPs or other allied health professionals, as patients are far more confident identifying and managing symptoms. Our ultimate goal is that no women should feel abandoned or alone and they have the sufficient tools to help them with on the road to recovery. The experience of cancer will never leave them but the fears and anxieties attached to the diagnosis can be managed with the good support end education.

O-219 COMPARISON OF NO STING BARRIER FILM AND STANDARD THERAPY FOR Radiotherapy SKIN PROTECTION IN NASOPHARYNgeal CANcer PATIENTS: A RANDOMIZED CONTROLLED TRIAL
Li-Lu Chang, Min-Chih Chen, Pei-Lin Hsieh.
Koo Foundation Sun Yat-Sen Cancer Center, Taipei, Taiwan.

Introduction
Radiation dermatitis is a common acute side effect of radiotherapy. The clinical manifestation of acute skin reaction ranges from erythema to dry desquamation, moist desquamation and, in rare cases, ulceration and necrosis. In the absence of clear and consistent data on the efficacy of preventive and therapeutic strategies, patterns of care for radiation skin reactions vary widely among treatment centers.

Purpose: The purpose of study was to investigate the effectiveness of Cavilon No Sting Barrier Film (NSBF) for the prevention or reduction of acute radiation-induced dermatitis of grade 2 or higher during radiation therapy for nasopharyngeal cancer patients, compared with no treatment.

Methods
The study was randomized controlled and longitudinal design. Nasopharyngeal cancer patient at any stage of both sexes, age 18 or older, and being given a fractionated radiation therapy, was eligible for the study. The enrolled patient was randomly assigned to be applied NSBF on the right side or left side of the treatment fields. Intra-individual left/right self comparison method (paired test) was used. The change from the baseline to the end of the study was scored and compared. Modified RTOG scores and the measurement of skin reaction area were used to assess the treatment efficacy; we also assessed patients’ subjective feelings: pain scores, burning sensation and pruritus. Effects of NSBF on the reduction of radiation-induced dermatitis was analyzed by GEE (Generalized Estimating Equation).

Results
A total of 38 patients met our research inclusion criteria participated and completed this experimental study from May 1st 2007 to October 31th 2008. The mean age of participants was 43.8 years old with a SD of 10.2 (range from 20 to 75). The mean dose of radiation therapy was 7203 cGy with a SD of 292 cGy (median=7000). The study results revealed that radiation skin reactions peak toward the end of radiotherapy (at the 7th week). At the 7th week there was a significantly greater reduction of RTOG scores and skin reaction area on the experimental sites than that on the controlled sites of radiation skin in participants. The participants reported significantly lower pain scores and burning sensation scores on the experimental sites compared to the controlled sites at the 6th and 7th weeks. In our findings, those participants with smoking and drinking history tend to develop higher grade of radiation dermatitis. Conclusion: The benefit of No Sting Barrier Film (NSBF) has been demonstrated that it protects intact or damaged skin. This research provides evidence of the effectiveness of NSBF in preventing skin breakdown during radiation therapy and consequently reducing the incidence of radiation dermatitis of grade 2 or higher in cancer patients.

O-220 PREDICTORS OF NATURAL KILLER CELL ACTIVITY IN SPOUSES OF PATIENTS WITH CANCER
Linda M. Goodfellow, PhD, RN.
Duquesne University School of Nursing, Pittsburgh, PA, USA.

Spouses of patients with cancer are a highly stressed group of individuals and often experience depression, loneliness, negative mood, and marital disruption due to their partner’s illness. They may also experience a reduction in immune function, specifically natural killer cell activity (NKCA). NKCA is an excellent indicator of overall health status. It is imperative that
nurses promote positive health and well being in the spouse of the patient with cancer and thus, help keep spouses healthy to care for their ill partners. The purpose of this study was to determine predictors of NKCA in spouses of patients with cancer. The specific aims of this study were to: 1) examine the relationships between depression, loneliness, mood, marital disruption, and NKCA; 2) determine whether the major variables under study were predictive of NKCA; and, 3) examine age and gender. Concepts from the psychoneuroimmunology literature and family systems theory were used to guide the original study. A secondary analysis was conducted on baseline data previously collected in a large intervention study. Male and female spouses of patients with cancer (N=42) were recruited from an out-patient chemotherapy unit. Strict criteria were used to qualify subjects for participation in the original study. Instruments used to collect data included the Center for Epidemiological Studies Depression Scale (CESD), the Profile of Mood States (POMS), the University of California, Los Angeles Loneliness Scale (UCLA), and the Marital-Adjustment Test (MAT). Regression analyses were used to determine predictors of NKCA in spouses of patients with cancer. Results indicated that depression and mood are predictive of NKCA. It is important for nurses to recognize depressive behavior and negative mood in spouses of patients with cancer and to promote interventions to reduce stress associated with caring for an ill partner. Future research should examine the effects of interventions used to reduce depression and improve positive mood on NKCA in spouses of patients with cancer.

CONCURRENT SESSION E3
“SUPPORTIVE CARE” (PEACHTREE BALLROOM B)
CHAIR: ALANA GEARY

O-221 COGNITIVE BEHAVIORAL THERAPY FOR CHRONIC INSOMNIA AFTER BREAST CANCER TREATMENT
Elynn E. Matthews, PhD, RN, AOCN.
University of Colorado Denver, Aurora, CO, USA.

The primary goal of the study is to examine cognitive behavioral intervention for insomnia (CBTI) in women after breast cancer treatment. Chronic insomnia is a highly prevalent and distressing symptom in cancer patients. CBTI is considered the treatment of choice for chronic primary insomnia, yet few studies have been conducted in cancer survivors to evaluate the effect of CBTI on sleep and clinically relevant outcomes. The overall goals are to: 1) test standard-component CBTI in women with breast cancer post-treatment and 2) determine effects of the intervention on quality of life (QOL) and daily functioning. Sixty women after primary breast cancer treatment, 21–63 years of age, who meet the criteria for chronic insomnia, are recruited from two Western U.S. Cancer Centers and community support groups. Participants are randomized to either CBTI or desensitization therapy, and both groups receive 4 in-person and 2 phone sessions. Sleep efficiency, sleep onset latency, minutes awake after sleep onset, quality of life and daily functioning are among the outcomes assessed at four time points: pre-, post-therapy, and at 3- and 6-month follow up mailings. It is hypothesized that women receiving CBTI treatment will demonstrate greater improvement in sleep outcomes, QOL, and daily functioning compared to those receiving desensitization therapy. Established instruments include the Insomnia Severity Index. Morin Sleep Diary, Dysfunctional Beliefs and Attitudes about Sleep-16, EORTC Quality of Life Questionnaire C30, Attentional Function Index, Revised Piper Fatigue Scale, and Hospital Anxiety and Depression Scale. Subjective data will be corroborated with actigraphy. ANOVA will be used to compare groups on each subjective dependent variable. Results are pending completion of analysis.

O-222 WOMEN’S EXPERIENCES OF INTERACTING WITH THE HEALTH-CARE TEAM DURING TREATMENT FOR THE FIRST RECURRENCE OF OVARIAN CANCER
Eva M. Ekwall, IV, ML1, Britt-Marie Tenestad, IV, Professor2, Bengt Sorhe, IV, Professor3, Ulla Hällgren Gramehn, IV, Associated professor4.
1School of Health and Medical Sciences, Örebro University, Örebro, Sweden, Örebro, Sweden, 2Department of Neurobiology Caring Sciences and Society, Stockholm, Sweden, 3Department of Nursing, Medical Faculty, Umeå, Sweden.

When patients suffer a recurrence of cancer, they often return to the same department where their primary cancer was treated. To identify their needs in this phase, the aim of this study was to explore what women with the first recurrence of ovarian cancer found important in their interaction with the healthcare team from the time of diagnosis of recurrence through completion of chemotherapy. Interviews were conducted at the end of chemotherapy treatment with 12 women diagnosed with recurrent ovarian cancer. The interviews were subjected to qualitative content analysis. Our analysis found that the women needed help to familiarize themselves with the disease, supported by the following sub-themes: being confirmed as a person, getting help to make sense of information about the disease and its treatment, having the opportunity to be involved and share responsibility, and feeling confident that medical expertise was good enough. Being confirmed as a person was a prerequisite to becoming familiar with the disease and facilitated the process of familiarization. The study confirms that patients’ needs when cancer recurs are somewhat different than during primary treatment. The findings stress the importance for the healthcare team to ensure individual support for becoming familiar with the disease.

O-223 ORAL MUCOSITIS IN RADIATION AND MEDICAL ONCOLOGY: MANAGEMENT SIMILARITIES USING ORAL RINSE
Marilyn L. Haas, PhD, CNS, ANP-BC.
Mountain Radiation Oncology, Asheville, NC, USA.

Oral mucositis (OM) is a painful inflammatory, ulcerative response to radiation or cytotoxic agents causing an interference with normal epithelial cell turnover, leading to direct and indirect destruction of the mucosal lining. Radiation-induced OM occurs after 20Gy (Kostler, et al, 2001). Differing in its method of injury, cytotoxic chemotherapies denude the epithelia lining after interfering with the DNA, RNA, or protein synthesis. Effects begin 2–14 days after initiation of chemotherapy (Epstein and Schubert, 2003). Both methods results in aguesia, hypoguesia and xerostomia. Basic oral care is not sufficient enough to maintain oral health during cancer treatments. Products that can reduce or ameliorate OM can be beneficial. A supersaturated electrolyte oral solution (SSEOS) of calcium and phosphate, distributed by EUSA, Pharma; a European and United States company, was studied by Dhaon and colleagues and found to have statistical significance in treating OM (2003). This research was to investigate the efficacy of SSEOS among patients undergoing chemotherapy/CT/ higher doses of radiation/RT) or combined chemoradiation (CRT) who were at high risk for developing OM. Methods

The study was a prospective, open-label observational registry that collected data from 26 multicenter sites, enrolling 218 patients. The registry included patients receiving CT/RT/CRT diagnosed with head/neck, breast, lung, colon cancers, and lymphoma. After IRB approval, patients were instructed to rinse 4–10 times a day, beginning at the initiation of chemotherapy. Physician/nurse researchers and patient completed surveys regarding four cluster symptoms: dysphagia, pain, and NCI clinical and functional OM. Additionally, pain diaries were kept.

Results/Conclusion
Overall, practitioners/patients reported low incidence of severe oral mucositis (3–7% NCI Grade> II), high rates of healthcare providers/patients satisfaction (80–95% and 82–85%, respectively) and high levels of compliance (95–98%). SSEOS was well tolerated, without adverse side effects. The study concluded that the SSEOS was a significant adjunct in the management of OM associated with high-dose CT/RT/CRT.

Nursing Implications
Although there are no universal treatment guidelines for OM, oncology nurses agree patients should perform basic oral care during oncology therapies (brush, floss, rinse with bland rinses, avoid alcohol/tobacco, maintain hydration (Harris and Eilers, 2009). Until scientists can understand how to eliminate OM, it is reasonable to offer supportive care products. Offering a SSEOS has excellent safety profile and therapeutic uses and is one strategy nurses can suggest that helps with the symptoms of radiation/chemotherapy-induced OM.
O-224 SELF-MANAGEMENT OF TREATMENT RELATED FATIGUE, NAUSEA/VOMITING AND ORAL MUCOSITIS IN CHINESE CANCER PATIENTS
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Background
Treatment related side-effects continue to place significant burden on cancer patients. Many side effects require patients to engage in a range of self-management actions. While some studies have explored self-management in western settings, no studies were identified that described self-management practices of patients in China.

Objective: This study aims to describe Chinese cancer patients’ self-management behaviours in dealing with fatigue, nausea/vomiting and oral mucositis, as well as the perceived effectiveness of these behaviours and related self-efficacy in performing them.

Methodology: A cross-sectional survey of patients from a large cancer hospital in China was conducted. Two samples were recruited. The first sample comprised patients from radiation treatment departments experiencing oral mucositis; the second sample included patients from chemotherapy departments with fatigue or nausea/vomiting.

Results
Overall 100 patients experiencing oral mucositis were recruited for the first sample. A mean of 5.16 (±1.67) self-management behaviours were reported to manage this symptom. The behaviours reported by more than two thirds of respondents were “drank more liquid” (92%), “ate bland and soft food” (91%) and “used a prescription mouthwash” (78%). Activities most commonly rated as providing patients “some to a lot of relief” were “avoided very hot/cold food” (85%) and “avoided alcohol/tobacco” (79%).

277 patients were recruited for the second sample, of which 255 participants reported nausea or vomiting and 271 reported fatigue. For patients with nausea or vomiting, a mean of 8.56 (±3.15) self-management behaviours were reported. The most common self-management behaviours included “ate less” (83%), “ate light food” (81%) and “took prescribed medication” (80%). None of these behaviours was reported as providing “some to a lot of relief” by more than half of patients using them. Amongst patients with fatigue, a mean of 4.71 (±1.98) self-management behaviours was reported. The most common self-management behaviours for fatigue included “went to bed earlier” (76%) and “got fresh air” (69%). Nearly all strategies were rated as providing “some to a lot of relief” by around one third of patients using them. Almost all actions for managing these symptoms were reported to be implemented with low self-efficacy.

Conclusion
Similar to reports from overseas, Chinese cancer patients initiate a wide range of self-management behaviours in response to treatment related side effects. While some behaviours were reported to provide relief, many did not. Importantly, for almost all behaviours, Chinese cancer patients reported low levels of self-efficacy. Such findings have important implications for development of evidence based patient education programs.

O-225 PARENTAL ACCEPTANCE OF THE HUMAN PAPILLOMAVIRUS VACCINE IN 9-18 YEAR OLD GIRLS
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It is estimated that 11,070 women in the United States in 2008 will be diagnosed with cervical cancer and that 3,870 women will die of the disease (American Cancer Society 2006). Globally, the statistics are more alarming, with 471,000 new cases of cervical cancer diagnosed each year, accounting for 300,000 deaths and making cervical cancer the second leading cause of death in women worldwide. These statistics translate into a sobering fact: Approximately every 2 min a woman dies from cervical cancer (CervicalCancer.org 2007). Human papillomavirus (HPV) is the most common STD worldwide, causing genital warts and nearly all cases of cervical cancer (Friedman, 2006).

Although the advent of the HPV vaccine holds the promise of preventing a major female reproductive cancer and genital warts, it is recognized that psychological and social barriers may compromise the effort. There is tremendous opportunity to prevent a female reproductive cancer through utilization of primary prevention tactics such as immunization. Public health opportunities are even wider in scope in developing countries where lack of access to health care may contribute to health disparities. Parental acceptance of HPV vaccine may be critical in decreasing the incidence of cervical cancer, since parents are the primary decision makers for adolescent immunization.

The purpose of this research project is to:
1. Test a model that predicts intention to vaccinate and that includes as predictors variables from two theories: the health belief model and the theory of reasoned action.
2. Examine the relationship between parental knowledge of HPV and intention to vaccinate.
3. Test the hypothesis that parents/guardians who have received information regarding HPV from their pediatricians or health care providers will be more likely to intend to have their daughters receive HPV vaccination than parents who have not received information from their pediatricians or health care providers.
4. Test the hypothesis that parents/guardians who have more intrinsic religious motivation and for whom religious faith is more important will be less likely to intend to have their daughters receive HPV vaccination than parents who have more extrinsic religious motivation and for whom faith is less important.
5. Test the hypothesis that parents/guardians who have had a personal history or know of someone who has had a sexually transmitted disease (STD) or cervical cancer will be more likely to intend to have their daughters receive HPV vaccination than parents who have not had a personal history or know of someone who has had a sexually transmitted disease or cervical cancer.

O-226 BELIEFS ABOUT SYMPTOMS: ARE THEY IMPORTANT IN UNDERSTANDING SYMPTOM AND PSYCHOLOGICAL DISTRESS?
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Physical symptom and psychosocial distress is common across cancer populations in response to cancer and treatment symptoms but individual variation in distress severity is not fully explained by demographics, underlying pathological processes or objective disease variables. Current symptom theories support earlier research that responses to symptoms such as pain are subject to modulation as part of a complex psychological-information processing system. Consequently, it is understood that symptom experience inclusive of related physical and psychosocial distress is the outcome of the individual’s interpretation and attachment of meaning and significance to symptoms. While there is emerging consensus regarding the importance of symptom appraisal in contributing to distress outcomes there has been little research that has examined how these constructed meanings and appraisal processes influence health behaviour such as self-management. The purpose of this paper is to present the findings of a systematic review of the literature that focused on examining the contribution of beliefs (perceptions) about illness and symptoms in determining physical symptom and psychological distress and subsequent health behaviour. Qualitative, descriptive findings will be presented based on a synthesis of the literature in the field, highlighting the role of beliefs on delays in diagnosis, decisions related to screening behaviours and prophylactic mastectomy for those at genetic risk for cancer, and psychosocial responses to treatment and advanced disease symptoms.
Fatigue is a common symptom in lung cancer patients undergoing chemotherapy. This research was designed in order to track the pattern of fatigue in lung cancer patients from initial diagnosis to one month after the completion of 6 cycles of chemotherapy at 8 time points. This study investigated the effect of energy conservation and activity management (ECAM) on lung cancer patients and its effectiveness in reducing fatigue. Sixty two lung cancer patients were recruited from one medical center (31 subjects for ECAM intervention and 31 subjects for usual care) to describe patterns of fatigue over time. In the data, fatigue was assessed by the General Fatigue Scale, and Energy Conservation Strategies, respectively. We also used the generalized estimating equations (GEE) to analyze these data. The findings of the study were (1) “energy conservation strategies” indicated significant differences over time. Subjects in the ECAM group used significantly more energy conservation strategies compared with the control group; as regards the effect of fatigue, using intent–to–treat analysis and per–protocol analysis, there was no significant difference in the duration of the two groups. (2) As for the long-term pattern of fatigue in lung cancer patients who underwent chemotherapy, the fatigue associated with chemotherapy peaked after treatment and remained elevated one week after each cycle of chemotherapy, and was observed to gradually diminish over time but never reached baseline values. These findings will help health care providers to understand fatigue patterns over time. They also can improve quality of care and baseline management strategies for lung cancer patients undergoing chemotherapy.

Keywords: lung cancer, fatigue pattern, energy conservation and activity management, intervention, longitudinal study.

The simulation experience exposes nurses to such discussions by involving them and providing repeated experiences (the over learning concept), encouraging them to take initiative in instigating discussion, assessment and subsequent intervention. This communication is observed by peers and recorded for analysis and support in the form of subsequent interactive debrief with immediate constructive feedback. Debrief, a pivotal aspect of simulation training within a safe environment, enhances knowledge and assists nurses to become more confident. This learner-centered approach encourages nurses to address difficult issues, resulting in new found confidence which transfers back into clinical practice, promoting holistic patient care.

Funding has been made available for five years to implement the Canadian Strategy on Cancer Control, through the auspices of the Canadian Partnership Against Cancer. One of the eight action groups charged with specific mandates is the Cancer Journey Action Group. Its mandate is to provide leadership to chart the course of the cancer system so that patient, survivor and family member needs are better served.

One of the key strategy plans to assist in achieving the vision of a person-centered care delivery is Patient Navigation. Navigation is an intentional, proactive process of charting a course through the cancer system, accessing services and actively overcoming barriers to quality care. This intervention can increase timely access to the full range of supportive care services required by patients. Professional led, peer led, and virtual approaches to navigation have been initiated across the country.

Cancer and its treatment have far exceeded a physical impact. There are psychosocial, spiritual and practical consequences. Patients and families need access to a wide range of services. Navigation through the complex cancer system is imperative to improve the patient experience. Research and evaluation on patient navigation is required to determine best models for particular settings.

This presentation will highlight the overall plans for the Action Group is its move toward creating a person-centered cancer system, with a specific emphasis on navigation as a system intervention. This work presents an excellent opportunity to influence the quality of psychosocial and supportive care services.

In today’s healthcare arena nurses often tend to shy away from discussing issues that do not pertain directly to patients at their presenting point of care. It has been well documented that people diagnosed with cancer often suffer psychosocial morbidity requiring considerable supportive care interventions. Much research and anecdotal evidence indicates extensive education in classrooms on the importance of supportive care issues. Despite the existence of oncology nursing mentor programs and interdiciplinary training, nurses are still reluctant to raise uncomfortable issues for fear of inadequacy or embarrassment. Nursing education is often didactic in nature, promoting an arena of passive learning. Nurses often understand what should be addressed, but providing strategies to raise or gain confidence in addressing such issues, is often lacking in curricula. This raises the question, how can nurses become more confident when addressing difficult and confronting issues presented by oncology patients in the clinical setting?

The use of simulation in nursing has traditionally been limited to training for clinical skill acquisition. The intention of introducing simulation for the purpose of emotional and delicate discussion is to improve communication skills. Scenario experience is provided using ‘standardized patients (SP)’ who simulate real patients. SP are actors trained to portray a range of clinical, emotional and behavioural problems in the oncology setting, whilst engaging with individual nurses in a given scenario. Discussions include those relating to death and dying; transition to palliative care; end of treatment; using the words ‘cancer’ or ‘death;’ inclusive of cross cultural concerns. The literature tells us we are particularly poor at discussing emotional and spiritual concerns of cancer patients. We often ignore discussions relating to anxiety regarding isolation, child and family support, infertility, premature menopausal symptoms and relationships with partners. Similarly issues regarding sexuality are often ignored or met with discomfort.

The simulation experience exposes nurses to such discussions by involving them and providing repeated experiences (the over learning concept), encouraging them to take initiative in instigating discussion, assessment and subsequent intervention. This communication is observed by peers and recorded for analysis and support in the form of subsequent interactive debrief with immediate constructive feedback. Debrief, a pivotal aspect of simulation training within a safe environment, enhances knowledge and assists nurses to become more confident. This learner-centered approach encourages nurses to address difficult issues, resulting in new found confidence which transfers back into clinical practice, promoting holistic patient care.

Materials and Methods
The study was derived from Lazarus and Folkman’s cognitive appraisal theory. A convenience sample of 100 men recruit from two strategies, one from prostate support group meeting which organize every month at Siriraj Hospital, Prostate Center. In the second strategy, a letter of invitation posting at prostate clinic at out patient department of the hospital where service prostate surgery. Instruments include: In-depth interview Guide and Coping Scale. Interview and Questionnaires were collected: 1 month, 3 months and 6 months after surgery. Data were analyzed using Content analysis for Stress Appraisal, Freidman was used for test change of Stress.

Results
The findings of this study highlight 3 categories of stressful encounters: symptom distress, role performance and embarrassment. These encounters were no change of different important to patients in each time period. It was found that patients suffered differing stressful experiences, which changed over the three time periods. These experiences were: T1 loss, T2 threat, and
T3 threat. When tested with Freidman’s test, it was found that experiences remained stable. Men most all (95%) used Situational control coping strategy by used containment devices such as pads, special undergarments, and even sanitary napkins as management strategies. Pelvic muscle exercises, is the method that majority men used for daily exercise but decline by the time: one month postsurgery (92%), two month postsurgery (86%) and three month postsurgery (80%).

**Conclusion**

Urinary incontinence is a prevalent postoperative complication for men, even up to five years after surgery, and a source of great distress for some. Men reported stress and urge incontinence symptoms and used an array of strategies to contain their urine. Finding effective treatments for postprostatectomy urinary incontinence and receiving adequate information before surgery is important to these men.

**IMPLICATION FOR NURSING** As the number of men who undergo surgical treatment for prostate cancer increases, oncology nurses need to be equipped with the necessary knowledge and information to answer preoperative concerns and provide effective strategies for managing postoperative urinary incontinence.

**O-231 QUALITATIVE EXPLORATION OF FAMILIES’ EXPERIENCES CARING FOR LOVED ONES WITH ADVANCED OVARIAN CANCER**

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Ovarian cancer is challenging, both physically and psychologically, because of the advanced nature of the disease at diagnosis, side effects of the disease and treatment, and impact on roles and responsibilities, (Howell, et al., 2003). The family plays an integral role in promoting and maintaining the health of family members as well as providing physical and emotional support (RNNAO, 2002).

Professionals are challenged to meet the comprehensive needs of women with ovarian cancer and their families. There is a need to better understand the family perspective when caring for loved ones who have advanced ovarian cancer. Research that explores the family experience is essential to inform practice and develop structures and processes that foster and support family centered care. Such an approach should transform care for women with ovarian cancer and their families.

The purpose of the qualitative study is to explore family members’ experiences of caring for a loved one with advanced ovarian cancer. The primary research question is: What is the experience of individuals caring for a family member with advanced ovarian cancer? A secondary question is: What challenges do these individuals face while caring for their loved ones?

This presentation will describe the iterative process of knowledge translation and exchange to develop the research project and preliminary qualitative findings will be shared.

**O-232 SUCCESSFUL RECRUITMENT, RETENTION AND ADHERENCE IN A PHASE II CLINICAL TRIAL**

Donna A. Tyrpak, MS, RN, ANP Jean K. Brown, PhD, RN, FAAN, Richard W. Browne, PhD, Peter Horvath, PhD, Donna A. Tyrpak, MS, RN, ANP, Gregory E. Wilding, PhD, Dhiren K. Shah, MD. University at Buffalo The State of New York, Buffalo, NY, USA.

**Background**

Recruiting and retaining participants for a longitudinal randomized clinical trial (RCT) is generally a daunting task, often taking longer than expected to accrue the projected number of participants. Usually only a small proportion actually enrolls in RCTs. Retention and protocol adherence issues commonly occur in longer clinical trials and are often problematic.

**Purpose**

To describe the methods used to successfully recruit and retain participants while promoting protocol adherence.

**Setting, sample, methods:** The Multivitamin/Minerals during Cancer Therapy study is a phase II, 3-armed, double blind, placebo controlled RCT. 53 prostate cancer outpatients receiving external beam radiation with or without brachytherapy were enrolled over 25 months from 5 sites in Western New York. Participants were seen at 4 time points over 21 weeks. Recruitment strategies included: ongoing analysis of recruitment approaches, focusing efforts on receptive sites, supporting clinical staff, integrating the study nurse into clinical sites, obtaining a partial HIPPA waiver for direct contact of eligible participants, reducing participant burden with time sensitive enrollment appointments, enrolling participants 5 days per week, and providing study literature and newsletters. Retention and adherence strategies included: clear explanation of participation expectations and weekly phone calls to assess protocol adherence and adverse events.

**Research variables**

Recruitment, retention, adherence.

**Findings:** Recruitment rates for the 5 sites averaged 28.5% with the largest site averaging 34%. 81% of participants came from the largest site. 98% of participants enrolled completed the study. Overall adherence was 88% with 96% adherence for those who completed the protocol.

**Conclusions**

Successful recruitment was attributed to: ongoing clinical staff support, familiarity with site scheduling process, ability to enroll participants 5 days per week, supplying written reference and contact information. High retention and adherence was attributed to: weekly phone calls for follow-up, appointment reminders, assessment of protocol adherence and adverse events, and realistic expectations of participation explained during the initial visit.

**Implications for nursing:** Ongoing analysis of strategies and willingness to reframe efforts are imperative for effective recruitment. Educating, developing, and integrating the study nurse with clinical staff are important to achieving successful results. Staff referrals of all eligible patients need to become part of the daily clinical site routine to overcome clinical gatekeeping.

**Funding Sources:** NIH/NCI #1R21CA102391-01A2

**O-233 RESPONSE TO ANTIOXIDANT DIETARY SUPPLEMENTS DURING RADIOTHERAPY FOR PROSTATE CANCER**

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**Purpose/Objective**

Whether antioxidants are beneficial or harmful during cancer treatment is a critical question without a clear scientific answer, yet 30%–77% of cancer patients in the US reported taking dietary supplements as a self-care strategy. The purpose of this study was to determine the effects of two commonly used dosages of dietary multivitamin/mineral supplements on men with prostate cancer receiving radiotherapy.

**Material/Methods:** This double blind, placebo-controlled, phase II clinical trial enrolled 52 men with prostate cancer receiving external beam radiation with or without brachytherapy from five outpatient radiotherapy facilities. All participants had adenocarcinoma with 83% at stage II, 69% Gleason grade 3, and 43% Gleason score 6. Treatment protocols were comparable across clinical sites with half of the participants getting external beam therapy and half brachytherapy (4500 cGy external beam with 10,800 cGy iodine−125). Participants were randomized into one of three multivitamin/mineral dose groups (Dietary Reference Intake, orthomolecular, or placebo) and asked to take capsules from 1 week prior to treatment until 3 months after treatment. Only one participant withdrew from the study with 52 (98%) completing all data collection time points. Measures included PSA, oxidative stress/damage, immune function, side effects, nutritional status, and quality of life. All measures have well established properties. Data were collected 1 week before treatment, at the end of treatment, and 3-months post-treatment. Protocol verification was determined by capsule counts and serum vitamin levels with excellent adherence. Analysis included random coefficient modeling and ANCOVA with Bonferroni adjustment.
O-234 RESEARCH NURSE: A BIOETHICAL ISSUE
Claudia Passoni, Research nurse, Irene Fenone, Research nurse, Chiara Pari, nurse, Alessandra Milani, Research nurse. Istituto Europeo di Oncologia, Milano, Italy.

In the history of nursing, there is a longstanding tradition of conscientious objection. In the research world there are so many issues which can carry a nurse to make this choice.

This is the case of an Italian research nurse involved in a clinical trial. Before starting the enrolment, and also after the onset of the trial, she had many doubts due to the treatment used, to the unsatisfying results of the treatment and also due to deterioration in the patients quality of life.

To arrive at a decision was long and difficult because of the implications that this situation caused.

In the literature, there are some guidelines for conscientious objection from the American Nurses Association: the refusal shouldn’t be based on “personal preference, prejudice, convenience or arbitrariness”. Moreover, it must be an “autonomous, informed and critically reflective choice” (Johnstone, M.J, 2004).

The nurse decided to be present, but not to take part in the enrolling visits to give patients the opportunity of a free choice; to assist patient after the treatment, but not to ad mister the treatment.

All this matter stimulates a discussion between research nurse, clinicians, and research staff.

It’s not a simple situation, because research nurse has a fundamental advocacy role for patients. Conscientious objection solved a part of the question, but the interior fight is still ongoing, because patients are alone in their making decision process.

O-235 GROUP CONSULTATION PHASE 1 PATIENTS
Helene M. Klein Wolterink - Blob, oncology nurse, Marianne M. J. de Jong, Oncology nurse, Saskia C. C. M. Tamissen, PhD. University Medical Hospital Utrecht, Utrecht, Netherlands.

Introduction
Early clinical research is of key importance within the Medical Oncology Department of the UMC Hospital in Utrecht, the Netherlands. Oncology nurses are regularly questioned by patients about the side effects of medication and are asked to provide more information with respect to the overall treatment. As several patients are at the same stage of the study, the idea came up to start a group consultation.

Hypothesis
Would a method to provide a semi-structured group consultation be adequate to:
- obtain information regarding the wishes of phase 1 patients and their relatives with respect to providing information and guidance by the hospital
- provide overall information to patients regarding the phase 1 treatment

Method
We contacted 15 patients and their partners in writing. We asked them questions about the following:
- what would be a good moment to start providing information prior to the study
- the patients’ preferences for guidance during the study
- tiredness
- emotional confrontation

Conclusions
This is the first clinical study to address the issue of whether cancer patients should take antioxidants during radiotherapy. Use of multivitamin/mineral supplements with antioxidants at dietary reference intake doses may be safe for prostate cancer patients during radiotherapy, but replication is needed. Funded by NIH/NCI #1R21CA102391-2.
O-237 VARIETIES IN SEXUALITY IN PROSTATE CANCER NARRATIVES
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Background
Men with prostate cancer experience due to their illness changes in their sexuality in individual and varied ways. In our society men are often socialized into understanding their sexuality through mechanical and technical metaphors, especially in relation to intercourse. Men are less prone than women to talk about their feelings and emotions in general and in relation to sexuality and intimacy specifically. Since prostate cancer treatments affect sexual function this can have great impact how they value their sexuality in the traces of the diagnosis.

Aim
The purpose of this study was to understand and analyse how middle-aged men with prostate cancer experienced changes in their sexuality from a lifeworld perspective.

Method
Qualitative in depth interviews were conducted with ten men. The median age for these men was 65 years. Four of them were retired and the others were still working. The empirical phenomenological psychological (EPP) method was used for the analysis.

Findings
All men in this study were aware of the risk for a lethal outcome of prostate cancer. In the light of this, to sacrifice their sexual ability as an effect of treatment was something they were prepared to accept. At the same time they felt cheated and missed sexuality as part of what they saw as a normal life. When and if treatment did not affect sexual performance, a stronger appreciation of sexual satisfaction than before was often experienced. Those who suffered sexual dysfunction felt inadequate in intimate situations and this feeling also affected other situations in the daily life.

For men living in trusting and reliable relations the feeling of inadequacy eventually was accepted and sometimes they could even feel more close to their partner than before. A desire for their partner in intimate situations was retained even if sexual lust and the ability to penetrate were lacking. In interaction with healthy men the participants didn’t usually talk about their cancer disease. Together with men in the same situation, sexual issues were an important subject to talk about. None of the ten men had been able to talk about changes in their sexuality due to cancer treatment in a deeper sense with anyone before this interview. Most of the men appreciated the opportunity.

(These findings are preliminary. The analysis is work in progress).

O-238 DERMATOLOGICAL SIDE EFFECT INTERVENTIONS FOR TARGETED CANCER TREATMENT UNTANGLED: A SYSTEMATIC REVIEW
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Significance & Background
Dermatological side effects, such as papulopustular rash, xerosis, pruritus, mucosal-, hair-, periungual- and ocular changes, often occur during cancer treatment with Targeted Therapy. Patients are hindered in their daily activities and cannot maintain privacy about their illness because of the visible side effects. These aesthetic discomfort can lead to a decreased health related quality of life (HRQoL) and to discontinuation of treatment.

Conceptual Framework: At present, clear terminology of the dermatological reactions caused by Targeted Therapy were included. Different categories were developed in advance and all data were analyzed accordingly: a. patient education, b. assessment tools, c. guidelines, d. pharmacological agents, e. interventions not otherwise specified, f. effect on the seriousness of the dermatological reactions, g. HRQoL, and h. treatment compliance. Two reviewers independently assessed the papers and extracted the data.

Findings & Implications
In the 135 included articles, inconsistent advices on management strategies and their influence on the seriousness of the dermatological reactions were found. Unconfirmed recommendations of the review are: Interventions like baseline assessment, patient education and measurement of HRQoL and treatment compliance can support managing the rash. The assessment tools FACT and SKINDEX-16 can be worthwhile in recognizing side effects and their influence on the HRQoL and compliance.

Discussion: Oncology nurses are in an ideal position to minimize the severity of dermatological reactions caused by targeted therapy.

O-239 USING THE ROY ADAPTATION MODEL TO IDENTIFY THE IMPACT OF TREATMENT-RELATED CORRELATES ON ROLE FUNCTIONING DURING RADIATION THERAPY
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Quality of life in individuals with cancer is a widely accepted priority for both research and clinical practice. The ability to function is one critical dimension of quality of life. Both cancer and its treatment can have profound effects on an individual’s functioning including ability to maintain usual activities, such as work, household chores, and social events. The purpose of the current study was to identify the impact of treatment-related correlates such as fatigue, side effects, and treatment site, on the ability of patients to carry out specific activities during radiation therapy.

The role performance mode of the Roy Adaptation Model guided the selection of items to be analyzed and the grouping of activities into primary, secondary, and tertiary roles. A secondary analysis was conducted on data from seventy-seven participants recruited from one community radiation therapy department. Data had been collected prospectively at baseline, weekly during treatment, and at the end of treatment. Individual items from two well-established fatigue instruments, the revised Piper Fatigue Scale and the Brief Fatigue Inventory, that were related to activities of daily living were analyzed. These items were grouped into primary (basic activities of daily living such as walking and general activity), secondary (work and school activities) and tertiary (socialization with family and friends) roles. Paired t-tests were used to test for differences in performance of each role at each measurement point. Functioning in all three roles declined during the course of treatment. There was greater disruption in secondary roles than in primary or tertiary roles. There was a statistically significant difference in functioning in all roles between baseline and the end of treatment. Patients continued to maintain their basic activities of daily living and tertiary roles such as socializing with friends. Patients had greater difficulty maintaining work, both in and out of the home, and school activities. Treatment to the lung, pelvis or head and neck was associated with greater disruption in functioning than treatment to the breast or prostate. Patients who lived alone experienced greater disruption in all roles than patients who lived with others. Oncology nurses are in a unique position to design interventions to help patients maintain those activities at greatest risk for disruption. Knowledge of predictors of change in functional status can be used to target interventions toward patients who might be at higher risk for disruption in function. Future research where performance of specific activities is the primary outcome of interest is indicated.
O-240 FACTORS THAT INFLUENCE PATIENT READINESS TO HEAR ABOUT COMMUNITY PALLIATIVE CARE SERVICES: RESULTS FROM THE PERCEPTIONS OF PALLIATIVE CARE INSTRUMENT

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Background
Appropriate, timely engagement between people with advanced cancer and community palliative care services (CPCS) results in improved outcomes for patients and family caregivers. The difficulty for health professionals is knowing when to raise palliative care for the first time. Little research has been done to examine patient perceptions of, and their readiness to hear about CPCS.

Aim
To identify factors that influence patient readiness to hear about CPCS.

Method: The Perceptions of Palliative Care Instrument (PPCI) was developed using an exploratory, sequential (QUAL◊Quant) mixed methods design combined with processes recommended by the European Organization for Research and Treatment of Cancer. Initial construct validity was established by testing for correlations between the PPCI and other established instruments with ‘like’ constructs: palliative care needs, symptoms, overall health, distress, reactions to a cancer diagnosis and preference for quality or quantity of life. A heterogeneous sample of 85 patients with advanced cancer completed all measures.

Results
The PPCI includes 41 questions. Average time taken to complete was 15 minutes. The measure contains four domains: 1. emotional and 2. cognitive reactions to palliative care, 3. palliative care needs and 4. perceptions of health. Readiness, assessed via a single item, was positively related to negative emotions (r = -.34, p < .001) and thinking the situation is hopeless (r = -.38, p < .001) but was not related to needs, perceptions of health, quality of life or overall health.

Conclusion
The PPCI utilised a patient focused approach to identify perceptions of CPCS held by patients faced with the possibility of needing such care in the near future. Patient readiness to hear about CPCS were influenced by internal (negative thoughts and feelings) as opposed to health or disease related factors. Consideration of patient perceptions may assist health professionals to discuss referral to CPCS in a manner that considers patient concerns.

Findings
278 patients were considered by a dedicated MDT and tracked on seven clinical pathways. As a direct response to patient feedback from the forum palliative care services are to be integrated into the PTS. 118 patients underwent major laparotomies: 81 (29%) underwent curative surgery & 37 (13%) undergoing debulking surgery. Several patients were managed along multiple pathways & their initial management was often staged into more than one treatment phase. The MDT process allowed for fluid & adaptable patient pathways & support mechanisms & was fundamental in a successful research programme. Collaboration as a result of the MDT process enables input from all disciplines across the research agenda.

References
1. Department of Health Guidelines April 2009

O-241 APPLYING RESEARCH & AUDIT FOR SERVICE DEVELOPMENT: THE EXPERIENCE OF A SPECIALIST SERVICE IN SUPPORTING PATIENTS WITH A RARE CANCER.

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Background
Pseudomyxoma Peritonei (PMP) is a rare tumour, originating from the appendix, producing extensive mucus accumulation within the abdomen. Recognising the rarity of these peritoneal tumours & the complex level of sub-specialisation required to deliver best standard of care, the Department of Health (DoH) in the UK commissioned services for the treatment of PMP through two national centres. Referrals are received for patients at every point on the disease spectrum making it a challenge to treat & meet the needs of this complex group. Research & audit in specialist centres are vital to increase the knowledge base in treating patients with rare cancers.

Method
In line with current UK policy to collect patient reported outcome measures (PROMS) we have mapped the patient journey to determine the specific needs of a cross section of patients referred to the Peritoneal Tumour Service (PTS). An audit review was undertaken from time of initial referral to MDT, first out-patient appointment & subsequent treatment have been recorded. The ongoing development of the PTS database allows audit into patient outcomes. These outcomes are used to review and develop patient pathways and improve the MDT process. The database has been extended to record feedback from a patient internet forum designed to enable patient peer support & information exchange. This forum has been directly developed from clinical research into patient experience.

O-242 EXPLORING THE PROCESS OF TAIWANESE HEALTH CARE PROFESSIONALS’ RESPONSES TO PEOPLE WITH CANCER WHO USE COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)

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Because of the long and entrenched history of complementary and alternative medicine (CAM) and Chinese medicine in Taiwan, people have traditionally incorporated this knowledge into their health care. With the appearance and growing acceptance of Western medical practices, multiple medical approaches have become more and more popular. Many health care professionals are aware or are not aware of their patients’ use of CAM. In Taiwan, regarding Taiwanese health care professionals’ responses to people with cancer who use CAM, there are no similar studies explored in depth. Therefore, it becomes very important to explore health care professionals’ responses when they encounter cancer patients who use CAM.

The purpose of this study is to explore Taiwanese health care professionals’ responses to people with cancer who use CAM. Utilizing a grounded theory approach, this research sought to explore the social processes by which Taiwanese health care professionals’ responses to people with cancer who use CAM, there are no similar studies explored in depth. Therefore, it becomes very important to explore health care professionals’ responses when they encounter cancer patients who use CAM.

The findings of the study demonstrate that the interactions between health care professionals, people with cancer and their use of CAM are complex. Health care professionals’ views and experiences appear to be an important category in the findings. If the use of CAM can improve the comfort of cancer patients, it can be considered as a supportive approach to cancer treatment. More specifically, health care professionals indicated that the meanings attributed to CAM are embedded in the social relationships that contribute to the lives of cancer patients. These findings suggest implications for health care professionals’ understanding of CAM and Western medicine by Taiwanese people with cancer and the social processes with which they engage. Furthermore, suggestions regarding clinical care and patient safety regarding patients’ use of CAM, are also provided.
The action research was aimed to development of the quality of knowledge management process in lung cancer patients from a holistic perspective. The research methodology was as follows: 1. Planning 2. Implementing 3. Observing 4. Evaluating. The subjects were divided into 3 groups: one is 20 health care workers and the other is 20 health care staffs and 5 lung cancer patients. The research instrument consisted of an in–depth interview and a questionnaire of the health care worker. Acquired data were analyzed on the basis of content and thematic analysis. The research findings were as follows: in the first stage there was one network of lung cancer patients. In the second, one unit of the lung cancer units were standardized as for the situation analysis, it was found that cancer center performed well on knowledge management on how to take care of the patients. However, there was no comprehensive and clear system. As a result, it was crucial to move to a holistic knowledge management development.

As regards the procedures, it was found that knowledge management covered 1) providing knowledge on disease and ways of taking care to patients 2) giving morale and involving the patients in a group 3) giving counseling 4) making environment suitable 5) building a good attitude to disease and treatment by creating morale and confidence.

O-244 CHEMOTHERAPY TRIAGE - AN ESSENTIAL SERVICE
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Chemotherapy is an essential systemic anti-cancer treatment which is used within the curative, adjuvant, neo-adjuvant, and palliative settings. Although good results are achieved for patients undergoing chemotherapy, the side effects can be debilitating or even cause death.

To ensure that patients have a thorough and comprehensive support system the development and use of a chemotherapy triage service/helpline is fundamental to how well the patient tolerates the treatment, how well they cope with the treatment and to the extreme, their survival whilst on treatment.

The development and use of triage services has been encouraged and supported by the National Chemotherapy Advisory Group 2008 publication Chemotherapy services in England – Ensuring quality and safety, who advise that all patients have access to 24 hour advice and emergency care. The National Confidential Enquiry into Patient Outcome and Death (2008) also imply that telephone triage services should be made available to assist in the prevention of side effects and possible death from chemotherapy 30 days post administration.

Each individual area is very different in how this advice is taken and acted upon. Within the cancer centre at Clatterbridge Centre for Oncology we have had a service here for patients for over 5 years, which has supported and advised patients, families and healthcare professionals as required with the current advice allowing for further development and expansion of the service. Due to our unique situation of being one of a few stand alone cancer centres this brings further challenges for the service. The geographical area covers 2.3 million people, covering Cheshire and Merseyside and patients can be treated in any one of 6 hospitals spread throughout the area.

With this in mind the development of the service has been essential to create a safe, standardised service for all users, and due to the geographical area and the need for patients to be treated nearer home, as advised in the NHS North West Cancer plan to 2012, several key areas are required to ensure a fit for purpose, safe, knowledgeable and effective telephone triage service is available, these are:  • Communication

• Knowledge of chemotherapy and side effects
• Good working relationships Detailed information for patients
• Education and competencies (UKONS)
• Algorithms for side effects
• Highly skilled, trained triage nurses

With all of the key areas covered the service will be patient focused and competency based. The aim is to prevent problems caused by chemotherapy, but if problems do occur to treat them quickly and effectively ensuring that the patient whilst on chemotherapy has adequate support to make certain of a smooth and supportive journey through their chemotherapy. It is for this reason that chemotherapy triage is a fundamental element to chemotherapy patients and oncology services as a whole.

O-245 THE IMPACT OF BREAST CANCER TREATMENT ON THE MEANING OF OCCUPATIONAL PATTERNS IN THE LIFEWORLD OF WOMEN WHO RETURN TO PAID AND UNPAID WORK: A PHENOMENOLOGICAL STUDY
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The diagnosis of Breast Cancer is devastating for many women on many different levels. The impact of the diagnosis, decisions made, treatment regimen and resulting cognitive changes (chemobrain) with effect on self, lifestyle, occupational work patterns and others is crucial to understanding personal coping from the perspective of the woman living the experience as a day–to–day basis. Occupational Patterns are defined as the performed roles, habits and rituals in meaningful activities one assumes at home, in the community and/or at paid or unpaid work.

This is the second study in an agenda of collaborative, interdisciplinary research focusing on Breast Cancer, Culture and the Meaning of selected variables on a woman’s response to diagnosis, choice, coping, social support and futurity. The purpose of this study is to capture the true depth of feelings, thoughts and behaviors that are part of the breast cancer treatment experience and the impact of these feelings on the occupational patterns of women who return to paid or unpaid work.

Women who have been diagnosed solely with Breast Cancer, have undergone either chemotherapy treatment alone or in conjunction with surgery, radiation and/or hormone therapy treatment, and have had no recurrence since their initial diagnosis will participate in this study. Semi-structured audio–taped interviews will be conducted during which the participant will be expected to give an extensive description of their breast cancer treatment experience, as well as discuss their occupational patterns before and after diagnosis and treatment. By sharing their story, it is expected that the participant would gain new insight into feelings regarding their experience and provide support to other women who have experienced similar issues and obstacles related to returning to work.

Participating in this study may provide an opportunity for unconditional acceptance of expressed emotion and should contribute to shaping a support strategy related to returning to previous and new occupational patterns. The findings of this study will contribute to the increasing body of evidence based collaborative interdisciplinary practice related to understanding the impact of Breast Cancer and treatment modalities on the development of culturally based support and empowerment strategies for women in all phases of their lives.

O-246 PUTTING THE PUZZLE TOGETHER FOR TOTAL PAIN
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“The cancer patient’s worse fear next to incurability is pain.” (Patt as cited in Abram and Haddox, 2000)

As the phrase total pain shows, the terms “pain” and “suffering” are often used interchangeably, both in the medical literature and everyday speech (Cook, M. and Downing, M., 1998). Pain is the most common symptom of cancer. It is said that thirty to seventy five percent of all patients experience pain from cancer (Cancer Net 2005). Pain is multifactorial and affects the whole person. The under treatment of cancer pain and its negative consequence on patient’s mood, functional status and quality of life has been documented many times. To understand the complexity of “total
pain” is similar to putting pieces of a puzzle together. The experience of pain is influenced by physical, emotional, social and spiritual factors. The concept of total pain acknowledges the importance of all of these dimensions of a person’s suffering. It is unlikely to have good pain relief without attention to all these areas.

Optimal pain management in the cancer patient may directly and indirectly influence the outcome of cancer treatment and the likelihood of survival. Uncontrolled pain detracts from overall performance status which may influence compliance. “Patient centered care is integral to ensuring the quality of pain management. Patient centered care has been defined as “an approach that consciously adopts the patient’s perspective about what matters.” (Cancer Care Ontario, 2007).

The presentation will review the evidence for good pain management, discuss the proper assessment of total pain and speak to the interdisciplinary management of total pain. The presenters bring a total of fifty plus years of nursing experience and 20 years of palliative/pain and symptom management experience. This oral presentation speaks to the human experience of total pain. The presenters recount the many memorable experiences which they have encountered in their years of nursing.

**O-247 LAVENDER OIL AS A INTERVENTION FOR SLEEP DISTURBANCE IN PATIENTS WITH CANCER - A PROSPECTIVE, RANDOMIZED, CONTROLLED TRIAL OF LAVENDER OIL VERSUS SWEET ALMOND OIL DELIVERED BY WARM COMPRESSES**

**Christian Wylegalla, Cand. Dr. rer. med. RN, Tumor Biology Center, An-Institut Albert-Ludwigs-University, Freiburg, Germany.**

**Background**

The prevalence of insomnia in Cancer patients is significantly higher than in the general population. Patients report sleep disturbances occur during all phases of cancer disease. It can be expressed by the difficulty to fall asleep or the intermittent sleep. The current treatments of choice are conventional hypnotic agents, but these have potential for adverse reactions. The patient’s often wish a nonpharmacologic intervention to support a better sleep. Aromatherapy is becoming increasingly popular and can be a good method for nurses to satisfy patient wishes. Lavender oil is frequently selected for aromatherapy as a sleep supporting substance. Uncontrolled evidence suggests that lavender oil could be an effective treatment for sleep disorder, but this has not been formally investigated.

**Aims**

Primary end point: Effects of the appliance of essential lavender oil on the daily total sleep time.

Secondary end points: Effects of the appliance of lavender oil on the subjective quality of sleep (QS) and the feeling of recovery after the sleep (FRS).

**Method**

It was a prospective, randomized, controlled trial from cancer patients with the nursing diagnosis difficulties falling asleep and/or intermittent sleep. The current treatments of choice are conventional hypnotic agents, but these have potential for adverse reactions. The patient’s often wish a nonpharmacologic intervention to support a better sleep. Aromatherapy is becoming increasingly popular and can be a good method for nurses to satisfy patient wishes. Lavender oil is frequently selected for aromatherapy as a sleep supporting substance. Uncontrolled evidence suggests that lavender oil could be an effective treatment for sleep disorder, but this has not been formally investigated.

**Results**

Lavender oil created an improvement of 20 minutes daily total sleep time compared to the nights before, and an extension of 18 minutes in comparison with the sweet almond oil. There were no statistically significant differences between treatment- and control groups. Both groups highly significantly improved Q5 in the PSQI (lavender: 10.5 to 8.9; p<0.005 / sweet almond: 11.2 to 10.4; p<0.005). Lavender oil significantly improved Q5 and FRS after 3 nights of treatment in the SF-A (p<0.05).

**O-248 THE LIVED EXPERIENCE OF FAMILY MEMBERS TRANSITIONING THROUGH 100 DAYS POST STEM CELL TRANSPLANT**

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Collège universitaire de Saint-Boniface, Winnipeg, MB, Canada.

Advances in treatment, technology and disease management in oncology has resulted in significant improvements in cancer patient survival rates. Contributing to the increased survival rates is the procedure of haematopoietic stem cell transplantation (HSCT). Innovations in HSCT have been made over time and are now used for the treatment of haematological malignancies, testicular cancer, and breast cancer. Treatment of cancer requiring HSCT affects not only the patient but also the family. The family is often crucial during hospitalization and recovery periods for patients undergoing a HSCT. Family members often find themselves isolated from their customary support systems, adding to their personal, interpersonal stress, and anxiety especially prior to and directly after transplant. While the psychological and psychosocial effects of HSCT on patients have been studied, the effect on the family unit has received less attention. Accordingly, a qualitative study is being conducted that seeks to gain insight into the lived experience of patients and their family members as they transition through one hundred days post HSCT.

Van Manen’s human science method for hermeneutic phenomenology is being used to address the research purpose. Three families are being recruited from a bone marrow transplant unit in a tertiary hospital located in a city in central Canada. Multiple data collection methods including open-ended interviews, photovoice, and journaling are being employed to arrive at a detailed description of the lived experience of patients and family members. Data collection takes place at three points in time: pre HSCT, day 50 and day 100 post HSCT. Themes from the data are being isolated using van Manen’s (1990) selective highlighting approach, and reflect the experiences and meanings patients and families assign to the one hundred days post HSCT. Themes emerging from the data reflect patients’ and families’ perspectives and experiences of transitioning through the one hundred days post HSCT. Attention is given to describing the meanings they assign to their experiences. Similarities and differences in the meanings patients and families assign to the one hundred days post HSCT experience are highlighted. The importance of this study is threefold. First, this study will provide nurses and other healthcare professionals with a deeper understanding of the lived experiences and needs of families who have transitioned through one hundred days post HSCT. Second, the knowledge generated from this study will help healthcare professionals better anticipate and fulfill the diverse demands and needs that families will encounter throughout this period of the cancer trajectory. Finally, the findings from this study will provide the groundwork for future intervention studies.

**O-249 THE EFFECT OF COMPLEMENTARY SYMPTOM MANAGEMENT PROGRAM ON FATIGUE IN FAMILY CAREGIVERS OF CANCER PATIENTS**

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1Faculty of Nursing Chulalongkorn University, Bangkok, Thailand, 2Queen Sirikit Hospital, Chonburi, Thailand.

Family caregivers of cancer patients could perceive fatigue experience because of the caring burden. Decreasing severity of fatigue will be affected to improve quality of life. Developing nursing therapeutic program for relieving symptom severity is the role of the nurse to promote quality of patient’s life. This quasi-experimental research aimed to compare the fatigue of the family caregivers after receiving the Complementary Symptom Management Program (CSMP). Participants included 40 family caregivers of cancer patients at out-patients clinic of Queen Sirikit Hospital. They were divided into two groups, the comparison group received the CSMP focusing Qigong while the experimental group received the CSMP focusing Qigong and Aromatherapy. The program based on the Symptom Management Model (Dodd et al, 2001) and Complementary concepts focusing Qigong and Aromatherapy. The instrument for collecting data was the Fatigue Questionnaire which was tested for reliability with Cronbachs alpha coefficient of .87. This same instrument was used to collect the data at the pretest phase, two weeks, and four weeks after receiving the program. Data were analyzed by using Repeated Measure Analysis of Variance.
The findings revealed that the posttest mean score of fatigue at 2 weeks of the experimental group were significantly lower than that of the comparison group (p<.05), and the posttest mean score of fatigue at 4 weeks of the experimental group were significantly lower than that of the comparison group (p<.05). The results suggest that the CSMP focusing Qigong and Aromatherapy could decrease fatigue experience of family caregivers of cancer patients. Keywords: Complementary Symptom Management Program, Qigong, Aromatherapy, Fatigue, Family Caregivers of Cancer Patients

O-250 KNOWLEDGE BASE AND RATIONALES UNDERLYING PAIN MANAGEMENT PRACTICES OF NURSES
Glory Metuge, RN, BSN, Carly Harvey, RN, BSN, OCN, Marie Pierre, RN, BSN. Reston Hospital Center, Reston, VA, USA.

Research Questions
(1) Do nurses have adequate knowledge to evaluate and address the comfort needs of patients?
(2) What are the rationales underlying clinical judgments to reduce the dosage or delay the administration of analgesics when patients state they are experiencing pain?

Background
Addressing the comfort issues of patients is an essential component of professional nursing practice. Multiple studies have revealed that inadequate pain management is common. Efforts to solve this problem have focused on educational programs for nurses and are sometimes based upon the assumption that lack of knowledge on the part of the nurse is at the core of the problem.

Methods
A 25-item survey instrument was developed and distributed to 450 direct-care nurses in a small community hospital. The survey included both true and false statements about pain management and respondents indicated the degree to which they agreed with the statements. A 45% response rate resulted in a sample size of 203 nurses who were 95% RNs and 5% LPNs. Years of experience ranged from 1 to 45 years with a mean of 17 years (SD = 11.6).

Results
More than 80% of nurses disagreed with false statements about irregular administration of analgesics for chronic pain, generalizations about gender responses to pain, use of placebos, and whether the nurse or the patient is the best judge of pain level. Almost all nurses (92.2%) agreed that behavioral pain scales are effective for non-verbal patients. The area that the nurses knew the least about was addiction rates in patients receiving narcotics for pain, with 72% responding incorrectly. In addition, 71% of subjects incorrectly agreed that changes in vital signs or behavior are valid indicators of pain. Only 14% said they would withhold medication for fear of addiction. Subjects indicated that the most likely reasons to reduce or delay analgesics were that the patient seemed over-sedated (86.2%) or the vital signs did not support the administration of a narcotic (74.9%).

Conclusions
Overall the subjects in this study demonstrated a strong knowledge base related to the assessment and treatment of pain. Rationales underlying decisions to reduce or delay analgesics were predominately related to patient safety. Nurses over estimated the risk of addiction, but reported that they did not withhold analgesia on that basis. Education is needed on the inconsistent association between changes in behavior and vital signs and the degree of pain experienced by patients with chronic pain.

O-251 EXPERIENCES OF FAMILY CAREGIVERS OF PATIENTS WITH ADVANCED HEAD AND NECK CANCER RECEIVING ENTERAL TUBE FEEDING
Jamie L. Pennex. McGill University, Montreal, QC, Canada.

Background
Dysphagia is a common symptom experienced by people with advanced head and neck cancer, who often require tube-feedings to help meet their nutritional needs. Family caregivers involved in the care of these patients report feeling ill-prepared to manage tube-feeding related aspects of care. The ability of the health care team to support these family caregivers is contingent upon a clear understanding of their experiences in caring for tube-feeding dependent patients, and the information and support needs they identify as being helpful to them in the provision of this care. To date these experiences have not been systematically examined and described, hence the need for, and purpose of this study.

Method
Consistent with the study’s aim, and in response to the paucity of research examining family caregiving experiences, a qualitative study using a descriptive phenomenological approach was conducted with family caregivers of tube-feeding dependent advanced head and neck cancer patients (n=6). Initial audio-taped face-to-face and follow-up interviews were conducted with family caregivers to obtain a rich description of their experiences. Interviews were transcribed verbatim and data analysis was carried out using Spiegelberg’s three step process of inductive data analysis. Rigor as it is understood in qualitative research and described by Lincoln and Guba (1985) were applied in this study.

Results
The experience of caring for a dysphagic family member with advanced head and neck cancer who is either totally or partially reliant on tube feeding means “negotiating a new normal”. Five major themes emerged from the data that captured family caregivers’ experiences. They included: i) decision making challenges; ii) matters of negotiation; iii) facilitators of negotiation; iv) levels of negotiation; and iv) triggers for renegotiation.

Conclusions
The specific and considerable needs of patients with advanced head and neck cancer receiving tube-feeding place significant caregiving demands on family members. The findings from this study underscore the importance of: i) clinicians taking the time to assess and respond to the information needs that family caregivers have, and supporting them in their caregiving role as they learn to “negotiate a new normal”; and ii) the need for future research geared toward developing and testing psycho-educational interventions aimed at supporting family caregivers in the important and difficult caregiving work they do. Such research will enhance the ability of those in clinical practice, education, and research to provide meaningful support to family members caring for tube-feeding dependent loved ones.

O-252 EXPLORING NURSE-PATIENT COMMUNICATION IN CANCER TREATMENT SETTING
Sonja McIlpatrick, Diane Hazlett. University of Ulster, Newtownabbey, United Kingdom.

Aim
An exploration of the complex processes and dimensions of communication between the nurse and cancer patients receiving chemotherapy in a day hospital setting in Northern Ireland.

Background
Good communication in cancer care is considered as fundamental to the provision of high quality care. However the health professional–patient interaction is a complex phenomenon, influenced by training, skills, attitudes and beliefs of health professionals alongside the health care environment.

Table of Contents
• Method
• Findings

Method
A mixed method approach comprised of three stages was undertaken with a sample of nurses working in a day hospital setting (n=11). This included: observing and recording the nurse–patient interaction at the time of the patient’s first chemotherapy; analysing the nurse self-appraisal on the interaction; and interviews with the nurses to investigate factors that influence the nurse–patient communication interaction. A nurse communication schedule modified from the Calgary–Cambridge Guide to the Medical Interview was used throughout all the stages of the study. Data collection took place from January 2008 until May 2008.

Findings
The nursing assessment focused on information giving, in particular on physical aspects of treatment, often to the detriment of listening and gathering information from the patients. Environmental and organisational issues were identified as barriers to communication, whilst enabling factors included the nurses’ ability to develop a rapport and relationship with the patient.
Conclusions
Holistic assessment of patients in ambulatory settings is crucial and improved communication could assist this. Communication needs to be balanced between information giving and information gathering; between physical and psychosocial aspects of care and between nurse-centred demands and patient centred concerns. (245)

Keywords
Cancer; Communication; Nurses; Qualitative; Chemotherapy

O-253 VITAMIN D DEFICIENCY/INSUFFICIENCY IDENTIFICATION AND TREATMENT IN HEMATOLOGY-ONCOLOGY PATIENTS.
Phyllis Coulter Everett, MSN, RN, AOCN, NP-C;
Lynchburg Hematology-Oncology Clinic, Inc, Lynchburg, VA, USA.

Vitamin D (VIT D) insufficiency has been found to include approximately 75% of community-dwelling people aged 65 years and over and has been associated with reduced muscle strength, falls, poor balance and sarcopenia. Patients with VIT D deficiency/insufficiency may be asymptomatic or be immune depressed, have decreased bone density, fatigue, muscle/bone pain, hypocalcemia, cancer and/or depression.

The presentation will describe data collected on oncology clinic patients in a private setting, highlight patients found to be high risk for deficiency, and make recommendations for screening, treatment and evaluation of oncology patients in the clinic setting. The practitioner’s management of reimbursement issues for patients who are not symptomatic but may benefit from evaluation is also discussed.

Data were collected over a 5-month period from 387 patients who were hypocalcemic, symptomatic or were breast cancer patients on aromatase inhibitors. Of three hundred eighty seven patients evaluated, 71.7% had VIT D levels below 30 ng/ml, the recommended norm and approximately 9.4% were severely deficient with a level of 10ng/ml or less. Patients with unacceptable levels were treated with ergocalciferol and/or cholecalciferol with a goal of achieving in a 50ng/ml level. Strategies for identifying high-risk patients, dosing and follow up are described in the presentation.

Acknowledging the role of VIT D as a possible contributing factor to illness and disease will motivate the provider to screen for and treat this condition, thus preventing exacerbation of treatment side effects. Reimbursement issues remain a challenge for the screening of patients who are asymptomatic, but further research in this area is likely to prove that the benefits of screening widely in the hematology-oncology patient population is likely to outweigh the cost of forgoing this preventive/treatment measure. Providing VIT D supplementation may contribute to the improved overall health/well-being of hematology-oncology patients.

MARCH 11, 2010 8:30PM – 10:30PM
CONCURRENT SESSION F1
“EXPANDED AND ADVANCED NURSING” (PEACHTREE BALLROOM C)
CHAIR: JULIET DREYER

O-254 QUALITY OF LIFE OF COLORECTAL CANCER PATIENTS IN ADJUVANT THERAPY
Adriana C. Nicolussi, Nurse, MS, PhD student, Namie O. Sawada, Nurse, PhD, Associate Professor;
University of São Paulo, Ribeirão Preto/ SP, Brazil.

Cancer has become a global public health problem and influences the life of patients and their families in different ways. The assessment of the Quality of Life (QoL) of this population is an important indicator of patients’ answer towards the disease, the treatment and their rehabilitation. This is a descriptive, exploratory and cross-sectional study, which was conducted at Oncology Specialized Center in Ribeirão Preto, São Paulo, Brazil, involving 22 colorectal cancer patients receiving adjuvant therapy, between July 2006 and September 2007, with the purpose to assess quality of life and the main socio-demographic, clinical and therapeutic characteristics of colorectal cancer patients and to correlate these characteristics with quality of life. The Quality of Life Core–30–Questionnaire (QLQ–C30) instrument was used for data collection. Patients considered their Quality of Life satisfactory (mean = 79.13) and the most affected domains were: Emotional Functioning, pain, insomnia and fatigue symptoms. In the correlations, women had worse scores on Emotional and Cognitive functioning; and pain, insomnia, fatigue, constipation and appetite loss symptoms. Patients who were receiving radiotherapy reported more pain and patients who had no symptoms during chemotherapy obtained the higher score of global Quality of Life. We concluded that Quality of Life was satisfactory for this sample of patients, with lower Quality of Life scores among women, and patients who were receiving radiotherapy and had side effects of chemotherapy.

Keywords
Quality of life; colorectal neoplasms; oncologic nursing.

O-255 A CENSUS OF THE SPECIALIST CANCER NURSING WORKFORCE ACROSS ENGLAND
Paul Trevatt, Msc, BSc (Hons), RN;

Introduction
Over the last thirty years the specialist cancer nursing workforce in England has grown in an unsupervised, unplanned manner. A lack of central guidance, uncoordinated workforce planning and blurred job titles have resulted in a specialist nursing workforce that at times appears confused and unsure of itself. Quantitative data on the cancer specialist workforce across England is sparse. This has profound implications for workforce planning and commissioning.

Methods & Purpose
A census of the specialist cancer nursing workforce in England was conducted in November 2008 in an attempt to establish baseline data. Data was collected via the 28 English cancer networks in partnership with the cancer network nurse directors. Specialist job titles were documented and a free text box provided to allow participants to record their own posts.

Results
The census response rate was 89%. There was a variation in terms of distribution of specialist nurses across England and also by title. 17 different specialist titles were recorded. Further analysis revealed a large degree of commonality between roles.

Conclusions
The findings of this study have profound implications for workforce planners, educationalists and managers. The large number of specialist titles may well weaken the development of advanced practice and lead to role conflict; it would be useful to rationalise titles.

O-256 ADVANCING CLINICAL PRACTICE FOR BREAST CARE PRACTITIONERS: OFFERING COMPETENCE AND CONFIDENCE WITHIN A CONTEXT OF CONFLICT AND CHANGE
Annette J. Thomas-Gregory, RCN, BSc (Hons) PG Dip Ed, Msc;
Anglia Ruskin University, Cambridge, United Kingdom.

Political Issues have wielded a huge influence over the delivery of Cancer services in the UK. Motivation for change was initiated by some worrying Cancer survival rates. In 1999 Breast and Bowel Cancer had a poorer survival rate in the UK than other European countries and the USA (Office of National Statics, 1999, WHO 1999). The NHS Cancer Plan (DOH 2000) aimed to rectify these inconsistencies by achieving a reduced waiting time for patients, with a maximum two week wait from urgent General Practitioner referrals.

The Advanced Clinical Practice module for Breast Care Practitioners was developed as a means of achieving the two week wait and achieving more favourable outcomes for patients. Advanced nursing practice is concerned with adjusting the boundaries for the development of future practice, pioneering and developing new roles, in response to changing clinical needs (Dunn 1997). The NMC published an approved definition of Advanced nurse practitioners as: highly experienced and educated members of the care team (Dunn 1997). The Advanced Clinical Practice module for Breast Care Practitioners was developed in an attempt to establish baseline data. Data was collected via the 28 English cancer networks in partnership with the cancer network nurse directors. Specialist job titles were documented and a free text box provided to allow participants to record their own posts.

Results
The census response rate was 89%. There was a variation in terms of distribution of specialist nurses across England and also by title. 17 different specialist titles were recorded. Further analysis revealed a large degree of commonality between roles.

Conclusions
The findings of this study have profound implications for workforce planners, educationalists and managers. The large number of specialist titles may well weaken the development of advanced practice and lead to role conflict; it would be useful to rationalise titles.
alongside qualified clinicians who have formally agreed to supervise their practice in examination and history taking. Following successful delivery, favourable evaluations, and impressive student outcomes we are currently collating detailed data pertaining to the student experience of attending this module and aim to present our findings.

References

O-257 EVALUATION OF THE WESTERN AUSTRALIAN CANCER NURSE COORDINATOR ROLE
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1Curtin University of Technology, Perth WA, Australia, 2Western Australian Cancer and Palliative Care Network, Perth WA, Australia, 3Peter MacCallum Cancer Centre, Melbourne VIC, Australia, 4Queensland University of Technology, Brisbane QLD, Australia.

Introduction
People with cancer experience many challenges, often due to an inability to access appropriate and timely care. This often results in fragmented care and a lack of ongoing support throughout the cancer trajectory. In 2006 a state-wide team of cancer nurse coordinators (CNCs) was implemented to facilitate a coordinated approach to cancer services and ensure patients experience efficient, effective, individualised treatment pathways that embrace multi disciplinary care and are equitable across WA. The team comprises 18 CNCs: 9 tumour-specific, 1 adolescent/young adult, 1 rural metropolitan, and 7 rural region-specific. We are conducting a 3–phase evaluation of how the CNC role contributes to meeting these objectives; to provide benchmarks and a framework for future evaluation. Methods Exploratory design using mixed methods. An in-depth exploration of the role from the CNC perspective using a comprehensive quantitative survey (n=18) and semi-structured qualitative interviews (n=21). Results Analysis of survey and interview is in train. Detailed findings will be presented. Data will be used to develop survey instruments for subsequent study phases; these will be administered to 255 patients, 255 family members/primary carers and 170 multi-disciplinary team members to obtain a comprehensive view of the CNC role.

Conclusion
The current lack of measurable patient-centred health outcomes has guided the proposed evaluation process that aims to develop a clear understanding of the role from the perspective of patients and families, CNCs, and key stakeholders. It is essential the CNC role is evaluated to determine efficacy and value adding from patient and clinical service perspectives.

O-258 IDENTIFYING ADMINISTRATOR’S RESOURCE NEEDS FOR THE INTRODUCTION OF ONCOLOGY ADVANCED PRACTICE NURSING ROLES
Denise E. Bryant-Lukosius1,2, Esther Green3, Bertha Paulse4, Jennifer Wiemikowski2, Nancy Carter1, Debra Bakker PhD5, R. James McKinlay1.
1McMaster University, School of Nursing, Hamilton, ON, Canada, 2Juravinski Cancer Centre, Hamilton, ON, Canada, 3Cancer Care Ontario, Toronto, ON, Canada, 4Sudbury Regional Hospital, Sudbury, ON, Canada, 5Laurentian University, School of Nursing, Sudbury, ON, Canada.

This presentation describes the results of a study designed to identify ad-

ministrator’s resource needs for introducing new oncology advanced practice nursing (APN) roles. Study results were used to inform health human resource planning and to develop and evaluate an APN Role Implementation Toolkit as part of a larger study. A questionnaire was distributed via email and post to 215 senior administrators and health care managers in 76 organizations responsible for adult cancer services in Ontario, Canada. A total of 173 administrators completed a questionnaire for an 80% response rate. Over 85% of respondents had some experience in working with an APN. Needs for improving cancer care practices by leading evidence–based practice initiatives (73%), improving cancer care practices through the education of nurses and other health providers (63%) and navigating complex patients through the system (62%) were identified as the top priorities for introducing new APN roles. Priority patient populations to be the focus of new APN roles included those with colorectal (53%), breast (50%), and lung (41%) cancer and those receiving palliative care (67%), post treatment (62%) and on treatment care (53%). Over 90% of administrators in cancer programs and tertiary care hospitals and 16 to 30% of those in community hospitals and agencies identified the need to increase their current complement of APNs. Administrators in community hospitals and agencies were less certain about their resource needs for oncology APNs. Administrators from 30 unique organizations estimated the number of new APNs they would require. Of these, 23% identified the need for 1 APN, 37% identified needs for at least 2 APNs, and 20% identified the need for 3 to 4 or up to 6 APNs.

Using research based information about current population of APNs, a variety of assumptions and conservative models were developed to estimate the number of new oncology APNs positions needed over the next 5 years. It was estimated that 119 to 147 oncology APNs will be required over the next 5 years to meet increasing demands for cancer services. Assuming the same pattern of role distribution, 81 nurse practitioners and 66 clinical nurse specialists would be needed to fill to these new positions. Based on study results, recommendations for health human resource planning and the recruitment and retention of a high quality oncology APN workforce will be provided.

O-259 CANCER NURSING CHALLENGES IN ZAMBIA
BIEMBA K. MAUTI, RN BSN.
CANCER DISEASES HOSPITAL, LUSAKA, Zambia.

Introduction
The Cancer Diseases Hospital is a tertiary institution that is providing specialized treatment for cancer patients using radiation, chemotherapy or both. Currently the hospital has got only 13 nurses, 5 of whom are in school undertaking a two year Oncology Nursing course in South Africa. Since commencement of clinical activities, a total of 37 patients were seen in 2006, 719 in 2007 and 1,204 in 2008. As at 30th June 2009, 668 new patients have been attended to at this facility. One of the major challenges in meeting the overall objective of providing quality care has been inadequate and appropriately trained human resource. Challenges in the Delivery of Nursing Care
• Our catchment area is the whole Zambian population of over 12 million people, and 60–75% of our patients are from districts and provinces outside Lusaka, making follow up of patients after they complete treatment a major challenge
• Lack of specialization in oncology for some staff since these trainings are not locally available. For nurses this means that some problems unique to cancer patients and their treatments may not be anticipated or addressed adequately.
• Scheduling of Chemotherapy for patients who are to receive chemoradiation is still challenging with some patients not getting their chemotherapy on the first day of their radiotherapy treatments.
• Handling of chemotherapy agents still hazardous because the system of preparation and administration is not closed exposing staff and other people to cytotoxic agents. The fabric gowns are worn out and not enough for everyone.
• The hospital does not have a Biological Safety Cabinet to maintain safety in the handling of chemotherapy.
• Patient monitoring with respect to treatment and management of treatment induced side effects remains a challenge, as does appropriate patient ed-
O-260 ENHANCING KNOWLEDGE, PROMOTING QUALITY - A LEADERSHIP TRIUMPH!
Kate A. Smith, RN.
Clatterbridge Centre for Oncology NHS FT, Merseyside, United Kingdom.

With the direction of the NHS firmly focussed on delivering high quality of care for its patients, carers and also clinicians, this paper outlines the visionary approach adopted by an Oncology Trust in it’s ambition to provide a leadership role which demonstrates commitment to the quality agenda. Combining responsibility for the delivery of the clinical governance agenda with accountability for practice development into a single role has led to a comprehensive and seamless approach to improving the quality of care for all. Quality assurance, improving patient safety, patient outcomes and the patient experience is combined with the practice development concepts of facilitation, empowerment, emancipation and transformational leadership, to develop shared visions and goals, challenging practice to improve the quality of patient care through promotion of evidence based practice. The beneficial diversity of this role is illustrated in the design and delivery of Trust wide education programmes and quality initiatives. Examples include leading on the introduction of the Global Trigger Tool (UK), Patient Group Directions ie non–medication administration of medicines and the Productive Ward–a releasing time to care initiative, based on lean methodologies and service improvement techniques. Also Non– Medical Prescribing, combined with involvement in the development of a bespoke Practice Development and Research Unit. As Trust lead for Moving & Handling and also working as a key trainer, the practical application of techniques is supported by response to National Patient Safety Agency alerts and incident reports, resulting in introducing changes to practice. Participation in national cancer audits and achieving compliance with quality management standards and legislative requirements are augmented by practice development projects both at individual and Trust level, to deliver safe, effective and high quality care. By developing staff knowledge and skills through comprehensive, competency based education models which take account of individual learning styles, this leadership role directly influences the delivery of the quality agenda. The association of a practical teaching element, working in direct partnership with clinicians, in combination with defined responsibility for ensuring improvements in the quality of service provided and safeguarding standards of clinical care, successfully produces effective change, ensuring high quality care is achieved.

O-261 ELEVATING EXCELLENCE IN ONCOLOGY PATIENT CARE: STANDARDS AND COMPETENCIES FOR ONCOLOGY NURSING
Jennifer A. Wieronskisi, MN NP-Adult, CON(C) 1, Kim Chapman, RN, MS-CN, CON(C) 2, Tracy Truant, RN, MSN, 3, Brenda Ross, RN, BScN 1, 2, 3.
1Juravinski Cancer Centre at Hamilton Health Sciences, Hamilton, ON, Canada, 2River Valley Health, Fredericton, NB, Canada, 3BC Cancer Agency, Vancouver, BC, Canada.

Oncology nurses across our country administer chemotherapy in geographically diverse clinical settings and have variable access to practice standards, competencies, and educational programs. A National Chemotherapy Administration Strategy (NCAS) was identified by the professional oncology nursing association membership as a top priority knowledge product for development through surveys, think tank and round table meetings. The vision for this project is that “every patient across the country, regardless of geography, receives chemotherapy treatment from oncology nurses who meet a predetermined standard of practice through a comprehensive education program to ensure continuing competency”. This strategy has been divided into three phases: 1) Completion of a literature review, environmental scan, and the building of an action plan and working groups for phases 2 and 3; 2) The development and pilot testing of the standards, competencies and educational resources; and 3) Full implementation, evaluation and sustainability planning.

This paper will present the findings from phase 1, and the work to date completed for phase 2 of the project. The presentation will include the evidence that exists to support the NCAS, resources that are already available nationally and internationally to use as building blocks within the NCAS, and gaps that need to be addressed to implement the strategy nationally. In addition the presentation will provide the results of an invitational workshop planned for October 2009 where content experts from across the country will meet to consider the final knowledge product that includes standards, competencies and education resources. Preliminary results of the pilot testing of the knowledge product for the administration of chemotherapy will also be presented along with strategies for forging partnerships to enable the implementation of the project through financial and in-kind support. The foundational knowledge generated through this project will ensure the development, implementation and evaluation of a knowledge product designed to meet the needs of nurses across the country who are responsible for the administration of chemotherapy to adult and pediatric cancer patients regardless of clinical setting.

O-262 LAYING THE FOUNDATION FOR A NATIONAL CHEMOTHERAPY ADMINISTRATION STRATEGY
Jennifer A. Wieronski, RN(EC), MN, NP-Adult, CON(C) 1, Kim Chapman, RN, MS-CN, CON(C) 2, Tracy Truant, RN, MSN, 3, Brenda Ross, RN, BScN 1, 2, 3.
1Juravinski Cancer Centre at Hamilton Health Sciences, Hamilton, ON, Canada, 2River Valley Health, Fredericton, NB, Canada, 3BC Cancer Agency, Vancouver, BC, Canada.

In our country, the national professional association for oncology nurses is an organization that supports oncology nursing to promote and develop excellence in practice, education, research and leadership. Established in 1984, the organization has been instrumental in identifying standards of care for oncology patients and, more recently, clarifying oncology nursing practice remains a major concern. More than half of our patients present with advanced or metastatic disease. This means that the need for palliative care is much greater than we currently have the capacity to deal with effectively, palliative care services only started in June 2009...
This planning process has included the involvement of patients, family members, volunteers and staff. This presentation will outline the some of consultation we undertook that ultimately impacted the final design which included site visits to centres in the United States and Canada, reviews by pharmacy and chemotherapy external design consultants and developing a multidisciplinary team to tackle key operational issues which impacted the design. We contracted with a unique consulting agency to provide patients and families with the opportunity to provide input into the design and esthetics of the unit through the use of photographic journals and one on one interviews. Currently we have confirmed the design and construction will start in the fall of 2009 we will be able to share key learning’s from our journey thus far in an oral or poster presentation.

O-264 NURSES PERCEPTION IN THE USE OF COMPUTERS IN PATIENT RELATED ACTIVITIES IN ENHANCING THE QUALITY CARE.
Sulochana, Retnamony, BSc Nsg, MA.
Tata Memorial Hospital, Mumbai, India.

Nurses perception in use of computer Technology in the patient related activities in enhancing quality care in a cancer hospital
Author : Sulochana Retnamony, Dy.Nsg Supdt.

The Tata Memorial Center (TMC) comprising the Tata Memorial Hospital and the Advanced Center for Treatment, Research and Education in Cancer (ACTREC) engaged in research, education and Comprehensive care of cancer patients is a grant-in-aid institution and it is under the administrative control of the Department of Atomic Energy, Government of India. The hospital is a comprehensive cancer center for diagnosis, treatment, education and research Institution with modern and state of art technology in all areas of cancer management. The hospital has 560 beds, 19 operation theatres and intensive care unit. On an average, over 5000 patients visit every day for availing various services.

Technology is important and inevitable in today’s world of cancer care. Cancer care also kept in pace with the ever changing technology include safety, costs, social impact, knowledge, understanding and maintenance. The computer technologies used in the hospital by nurses are HIS, PABR, DIS, EMR, Indents, On line prescription, centricity, OT schedule, Nurses duty list, Leave application, Time and Attendance, Test directory and Intranet to communicate all the events etc. The technology plays a vital role in prevention, diagnosis, treatment and rehabilitation. It is adapted into the areas of out patient services, casualty, various other departments and inpatient care services. Nurses who were appointed in the 90’s and later are more equipped to handle the computers effectively than the others. Thus a need is felt to conduct a study with the following Objectives To study the different levels of perception regarding technology among the nurses.

To evaluate the knowledge of the end users and help them in reducing the knowledge gap.
To compare between the senior and junior nurses in embracing and working with Technology
Perceptions changes to person to person based on their values and knowledge. Always many issues nurses encounter like resource planning, continuing education and needed updates with in the unit and in the institution
Effectiveness in the performance of a Technology, ideal and appropriate use of the Technology best use of resources and the personal attribute like care , competent , capability ensures the quality in care related activities. The quality care is the on going and is never to be completed mission. A semi structured questioner was administered to nurses and the perceptions of nurses in varied nurses led activities are evaluated. The results will be discussed.

O-265 INTERVENTION IN THE SAFE ADMINISTRATION OF CHEMOTHERAPY
Paulina I. Suarez, Silvana Arellano.
Clínica Alemana Santiago S.A., santiago, Chile.

Knowing the seriousness that can mean a cancer patient where the doses used are highly toxic by itself, an error can cause death or serious complications.
Faced with the visible commitment by the organization, to improve safety and quality of patient care, ensuring a safe environment, and continuously work on reducing risks to patients and employees was necessary to initiate two important processes in the safe administration of chemotherapy
If we recall that the cancer risk is high because there is a narrow thera
cut index, with multiple drug interactions / disease, and severe side ef
fects, which can be life threatening, they require special monitoring
before, during or after the drug administration, and it can affect who han
dles it, is that it opens two important processes
1. Double–check the medical indications for the nearmiss where
the Nurse–chemicals
Results are grouped in: patient identification errors,
Error indicated, Lack of data to check, It requires confirmation with
physician, Calculation of dose
2-Double approved of the administration of drugs by a second nurse, in
volves the review of medical pre–administration with a double–check the
programming of the pump by two professional, accurate 5 check and
double check register from both professionals in the register of patients
Since September 2008 records are kept, where it has reviewed a total of
1233 medical indications, covering a total 4202 drugs, detecting error rate of 2%
In relation to the visa of the entries is met in a 90% detection, 1.5%, errors in the preparation
These processes reduced medication errors of hazardous substances in the period studied the medication error rate has dropped to zero

O-266 WHAT’S YOUR STORY? THE IMPORTANCE OF INCORPORATING CANCER SURVIVORS’ STORIES INTO UNDERGRADUATE NURSING EDUCATION.
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Mount Royal - School of Nursing, Calgary, AB, Canada.

Safe and competent practice is the foundation of nursing. As nursing educators, we strive to provide a framework of learning whereby knowledge, skills and critical thinking become part of the individual as they evolve into their role as a registered nurse. The use of a narrative pedagogical framework within a nursing theory course is being utilized in order to draw students into the unique reality of an individual living with cancer.
Through the use of individual presentations by cancer survivors, nurse educators challenge students to develop purposeful, reflective reasoning during which time their assumptions, beliefs, principles, and conclusions are examined within the context of an individuals’ situation. The overall goal of this pedagogical approach is to expose nursing students to the lived experience of individuals diagnosed with cancer in order to create new understandings. This nursing theory course has been implemented not without challenges however the educators, students and cancer survivors alike have reported that this has been an empowering process for learning.

O-267 PSYCHOLOGICAL ADAPTATION IN THE SCHOOL AGE CHILD WITH ALL WHILE RECEIVING MAINTENANCE THERAPY
Julia A. Fitzgerald, PhD, RN.
Kean University, Union, NJ, USA.

There are conflicting findings regarding the psychological health of childhood cancer survivors. A descriptive correlational design was used to examine the relationships among self-concept, family functioning, functional status and psychological adaptation in school age children with leukemia undergoing maintenance therapy. A purposive sample of 25 children with leukemia was recruited for this study from four oncology clinics. Children with cancer reported on self-concept, functional status, family functioning, anxiety, and activity level. Parents reported on child behavior and social competence.
Pearson product moment correlations were performed on all variables using Statistical Package for the Social Sciences software (SPSS Inc., Chicago, IL). Positive self–concept correlated with social competence .455 (p<.05), participation in activities .459 (p<.05), and negatively with behavior problems -.437 (p<.05). Poorer functional status correlated with anxiety .662 (p<.001) and worry .586 (p<.001). Positive family functioning correlated negatively with behavior problems -.705 (p<.05) and positively with social competence .524 (p<.001). The results of this study indicate high correlations between physiological functioning, psycholog--
0-268 CULTURAL VALIDATION AND DEVELOPMENT OF AN INSTRUMENT TO MEASURE THE APPRAISAL OF CANCER-RELATED FATIGUE IN CHILDREN DIAGNOSED WITH CANCER IN SAUDI ARABIA
Eyad M. Al-Heish, Doctor of Nursing Science.
King Saud University, Riyadh, Saudi Arabia.

Fatigue is highly prevalent among children with cancer and has great impact on their lives. The cancer-related fatigue (CRF) experience is subjective and multidimensional; understanding it from the children’s perspective and perception is essential. Based on a cultural validated conceptual definition and model of fatigue, a three-phase descriptive study will be conducted to adapt and develop an instrument to measure the appraisal of fatigue in children diagnosed with cancer in Saudi Arabia.

In phase I, interviews with children experiencing cancer-related fatigue and review of the literature will be used to generate items to sample four constructs of appraisal of fatigue: Fatigue, meaning, impact, and cultural adaptability to fatigue. In phase II, items will be refined based on recommendations of panel of content expert, instrument development expert, and pilot study results. In phase III, reliability and validity estimates of the Developed Fatigue Appraisal Scale will be evaluated based on responses of a heterogeneous sample of children diagnosed with cancer.

Acceptable estimates of internal consistency reliability (Cronbach’s alpha) will be determined for subscales of Fatigue, Meaning of Fatigue, Impact of Fatigue, and Cultural Adaptability of Fatigue. To assess construct validity, hypotheses will be generated and tested about the relationships of the subscales of the Developed Fatigue Appraisal Scale and selected subscales used in previous studies. Construct validity will be examined further through factor analysis, using principal components analysis with varimax rotation.

*** This is ongoing research which is Totally Sponsored by SANAD Cancer Childrens Association / Saudi Arabia

0-269 CARING FOR THE CHILD WHO HAS COMPLETED TREATMENT FOR CANCER: THE LIVED EXPERIENCE OF PARENTS WHO DO NOT LIVE NEAR THEIR CHILD’S TERTIARY CANCER CENTRE
Erin J. W. Shepherd, RN, BScN, Graduate Student, Roberta L. Woodgate, RN, PhD.
University of Manitoba, Winnipeg, MB, Canada.

For parents, having a child diagnosed with cancer is extremely frightening and stressful. Families confront many new stressors and challenges along the cancer trajectory. Families who live at a distance from the tertiary cancer centre have the added burden of far distances they must travel in order for their ill child to receive treatment. Once the treatment is complete, these families return to their home which may be far from healthcare providers with pediatric oncology expertise. Little is known about what parents who do not live near their child’s tertiary cancer centre experience while caring for children after completion of childhood cancer treatment. Accordingly, a qualitative research study is being conducted that seeks to arrive at an understanding of the lived experiences of parents who are transitioning through a time when their child has completed his/her cancer treatment and who do not reside near a tertiary cancer centre.

Van Manen’s human science method for hermeneutic phenomenology is being used to address the research purpose. Parents from 10 to 15 families of children who have completed their cancer treatment are being recruited. Individualized open-ended interviews and field notes are the sources of data. Themes emerging from the data reflect parents’ perspectives and experiences of transitioning through a time when their child has completed his/her cancer treatment. Attention is given to describing the meanings they assign to their experiences.

The knowledge gained from this study will help to inform clinicians, researchers, and policy makers about how to improve the care of these families of children who have been treated for childhood cancer. More specifically, it may be used to develop and/or expand existing programs that are focused on meeting the individual and collective needs of families who do not live near the tertiary cancer centre experiencing childhood cancer. With supportive programs, parents of children diagnosed with cancer will be helped through the difficulty and stress of active treatment and also during the period when children and families transition back to “normal” life once treatment is complete. Results from this study will provide nurses with a deeper understanding of the experiences and needs of parents who live at a distance from the cancer centre who have children diagnosed with cancer. Nurses will be better able to anticipate the changing needs of these parents as their children complete their cancer treatment.

0-270 BURKITT LYMPHOMA IN CAMEROON
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Background
Burkitt lymphoma (BL) is a very common deadly form of cancer attacking mainly children of 3–15 years old here in Cameroon. Chemotherapy of cyclophosphamide, methotrexate and other drugs like allupurinol, phenergan or reglan ensuring excessive fluid intake during course of therapy are the common treatment options. BL is often misdiagnosed by many health practitioners. Diagnostic methods include: bone marrow aspirate under ketelar for specimen analysis, ultra sound or X-ray(s).

METHOD
Reviewing 10 years of clinical nursing experience of prevalence, palliative and curative care as well as its prevalence and the age group; also using data analysis from the clinics. Interviews, questionnaires and financial viability were methods/approaches applied in the study.

RESULTS
About 65% of BL cases are successfully cured with the stated treatment, about 99% present with painless rapidly growing mass(es), about 35% are misdiagnosed–example swollen mouth misdiagnosed for dental abscesses, swollen abdomen for peritonitis or metastasis; reflecting possible high deaths for failure diagnosis. Averaging poverty rate as well as very few clinics with such diagnostic and treatment services is also issues of concern.

Conclusion
Cameroon has a population of about 17 million people with about 250 ethnic groups speaking about 200 different dialects. Lack of educational programs like conferences, poverty, illiteracy, ignorance, few clinics, makes palliative care and burkitt lymphoma very difficult. Proper education, sensitization and proper diagnosis as well as treatment can better be applied with participation in international programs like the ICCN event in Georgia as this can give discussion forums, interaction with experts and many others.

0-271 PSYCHOSOCIAL ASPECTS OF CHILD CANCER CARE IN PAKISTAN
Barkat Hooda, MBBS1, Rozina Essami, Master In Nursing2, Gulrose Sikander Kassemali, Diploma In Nursing3, Veronica Brigantia, BSCN4, Gaffar Bilko5.
1Saad Hospital, Dammam, Saudi Arabia. "The Aga Khan University Hospital, Karachi, Pakistan. Barkat Hooda, Rozina Rosman Essami, Gulrose Sikander, Veronica Brigantia, Gaffar Bilko.

Introduction
Cancer creates an emotional storm anywhere in the world. This storm becomes sensational if it is the child who gets the cancer. While a diagnosis of cancer in a child is not necessarily synonymous with poor prognosis and death in Pediatric Oncology, it results in significant mental and psychosocial trauma for the entire family structure centered around the child with this potentially life threatening condition. Hence, psychosocial aspect of care has become an integral component of the multidisciplinary care delivered to a child with a cancer all around the world. Purpose: The purpose of the study is to identify the major contributor/s of psychosocial stress in families with a child having cancer. Method: This is a descriptive exploratory study of randomly selected families having children diagnosed with cancer treated during 2009 at the Pediatric Oncology service at tertiary care hospital Karachi. In–
O-272 CARNITINE PLASMA LEVELS AND FATIGUE IN CHILDREN/ADOLESCENTS RECEIVING CISPLATIN, IFOSFAMIDE, OR DOXORUBICIN
Marilyn J. Hockenberry1, Mary C. Hooke2, Mary Ann Gergurich1, Kathy McCarthy1
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Fatigue is the most frequent symptom experienced by children/adolescents with cancer. One mechanism contributing to cancer related fatigue involves abnormalities in adenosine triphosphate synthesis caused by carnitine deficiency. The purpose of this study was to examine fatigue and carnitine in children/adolescents before and after ifosfamide, cisplatin, or doxorubicin chemotherapy. Sixty-seven patients from two children’s cancer centers participated. Fatigue and carnitine measures were obtained before chemotherapy and a week later.

Free and total carnitine levels of newly diagnosed children and adolescents receiving their first course of chemotherapy were compared to those who had received prior chemotherapy. This comparison revealed that newly diagnosed patients had a more significant increase in free carnitine t(64) = 2.425, p = 0.018 and total carnitine levels t(64) = 2.442, p = 0.017 a week after chemotherapy compared to those who had prior therapy.

Within the newly diagnosed children/adolescents cohort there were significantly higher free carnitine t(19) = 3.608, p = 0.002 and total carnitine levels t(19) = 3.451, p = 0.003 a week following chemotherapy. Patients who received doxorubicin experienced a significant increase in free carnitine levels compared to patients treated with cisplatin (p = 0.035) or ifosfamide (p = 0.003). Similar results were shown for total carnitine levels with a significant increase for patients receiving doxorubicin compared to cisplatin (p = 0.039) and ifosfamide (p = 0.002). Increased fatigue and decreased carnitine were significantly correlated a week after chemotherapy in children/adolescents who had received prior chemotherapy.

Increased carnitine in newly diagnosed patients is likely associated with rapid tissue release into the bloodstream, replacing carnitine lost by chemotherapy metabolism. Decreased carnitine and increased fatigue occurred after 1–2 courses of chemotherapy. This study provides support for a relationship between carnitine and fatigue in children/adolescents with cancer.

O-273 JORDANIAN MOTHERS EXPERIENCE WITH LEUKEMIC CHILD
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Introduction
Leukemia is the most common form of childhood cancer; the annual incidence is 3 to 4 case per 100,000 children younger than 15 years of age. Few qualitative studies explore the mothers experience with leukemic child. Issues such as how leukemia has an impact on the mothers and families life and the consequences were not addressed.

O-274 EXPLORING THE IMPACT CARING AT HOME FOR AN ADOLESCENT WITH CANCER HAS ON FAMILY ROLES AND RELATIONSHIP IN TAIWANESE FAMILIES
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Adolescence is a particularly challenging period of life, and suffering from cancer compounds the challenges for the adolescent and significantly influences family functioning with respect to roles and responsibilities. Research indicates that treatment outcomes and survival rates from cancer in the adolescent population are poor. Most research focuses on symptom management and the identification of effective medical treatments for this group. In Taiwan this is a particularly stressful time for families caring for adolescents with cancer at home because currently there is little support for such families. This paper explores the impact caring for an adolescent child with cancer has on family roles and relationship in Taiwanese families.

Method
Grounded theory was used in this study as it provides an approach to examine the nature of family dynamics whilst caring for adolescents with cancer. Family members were asked to be involved in audio-taped semi-structured in-depth interviews, either individually or in a family group following ethics approval.

Conclusion
The delivery of appropriate care and services depends upon gaining better understanding of, and gaining insight into, how care-giving influences family roles and relationships when caring for an adolescent with cancer at home. Such understanding serves as a platform for recommending services and supports for care-giving families in a health care system that traditionally has not provided such assistance.

O-275 DESCRIPTION OF ARTERIAL LINES IN HOSPITALIZED CANCER PATIENTS.
Cynthia Chernecky, PhD1, Jennifer Edmunds, MSN2, William Parrish, MSN2, Angela Daniel, MSN1.
1Medical College of Georgia, alpharetta, GA, USA, 2Medical College of Georgia Hospital, Augusta, GA, USA

Significance
Arterial lines (A-lines) are commonly used in cancer patients in critical care and intensive care units (ICUs) yet no descriptive data exists.

Purpose
Describe cancer patients in ICUs with A-lines focusing on dwell time, race, family roles and relationships when caring for an adolescent with cancer at home because currently there is little support for such families. This paper explores the impact caring for an adolescent child with cancer has on family roles and relationship in Taiwanese families.

Method
Grounded theory was used in this study as it provides an approach to examine the nature of family dynamics whilst caring for adolescents with cancer. Family members were asked to be involved in audio-taped semi-structured in-depth interviews, either individually or in a family group following ethics approval.

Conclusion
The delivery of appropriate care and services depends upon gaining better understanding of, and gaining insight into, how care-giving influences family roles and relationships when caring for an adolescent with cancer at home. Such understanding serves as a platform for recommending services and supports for care-giving families in a health care system that traditionally has not provided such assistance.
56. After IRB approvals, retrospective chart review based on hospital charge systems of most recently discharged patients based on inclusion criteria of >18 years with A-line > 24 hours dwell time. Subjects, 50 per hospital times 4 sites (N=200), from September 2007 to February 2008 with a subset of 56 patients with a primary diagnosis of cancer. The self developed Arterial Line Study Sheet (ALSS) has reliability of 0.98 Data analyzed using SPSS.

Findings and Implications: Subjects were 30% male, 70% female, 80% Caucasian and 20% minority with a primary diagnoses of cancer. Average A-line dwell time 1–3 days, greater dwell time in minorities (> 7days 16% minorities and 7% Caucasians), with 1% having bilateral A-lines. Body sites of insertion were the same for all hospitals, right and left radial arteries followed by right and left femorals, however, only right and left brachials were used in African–Americans. Caucasians had most A–lines inserted in the operating room and African–Americans in the ICU. Comorbidities, type of cancer or stage, medications, DRGs (diagnostic related groups) and acuity were not assessed. Sample size is too small and geographically biased to change practice. Racial disparities may exist in ICU cancer patients with A–lines. Dwell time and body site of insertion may impact catheter related blood stream infections (CRBSIs) in cancer patients. Further research needed using the ALSS, in multiple geographic regions with adding variables of specific tumor types, comorbidities, medications and outcomes (CRBSIs, sepsis).

**CONCURRENT SESSION F4**
**“EXPANDED AND ADVANCED NURSING”**
**PEACHTREE BALLROOM E**
**CHAIR: WENDY WOOD**

**O-276 THE INFLUENCE OF SYMPTOMS, SOCIAL SUPPORT, UNCERTAINTY, AND COPING ON HEALTH-RELATED QUALITY OF LIFE AMONG CHOLANGIACARCINOMA PATIENTS**
Basaba Somjaiwong, Doctoral student, Sureepom Thanaskul, Doctor of Nursing Science, Sunida Peecheawong, Doctor of Philosophy (Nursing), Faculty of Nursing, Chulalongkorn University, Bangkok, Thailand.

Health related–quality of life (HRQOL) is an important outcome for evaluating the effect of therapeutic interventions on treating cancer. Cholangiocarcinoma (CCA) is a major public health problem in the northeast of Thailand. However, there is little information regarding factors influencing HRQOL in CCA patients. Understanding the associated factors of HRQOL in CCA patients is necessary in developing nursing interventions to improve the HRQOL.

A cross-sectional descriptive study was conducted to develop and test a predicted model of HRQOL among CCA patients. The selected factors were symptoms, social support, uncertainty, coping, and HRQOL. The uncertainty in illness theory was applied as the conceptual framework of the study. A random sample of 260 patients was recruited from a regional and a university hospital in the northeast of Thailand. The instruments included a set of six questionnaires: Demographic questionnaires, Modified Memorial Symptoms Assessment, Mishel Uncertainty in Illness Scales: Community Form, Social Support Questionnaire, Jalowiec Coping Scale, and Functional Assessment of Cancer Therapy General Scale (version 4). The hypothesized model is tested using LISREL 8.52. Study is in data collection process. The results will be presented at the conference.

**O-277 DEVELOPING A FOUNDATION DEGREE PROGRAMME FOR ASISTANT PRACTITIOnERS IN CHEMOTHERAPY AND SUPPORTIVE CARE**
Sarah S. Rushbrooke, Bsc(Hons) Nursing Science, Ann Fox, Nurse Director North of England Cancer Network, Team Valley Gateshead, United Kingdom.

Chemotherapy-trained nurses are in relatively short supply across the United Kingdom. Recruitment and retention is a problem in some units and the training required to specialise in chemotherapy nursing is intensive and lengthy.

To respond to the challenges of increasing demand, resource constraints and the need to explore new and innovative models of care, it is acknowledged that a flexible and adaptive chemotherapy workforce is required across North of England Cancer Network (NECN).

Assistant Practitioner roles have been successfully implemented in England and Scotland in other health care areas. NECN and the Strategic Health Authority (SHA) propose to develop and pilot a Foundation Degree programme for Assistant Practitioners in Supportive and Palliative Care Services. Developing this role across NECN will enable skill mix review in chemotherapy units and develop a career pathway for health care assistants. The health care assistants who could be involved in this role development would in the first instance, be existing staff with a minimum of 2 year’s experience of working in Chemotherapy services across NECN.

This course will encourage and support equality and diversity by attracting mature learners who have not undertaken formal qualifications in the past and could forge a pathway to engaging them in their nursing degree and support wider workforce development. The programme will also increase the participants’ scholarship skills in academic thinking and reading and would allow them to undertake further study as well as their ability to function at an expected Band 4 (Agenda for Change).

**Pilot Aims & Objectives**
1. Scoping of current educational provision, clinical need, national drivers/guidelines and trust workforce requirements across the NECN.
2. Scope current patient and clinical staff experience of chemotherapy services.
3. Develop foundation degree programme with Teesside University, clinical staff & partner organisations such as Skills for Health and Government Office North East.
4. Agree funding arrangements to allow practitioners selected to participate in the degree programme.
5. Develop job description, operational policy and competencies.
7. Robust evaluation during programme and upon completion to assess the impact of the new role.

Chemotherapy related supportive care represents a significant proportion of the workload in chemotherapy units. Expanding the role for support workers to undertake some of this work will release registered nurse time to perform more complex procedures/assessments, and enable more efficient and effective use of skill mix.

**O-278 DEVELOPING CORE COMPETENCIES FOR THE NOVICE ONCOLOGY CLINICAL TRIALS NURSE**
Linda E. Schneider, MSN, RN, CCRC1, Penny Daugherty RN, MS, OCN2, David Leos, RN, BSN, MBA, OCN, CCRA3, Marge Good, RN, BSN, MPH, OCN4, Patricia Weiss, RN, MSN, OCN5, CCRP6, Barbara Lubejko, MS, RN6.
1. Roswell Park Cancer Institute, Buffalo, NY, USA, 2Southeastern Gynecologic Oncology, Atlanta, GA, USA, 3Memorial Hermann Southwest Hospital, Houston, TX, USA, 4Wichita Community Clinical Oncology Program, Wichita, KS, USA, 5Cleveland Clinic Foundation Taussig Cancer Center, Cleveland, OH, USA, 6Oncoogy Nursing Society, Pittsburgh, PA, USA.

Oncology clinical trials play a crucial role in the improvement of outcomes for people with cancer. Many of the people involved in oncology clinical trials have complex care needs that require management. Because of the complexity of oncology clinical trials and the needs of cancer patients, nurses play a crucial and unique role. However, there is great variability in how the role of the nurse on the research team is operationalized. Our goal was to identify and document the core competencies required of a novice oncology clinical trials nurse that would apply across diverse settings. We were particularly interested in what knowledge, skills and expertise a nurse new to clinical trials would need to develop during their first 1–2 years as the member of the research team. A national professional oncology nursing society identified a team of 5 nurses with expertise in oncology clinical trials from their membership that were interested in participating in a process to develop core competencies. The development of the competencies followed a six step process: 1) Development of process plan for competency identification; 2) Creation of a definition of core competencies; 3) Drafting a listing of core competencies based upon a review of the literature, a survey of a sample of organization members, and personal experience of team members; 4) Field review of the draft competencies by a large group of organization members who specialize in oncology clinical trials; 5) Review by an expert panel with experience in oncology clinical trials; and, 6) Dissemination of the final core competencies on the internet and in print. By identifying key knowledge, skills and expertise, the core competency document provides a guide for nurses new to oncology clinical trials to help focus their development into competent, effective clinical trials nurses. Also, by focusing on the role of the oncology clinical trials nurses, this document helps bring recognition to the unique and critical role of the nurse in managing patients on clinical trials.
Continuing education courses for specialist breast nurses: what have we learnt from the implementation of the nationwide first course in 2004 in Germany up to now?

In 2003 we designed the first curriculum and started with the nationwide first course in 2004. At this time these nursing specialists were neither implemented nor even known in the German health system. Since that starting point, we run seven courses for nurses from all over Germany and from Switzerland, too. Meanwhile other providers in Germany offer this kind of education also. There must be about 300 colleagues with this qualification working in all parts of our country.

The aim of this speech is to introduce the development and content of the curriculum, to reflect on the experiences with seven courses and to discuss, if education alone may foster the implementation of a new role for nurses within a national health system or which accompanying other interventions are needed.

Development, Implementation and Evaluation of Education Packs for Newly-Diagnosed Haematology and Oncology Patients

John Robinson, Clinical Nurse Consultant, Palliative Care, Barbara O’Callaghan, Clinical Nurse Consultant, Haematology/Oncology Fremantle Hospital, Fremantle, Australia.

Communication in healthcare is an illusion that occurs across disciplines. Nurses and physicians struggle to effectively communicate and recognise the needs and concerns of patients and their families. This often results in unmet needs and crisis management.

It was against this background that we looked at ways in which to deliver timely, accurate and current information consistently to newly-diagnosed haematology and oncology patients.

Whilst education around treatment and the disease itself is given at the time treatment starts, education regarding support available was generally given on an adhoc basis, either when asked for or when an issue was perceived by staff. There was concern that patients or their carers were missing out on valuable referrals and resources that may enhance their well-being.

An education/information pack in the form of a plastic folder was introduced to hold general information booklets, as well as business card holders with easily accessible emergency contact numbers. Information on nutrition, exercise and emotional issues is provided, as well as contacts for support agencies. It also contains details of the multidisciplinary team members and how to access them.

The project began in January 2008 and it was decided that an audit of patient satisfaction, in the form of a questionnaire, would take place after six and twelve months.

Results have been very favourable, with all respondents giving high scores for quality and quantity of information contained in the packs and quality of the packs themselves.

Patients and their families have found that the packs have enabled them to contact various support agencies and multidisciplinary team members and help them to come to terms with their disease and treatment. It has helped to open up dialogue and to break down some of the barriers that exist in cancer care, such as the fear of speaking to the patient with cancer.

Staff members have also found that the packs have helped them in their practice and enhanced the care and support that they give to cancer patients.

O-282 EVIQ - Enhancing Knowledge, Promoting Quality through an Innovative Web Based Resource


1 Cancer Institute, NSW, Alexandria, Australia, 2 Prince of Wales Hospital, Sydney, Australia.

In order to deliver optimal treatment to cancer patients, nurses need to have a comprehensive understanding of contemporary literature, key evidence, and internationally acceptable standards. evIQ – Cancer Treatment Online, is a single web based repository of standardised evidence based cancer treatment information. This uniquely holistic resource provides nurses with information that is current, comprehensive, and relevant to their local units at no cost to the user.

In order to address the accuracy and currency of the content, reference groups of practising clinicians are established to discuss the validity, reliability, and transferability of the information to the clinical environment. The evIQ Nurses Reference Committee, established in 2006, has a current membership of 250 oncology and haematology nurses. The committee utilises a network model of governance driven by peer trust, voluntary participation and professional commitment.
The potential benefits for nurses standardising their information in a single repository such as eviQ are multiple allowing equity of access, confirming that they are practising within safe, current and valid clinical guidelines and reducing unnecessary duplication. It is hoped that these benefits will ultimately lead to a more streamlined patient journey and, therefore, improved patient outcomes. An evaluation survey of both the 2009 Nurses Reference Committee annual meeting and governance process was conducted in May, using a 17-item questionnaire based on a Likert Scale of 1 to 10 (1 requiring significant improvement and 10 being exceptional). Respondents (n=146) reported favourable scores for a range of items, including workshop usefulness (mean =9.0), content approval process (mean =9.6), opportunity to contribute and participate (mean=9.2), and appropriateness of content to their clinical environment (mean=9.1). Whilst participants valued the guiding principles of the governance model, particularly the collaborative approach and consensus decision making, they highlighted the challenges of evidence identification within the literature, mostly due to the dearth of clinically-driven oncology nursing research.

The purpose of this presentation is to demonstrate how eviQ can support nurses in clinical decision making through safe application and effective management protocols and educational resources.

O-283 COMPLEXITIES OF CARE, RADIATION THERAPY: JUST ANOTHER OBSTACLE.
Linda F. Berry, Bachelor of Nursing, Lisa A. Barry, Bachelor of Nursing. Calvary Mater Newcastle, Warnaralu NSW, Australia.

Complexity of care of patients undergoing Head and Neck radiotherapy can be particularly challenging due to issues such as co-morbidities and psychosocial concerns. Lifestyle issues may compound this experience. These could include alcoholism, non compliance, smoking and unemployment. When a mental health problem exists the whole experience can become overwhelming to the patient and immensely challenging to the radiation oncology nurse and the multidisciplinary team. These problems exacerbate the cancer diagnosis and treatment trajectory. Radiation treatment can be debilitating experience with multiple treatment induced toxicities and problems. These include pain and nutritional deficits to add to the patient’s other significant concerns. The radiation oncology nurse needs skills and expertise to recognise these wide range of issues so they can be addressed with empathy, respect and professionalism. Management of radiation induced toxicities remain the radiation oncology nurse’s primary role. However these problems can be overcome by the wider picture of the patient’s lifestyle factors and other significant issues. Therefore these patients are a challenge for the entire multidisciplinary team. The nurse is an integral member of the team and is often the first person to identify significant issues, as they develop a rapport and trusting relationship with these especially needy patients. Radiation therapy treatment is just another obstacle in the complicated and problematic life of a person with mental health problems and multiple negative lifestyle factors.

O-284 INTEGRATION OF SHARED GOVERNANCE IN A MATRIX ONCOLOGY ORGANIZATION
Deena E. Gilland, MSN, Lisa Landry, BSN. Emory Winship Cancer Institute, Atlanta, GA, USA.

When it comes to patient safety, quality, satisfaction, and nursing practice the most knowledgeable people are those at the bedside. In order to improve patient outcomes, the bedside practitioner must be driving the practice. Nurses throughout the institution need to be involved in shared governance and shared decision making in order to deliver excellence. The flow of information and decision making should be in a horizontal, bi-directional model versus a vertical direction only. Nurse leaders and bedside nurses serve congruently on committees addressing excellence in patient care as well as ensuring efficient, effective and top quality operations.

The purpose of this project is to illustrate how shared governance can work in a complex, matrix, academic Oncology setting. The evolution of shared governance is on-going, along the way many lessons have been learned and applied to the current model. The establishment of unit practice councils on every oncology unit, both inpatient and outpatient was step one. The members of the council were elected by their peers based on their clinical knowledge, innovative thinking, unit engagement and dedication to improve outcomes. Once these unit practice councils were functioning well across each hospital oncology unit and outpatient areas, an Oncology Specialty Council was formed. This council was made up of representatives of all of the unit councils. This group meets monthly and discusses standards of practice, issues of concerns, best practices and new ideas across the Oncology service line. From this Oncology council, the chairperson represents the group on the overall System Council chaired by the Chief Nursing Officer. The Oncology Specialty Council has expanded to become an interdisciplinary team, including pharmacy, physician, and patient advisors partnering with the professional nurses to improve care delivery. This model has demonstrated how the flow of information and decision-making is truly bi-directional and horizontal between professional nurses at the bedside and the leadership team. Examples of accomplishments of the Oncology council this year include standardization of central line care, production of patient education video both web-based and DVD form, development and initiation of communication form when transferring patients between inpatient/outpatient settings.

O-285 FROM THE GYM TO A HOSPITAL BED: A CRITICAL ANALYSIS OF THE EXPERIENCE OF BEING DIAGNOSED WITH ACUTE LYMPHOBlastic LEUKAEMIA (AND LIFE AFTER)
Maureen A. Boughton, Lesley Halliday. The University of Sydney, Sydney, Australia.

This presentation will explore the journey of a ‘healthy’ 22 year old woman who was diagnosed serendipitously with acute lymphoblastic leukaemia (ALL). The diagnosis was sudden and unexpected. The personal journey will take account of the physical, psychosocial and psychological impact of a diagnosis of this life threatening illness for the woman and her mother. The story is told by the young woman’s mother – a nurse for more than 30 years. Based on the personal journey of the young woman as described by her and her mother, a critical analysis of the experience from the diagnosis to the immediate hospitalisation and subsequent treatments will be articulated. The critique of the experience will be presented in light of what is known about the experience and will be specifically related to the role of nurses throughout the journey.

The presentation will include: being diagnosed, tests and more tests, chemotherapy treatment, achieving remission, stem cell conditioning to transplant and survival. An important element of each stage of the journey is ‘the waiting game’ and ‘uncertainty’.

O-286 NURSING SERVICE STRUCTURE AND CARE PROCESS FOR THE PREVENTION OF SURGICAL SITE INFECTION AT A UNIVERSITY HOSPITAL, SAO PAULO, BRAZIL
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Breast cancer ranks 2nd place among death causes and 1st place in deaths by neoplasms in women. Surgery, one of the main modes of treatment is considered clean and without infection rates from 1.74 to 3.42%. High infection rates can reveal the quality of the service. In order to analyze the nursing service structure and care process and the possible relation with SSI prevention and control we developed this descriptive observational study using document analysis in the Onco-mastology Outpatient Clinic (OOC) and the Gynecology Hospitalization Unit (GHU) in the university hospital of São Paulo, Brazil. The study was approved by the Research Ethics Committee. Data collection was performed by systemized observations, between August 2007 and March 2008, using six tools designed for this study and previously submitted to an evaluation for coherence and consistency by a board with three judges. The normative documents were in agreement with that recommended in the literature, but the physical structure and the care service process presented important limitations with a negative impact for SSI prevention. There were structural inconsistencies in 37% of the 146 items evaluated at the OOC and 45.2% of the 126 items evaluated at the GHU. As for the care services processes, unformities were observed in 42.6% of the 103 evaluated items at the OOC and 54% of the 108 items evaluated at the GHU. The unformities regarding structure and process were related with: hand washing, pre-surgery dermegerming, solid waste disposal, cross flow between infected and sterile material harming the disinfection process and the forwarding of tools to sterilization; failures in the asepsis technique to make punctures, dressings, and other nursing interventions. It was evidenced that the process of identifying and storing equipment for anato-
O-287 WHAT KNOWLEDGE AND ATTITUDES DO PAID CARERS OF PEOPLE WITH LEARNING DISABILITIES HAVE ABOUT CANCER? A RESEARCH STUDY.
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What knowledge and attitudes do paid carers of people with learning disabilities have about cancer? A research study. This paper describes a research study to explore knowledge and perceptions that paid carers of people with learning disabilities have about cancer. It will specifically focus on what sort of attitudes participants have about cancer and the extent of knowledge that staff caring for people with learning disabilities have about cancer prevention, early screening and early detection.

Rationale
The pattern of health care needs for people with learning disabilities is influenced by the changing profile of this client group. Many people with learning disability now experience a life expectancy that is approaching that of the general population. Studies indicate that those who achieve adulthood are now more likely to die of life limiting illnesses that are similar to those seen in the general population. There is a lack of consistent and reliable epidemiological data, however, many people with learning disabilities will be touched by cancer, either in relation to their own health or that of family or friends. In relation to the provision of information about cancer for people with learning disabilities, studies indicate that paid carers found this difficult, due to a lack of knowledge, experience and support.

Methodology
The choice of research approach was the survey method, selected primarily because of its ease of administration and appropriateness as the most effective means of accumulating data responding to the questions set. Postal questionnaires were sent to four social care organisations to be distributed to paid carers of people with learning disabilities. The questionnaire adopted a semi-structured format, some questions focusing on biographical and background information, others on knowledge and attitudes related to cancer. Of the 1400 questionnaires, 325 were returned. Data was analysed and themes generated.

Preliminary findings
- Participants’ responses to the word “cancer” were predominantly emotive, such as “despair” and “anguish”. However, others were related to facts and outcomes.
- A higher proportion of respondents indicated some knowledge and understanding of cancer. Participants were able to identify the four most common causes of cancers and the benefits of treatment. However, the majority of respondents believed that cancer is commonest in adults rather than elderly.
- The majority of respondents indicated that they have not undertaken any cancer education/training and felt that they had insufficient knowledge about cancer and how to help reduce the risks of cancer in people with learning disabilities.

Full analysis of the findings will be completed by the end of 2009.

O-288 HEALTH PROMOTION AND RISK REDUCTION IN YOUNGER FEMALE SURVIVORS OF CANCER
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While the number of cancer diagnoses in younger females is rising worldwide, improved detection of early stage cancers and increasingly successful treatment regimens have also meant a subsequent increase in cancer survival rates. These days, cancer is conceptualised as a chronic and sometimes curable disease, rather than an invariably fatal one. However, the late effects of cancer therapies in cancer survivors, particularly those women who are premenopausal at the time of treatment and experience ovarian failure as a result, can compound this chronicity and may be fatal in the long-term if preventive or risk-reducing measures are not practised early and consistently throughout the lifespan.

It is clearly important that survivors of cancer understand how to promote their future health and reduce their health risks in order to lessen the impact of the later effects of therapy. Overseas data indicate, however, that younger survivors of malignancy may engage in health-risk behaviours at rates equal to, or greater than, their healthy peers. This is an increasingly urgent, but unresearched aspect of cancer care in Australia. Quantifying and understanding the health behaviours of cancer survivors may ultimately assist in the development of cancer nursing education interventions that improve the potentially high personal and community burden of cancer survivorship.

This paper presents the findings of a multimethod questionnaire and in-depth interview pilot study undertaken with an n = 86 sample of younger women who have survived cancer. Quantitative data have been collected on the prevalence and determinants of health-risk and health-protective behaviours of the participants using the Australian Health Survey. Additional variables that are believed to influence health behaviours have also been measured. These include current treatment-related symptoms as assessed by the Brief Symptom Inventory; current quality of life in all domains of health through the WHQLQ-25; and dispositional optimism. Interview data with 25 participants provide more insight on the prevalence and relationships between many of these variables. Data collection will be completed in July, 2009 and data analysis is due to commence in August 2009.

O-289 PREFERENCES FOR BREAST SURVIVORSHIP CARE PLAN POST TREATMENT
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A qualitative approach was used to explore breast cancer survivors’ experiences since completion of treatment and preferences for survivorship care. Focus groups were conducted with 28 women with non-metastatic breast cancer, 3–12 months post–completion of last surgery, chemotherapy or radiation. Groups were stratified by age. Data was subjected to thematic analysis by age group (life stage).

Results
The impacts of breast cancer after completion of treatment are broad and vary by age group. Physical, emotional and social effects are more intense in younger patients. Older patients experience consistent, positive social support and develop closer relationships after breast cancer. Fatigue and fear of recurrence are the most universal effects. Preferred content of survivorship care plans echoes the wide variation in impacts of breast cancer. Patients want individualized, yet comprehensive, information. While preferred content varies by life stage, preferred format is similar. Organized transition from specialist to primary care is emphasized. The ideal time for information is upon completion of treatment, or shortly after. Patients identify a health–care professional such as an on-
O-290 TEMPORAL ANALYSIS OF LIMB VOLUME CHANGES IN BREAST CANCER LYMPHEDEMA PATIENTS
Soujanya Paladugu, MS, Jason Green, MS, Robin P Shook, MS, Jane M. Armeer, PhD, RN, Bob R. Stewart, EdD, Chi-Ren Shyu, PhD, University of Missouri, Columbia, MO, USA.

Introduction
The objective of this research is to identify commonly occurring patterns in limb volume (LV) changes in breast cancer survivors before the development of lymphedema. The identified patterns can be used to identify survivors at greater risk and provide opportunity for an appropriate early intervention.

Methods
Perioperative and circumferential LV was recorded for 233 breast cancer patients participating in a 30-month study consisting of one preoperative and eight postoperative visits. The LV changes between successive visits for every patient were calculated and categorized as increased, decreased, or stable based on 3% volume change. Patterns in volume changes before a patient met the 5% BMI-adjusted LV change criterion were recorded using episode mining. The study participants were divided into groups based on BMI. For each of these groups, the probability of a LV change pattern resulting in lymphedema was calculated.

Results
The probability that a particular pattern resulted in lymphedema varied by BMI group. For example, when the LV remained stable between two visits and then increased over the next two visits, there was a 14.71% probability of a normal BMI person developing lymphedema by the next visit. The same pattern resulted in a probability of 27.27% and 44% for an overweight BMI person and an obese BMI person, respectively.

Conclusion: Temporal analysis may be used to identify breast cancer survivors at increased risk of developing lymphedema by monitoring changes in LV over time. These findings can be used to target early interventions for risk reduction and management of lymphedema.

O-291 BODY IMAGE AND PSYCHOSOCIAL FUNCTIONING IN WOMEN WITH BREAST CANCER: CAN WE FIX WHAT WE’VE BROKEN? A RANDOMIZED TRIAL
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The number of survivors of breast cancer is increasing due to advances in treatment and early detection. However, a significant number of them face adjustment difficulties post-treatment, such as fear of recurrence, disfigurement, emotional disturbance, and other long term medical sequelae. Approximately 20% to 40% of them report sexual and body image problems. Such problems are often not raised due to their highly private nature.

The aim of this randomized controlled trial is to test an innovative group intervention geared towards improving body image, psychosocial, sexual and relational functioning and quality of life for breast cancer survivors. Delivered in group and led by two experienced therapists, the intervention includes supportive and educational component, problem-solving component and a guided imagery component. The supportive educational component of the intervention is designed to facilitate emotional expression of highly personal issues such as relationship patterns, identity shifts, inner values and priorities and self esteem, while the guided imagery component uses constructed exercise to help to converse one’s inner feelings.

To date, a total of 100 breast cancer survivors have been recruited and randomized into either the intervention group (8 week psychosocial support group incorporating guided imagery) or a control condition (standard care plus written educational materials) with follow-up up to one year post-intervention. Seven groups of participants (n=56 / 7 groups) have already completed the invention and initial findings will be shared with the partici-

pats. Areas for discussion will include baseline characteristics of the participants, such as age at the time of the surgery and the type of surgery and their association with post surgery psychosocial adjustments, common concerns on body image and self identity, the availability of social support, and women’s coping style and its relationship with the emotional adjustment to cancer. Also presented will be emerging themes from the intervention sessions such as common negative self-image, challenges around dealing with changes in body size or shape, fatigue, decreased libido, fears and anxiety around sexual activity, challenges in communicating with partners and altered identities. The implication of the study findings in terms of effective intervention components that could be incorporated into routine nursing care for breast cancer survivors will be highlighted and discussed.

O-292 THE WORK OF LIVING WITH MYELOMA
University of Sydney, Sydney, NSW, Australia.
The work of living with Myeloma

Introduction
This is a 3-year longitudinal study of the experience of living with myeloma. Myeloma is a rare incurable B-cell malignancy of the bone marrow. The main aims of treatment are to control disease, secure remission and maximise quality-of-life. With improvements in treatment, the median duration of survival has doubled to 5 years over the last 10 and many patients now survive 10–15 years. Most patients die from their disease despite onerous and complex regimens involving multi-disciplinary support and treatment from a number of different modalities. Living with, and dying from, myeloma is both resource intensive and often a painful and difficult journey, there is little research examining the experiences of people with myeloma.

Methods
Ten patients, with myeloma and attending one of three hospitals, were recruited together with a lay carer. Participants were interviewed on three occasions over 14 months. A total of 47 interviews were generated. These data have been analysed using the constant comparative method of Grounded Theory. Interviews were digitally recorded and transcribed verbatim. Data were managed using NVIVO software.

Results
Data from this study can help to build a rich description of the myeloma experience. The notion of ‘living with’ as people do live longer emerged from the data and this paper presents an interpretation of one aspect of this. Just how participants construct what they do to manage, organise and enable living with myeloma has been interpreted as ‘work’. Having myeloma requires effort, planning and organisation and thus, is work. Participants also put effort into managing complications and side effects of myeloma and it’s treatment and into integrating them into how they live with myeloma. Living with myeloma requires organisational skills, physical and emotional effort and is undertaken by both patients and significant others.

Conclusion
Increased duration of survival has implications for service delivery and future research into myeloma. Understanding how people manage the experience of living longer with myeloma can help tailor services to patient’s needs. The constellation of activities that require toll and effort by those living with myeloma have been conceptualised as work as it takes effort to live day to day with myeloma. Understanding this notion may be useful in for nurses in working with patients to assist them and offer support in living with myeloma.
narrative inquiry, and data collection consisting of focus groups, individual interviews, field notes, thematic analysis, and researcher's journal.

Main Research Variables: The healing attributes of the human–equine bond.

Findings: The emergent categories of meaning included a concept of Safe Haven, Self–Actualization, and Living in the Present.

Findings suggest the benefits of a structured horsemanship program include: Psychosocial benefits of enhanced self-esteem, increased self-awareness, and increased socialization. Emotional benefits include: social support, enhanced coping skills, decreased anxiety, and decreased fear. Beneficial outcomes appear to be unrelated to the structure or curriculum of the program: no differences were noted between an 12 week, 8 week or 6 week program. The likelihood of beneficial outcomes is increased when the environment and instructor/trainer are perceived as nurturing, promoting a sense of emotional and physical safety.

Conclusions

Interpretation: This study seemed to highlight the potential of an equine facilitated intervention to effect over–all recovery after cancer, encompassing concepts of self–actualization, self–esteem, coping, and spirituality. An equine facilitated intervention may be a useful service to offer cancer survivors. A variety of equestrian facilities may be viable sites for survivors' instructional programs. This is a rich area for study, lending itself to qualitative and quantitative methods.

O-294 FACTORS RELATED TO LONGTERM FUNCTIONAL STATUS IN OLDER PERSONS FOLLOWING CANCER TREATMENT

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Issue

Management of survivorship in older persons following cancer treatment is an increasingly common and complex health care concern. Concerns are raised about how to best optimize functional reserve for patients, to promote tolerance to ongoing treatment, to minimize the effect of age-related decline in physical, emotional and social reserves, and to maintain independence and optimize quality of life.

Objectives: The objective of this study was to determine the clinical, personal and social factors related to long-term functional status and quality of life in a cohort of older persons diagnosed with cancer at 1 year following active treatment.

Research Design

This study used a prospective, longitudinal design, following subjects over the course of a year, at three month intervals.

Participants: 440 participants aged 65 years and older were recruited following baseline consultation for treatment at a regional cancer centre.

Measures: Participants completed questionnaires, at baseline and 3 month intervals, containing validated measures of: 1) physical function and quality of life: Medical Outcome Short Form 12 (SF 12) and the European Organization for Research Treatment Quality of Life (EORTC QLQ – C30); 2) symptom experience: Memorial Symptom Assessment Scale (MSAS); 3) social support: Medical Outcomes Social Support Scale and 4) physical activity: Physical activity scale for the elderly (PASE). Demographic and clinical data were collected at baseline.

Results

For participants who completed the 12 month questionnaires (n = 270), levels of physical function at one year were comparable to older persons in general, to persons living with other chronic illnesses, and changed minimally across the year. Lower levels of physical functioning at one year were significantly (p<.05) associated with female gender, living alone, older age, cardiovascular illness, comorbid conditions, symptom distress, lower levels of baseline physical activity, and less support. Mental functioning was significantly associated with increased symptom distress and less support.

Conclusions

Findings from this research suggest that many older persons with cancer are able to maintain optimal functional levels following cancer treatment; however, there is a group of older persons who have a personal and clinical profile indicative of a need for increased health care support.

Funding support: Oncology Nursing Society

Keywords

Survivorship, functional status, aged.

O-295 ONCOLOGY REHABILITATION - A NEW MODEL OF OUTPATIENT CARE IN AUSTRALIA

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Patients with cancer as a diagnosis have been demonstrated to have multidisciplinary therapy needs throughout the course of their treatment. Best practice guidelines recommend this approach. “Evidence indicates that a team approach to cancer care can reduce mortality and improve quality of life for the patient.” (National Breast Cancer Centre, 2005)

Currently there are no formal, structured, interdisciplinary outpatient oncology group rehabilitation programs in Australia despite the growing need for ongoing maintenance of health and functional independence whilst undergoing complex, prolonged and physically, psychologically and emotionally difficult taxing treatments.

In line with St John of God Healthcare’s philosophy of fulfilling unmet need in the community and excellence in care, a new model for outpatient Oncology Rehabilitation programs in Australia has been developed, modeled on a successful Netherlands program. These are currently running at the Nepean Rehabilitation and Ballarat divisions in Victoria.

The programs are group programs for patients from all cancer streams and run over seven weeks and twelve weeks respectively. They consist of group education / discussion sessions and an individualised structured exercise program run in a group setting with the 12 week Ballarat program having a more comprehensive psychosocial component.

This paper details the development and content of the programs and evaluation and comparison of the outcomes of the programs including: attendance, quality of life, fatigue and exercise tolerance upon completion and at three month follow up. Early data indicates between 31–36% drop out rate due to death or ongoing deterioration in symptoms in both programs. However of those completing the program all physical outcome measures and anxiety and depression remained the same or improved in the majority of patients upon completion with 3 month analysis data not yet complete. Analysis of quality of life data is yet to be completed but early analysis indicates improvement in those patients completing either program.

Reference


O-296 IMPROVING THE PATIENT SYMPTOM MANAGEMENT EXPERIENCE: SYSTEM AND REGIONAL LEVELS

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Improvement in the patient's experience of cancer care requires greater attention to the management of physical and emotional symptoms throughout the disease trajectory in addition to treatment. The purpose of this presentation is to present our experience at regional and system levels in improving symptom management by working across disciplines and regional cancer programs. Although clinicians assume that they pay attention to both physical and emotional symptoms, chart audits and the literature reveal that this is not the case. Furthermore, use of a variety of tools complicates communication between and among health providers in regards to patient symptoms. Moreover, it is essential that patients have the opportunity to express and report on their symptoms. The literature also outlines that nurses and physicians judge symptoms differently than reported by the patients. Therefore we undertook this initiative to give the patients a 'voice' and control in symptom management. The interventions included: use of paper and electronic versions of the Edmonton Symptom Assessment System (ESAS) as a screening tool; functional...
assessments with PPS; development of an electronic database: Interactive Symptom Assessment and Collection (ISAAC) and monthly data reporting. The essential success factors included: centralized project management, regional engagement, identified aims, monthly regional reporting and implementation of quality improvement methodologies. The challenges have been: lack of consensus on the screening tools; different institution and professional cultures; resistance to change; resource implications and lack of established system level indicators and measures. From a system perspective, the involvement of senior leaders and clinical champions was essential for success; data was critical to track and monitor use of tools; and coordinated implementation supported change management.

O-297 MEASURING THE PATIENT EXPERIENCE OF CANCER CARE: THEY WON’T TELL US IF WE DON’T ASK.
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A comprehensive approach to continuous quality improvement in cancer care must include not only the monitoring and reporting of access and treatment quality indicators, but also a multi-faceted assessment of the patient’s perspective of the cancer care experience. To meet this goal our organization implemented the Ambulatory Oncology Patient Satisfaction Survey (AOPSS) to assess patient experiences with the cancer system. The AOPSS was designed using the Picker framework of the domains of Patient-centered Care, which include: respect for patient preferences, physical comfort, emotional support, coordination and continuity of care, information, communication and education, and access to care. The AOPSS was validated in a large study of 8000 patients in three provinces in Canada in 2003. Since 2004, our organization has been using the AOPSS in all regional cancer programs. The survey is completed annually; it is a mailed survey with one reminder; the results are analyzed centrally and reported both regionally as well as provincially. The response rate from patients is over 60% for each year; an indicator that patients wish to provide feedback to the system. Public reporting of the results is done through the Cancer System Quality Index. While there have been a number of patient satisfaction tools developed to measure satisfaction with interventions, such as within a research study; or developed to measure the perceptions of patients with respect to the providers; this tool measures the patient experience in key areas allowing for quality improvements to be implemented as a regional and system level. The purpose of this presentation is to provide an overview of the state of the art and science in patient experience measurement and discuss the lessons learned over the 5 years of administering the tool. The presentation will include data from the AOPSS and the challenges in reconciling the findings with quality improvement initiatives in the cancer programs. Providing public reporting on patient experience is one of the areas of focus in this presentation; as well as the clinician understanding of the data and how to use the information. Final recommendations for future improvements to cancer experience measurement and reporting will stimu-
late discussion about how this tool can be applied to other cancer programs.

O-298 PROMOTING QUALITY ONCOLOGY CARE THROUGH EVIDENCE-BASED PRACTICE: A WEB-BASED APPROACH TO SKILL DEVELOPMENT
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The ability to find, interpret and apply evidence to clinical practice offers the nurse the best opportunity to provide optimal, high quality patient care. In our current era of accountability, it has become imperative for the nurse to stay on top of recent updates in knowledge that may offer their patients the best outcomes. However, many nurses do not have the educational background or resources to develop the knowledge and skills required to integrate appropriate research into their practice setting. As part of an overall effort to provide its members with tools to help with this process, an oncology professional nursing organization developed a web-based educational program which focuses on the knowledge and skills required to find, interpret and apply evidence to clinical practice. This interactive webcourse takes learners step-by-step through increasingly complex information to teach the skills needed to implement evidence into practice. The course provides information and hands-on opportunities to: 1) Learn the basics of research, including types, components and related terminology; 2) Search for and review research literature; 3) Determine the strength of different types of ev-
idence, and 4) Evaluate a body of literature for application to practice. Through a series of activities, learners demonstrate the ability to develop a clinical question and search strategy, identify pertinent literature through a database search, evaluate the strength of research and non-research evidence, and make a clinical recommendation for practice based upon the best evidence. In addition, the flexible format allows nurses to learn at their own pace at a time convenient for them. It is essential for nursing and healthcare organizations to support evidence-based practice, and this learning format provides one method by which to acquire the knowledge and develop the required skills.

O-299 WEIGHT LOSS AND CACHEXIA IN PATIENTS WITH ADVANCED COLORECTAL CANCER
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Colorectal cancer (CRC) is the second and third leading cause of cancer-related deaths in Canada and the United States, respectively. Although CRC patients experience a myriad of symptoms, unintentional progressive weight loss is a common and distressing problem. Weight loss leading to cachexia has also been demonstrated to negatively affect quality of life and emotional well-being of CRC patients. Thus, a comprehensive understanding of weight loss and cachexia in CRC is central to optimizing health outcomes for this patient population. The Human Response to Illness (HRTI) Model (Mitchell, Gallucci & Fought, 1991) suggests that nursing knowledge and research related to human responses can be organized and viewed from physiological, pathophysiological, behavioral, and experiential perspectives.

In the proposed presentation, I will use an in-depth case study of one advanced CRC patient to demonstrate how the application of HRTI model establishes the foundation for an evidence based, holistic approach to care for CRC patients experiencing weight loss and cachexia. Accordingly, I will review the physiology of normal weight loss and provide an overview of research evidence related to the pathophysiological processes associated with weight loss and cachexia in CRC patients. As well, I will review the current state of knowledge related to the behavioural and experiential perspectives to provide insights into evidence-based, accurate, and comprehensive assessments of weight loss and cachexia in these patients. Based on this evidence, I will highlight strategies for a nurse-led multi-disciplinary plan of care to minimize weight loss and improve quality of life for CRC patients. Finally, I will highlight gaps in the research and make recommendations for future research to improve the health outcomes for CRC patient population.

O-300 THE LIFE QUALITY AND THE NURSING INTERVENTION OF THE CHINESE MALE ADULT PATIENTS WITH GASTRIC CARCINOMA AFTER TOTAL GASTRECTOMY
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Background and objectives: Several studies report the impact on patients’ postoperative symptom experience and quality of life (QOL) after total gastrectomy in short term, but little is known about the long-term results and how to improve the life quality of the discharged patients. The purpose of this study was to describe overall QOL and symptom experience of patients who underwent total gastrectomy for gastric carcinoma. Methods: The questionnaires(EORTC QLQ-C30)of life quality is carried on 200 postoperative male adult patients undergoing the total gastrectomy between the age of 35 and 60 with gastric carcinoma from the year of 2006 to 2008. All the patients are divided into three groups by the months after operation(less than 6 months, 6 to 12 months, and 12 months–1 year and 1–2 years after operation). Researchers provide the interventions of the health education, psychological direction and so on according to the result of the questionnaire. And they did the self-contrast after two months. Results: The study shows that the patients who received the intervention get a higher score in the QOL in the aspect of improving self-confidence, emotion and energy. But the results indicate there are no distinguish in other aspects of QOL. There is a best result of the effect on the postoperative patients one year later and they can recover to the normal life quickly after the intervention. The distinguish is obvious among the three groups(P<0.05).Conclusions: The results of the present study show that patients who had total gastrectomy for gastric carcinoma had greater symptom frequency and significantly poorer QOL. However, the quality of life can be improved by the interventions of sufficient postoperative Psychological care, nutritional management and so on for the post-op-
O-301 FACTORS PREDICTING QUALITY OF LIFE OF BREAST CANCER PATIENTS
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To improve quality of life of breast cancer patients is an important issue for nursing staff. So, understanding predictive factors of quality of life is an essential knowledge to develop nursing intervention. Symptoms compose pain, fatigue, depression, and sleep, social support, and stage of disease are the major factors that involve quality of life among cancer patients.

The purpose of this cross-sectional predictive design was to examine predictive relationships among symptom experience, self-care strategies, family support, and stage of disease on quality of life. The Symptom Management Model was applied as the conceptual framework of the study. One hundred and fifty breast cancer patients receiving chemotherapy were asked to answer a set of ten questionnaires: Symptom experience Questionnaires; Piper Fatigue Scale, Pain Scale, Depress Scale, and Sleep Disturbance Scale; Self-Care Strategies Scales with each symptom, Family Support Questionnaires, and Quality of Life Index. Data were analyzed using Stepwise Regression Statistic.

The findings revealed that the mean scores of quality of life(ßX=66.43) was at the moderate level. Significantly predictors quality of life of breast cancer undergoing chemotherapy were depression (ß= -.56; p<.01), fatigue (ß= -.31; p<.01), and stage of disease (ß= -.15; p<.01). The predictive power was 72% of the variance (adjust R2=.71; p<.01).

The findings indicate that The Symptom Management Model is a useful guide for explaining and predicting quality of life of breast cancer undergoing chemotherapy. Designing effective nursing interventions to control cancer stage, and reduce depress and fatigue experience should be further explored.

Keywords
Quality of Life, Breast Cancer Patients, Fatigue, Depression, Stage of Disease.

O-302 PRE-OPERATIVE INFORMATION, WHY, HOW AND WHEN? IMPROVING CARE WITH EVIDENCE BASED PRACTICE.
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Peter MacCallum Cancer Centre, Melbourne, Australia.

Background
Following identification of a potential gap in service within the gastrointestinal unit a research program that gives nurses and allied health professionals an opportunity to develop knowledge and research skills was undertaken. The program, run over 3 months allows health professionals to investigate a clinical issue and, when guided by evidence implement a practice change.

Aims
To identify the best available evidence on the need for preoperative patient information, how it should be produced and the most appropriate timing for delivery.

Methods
The Medline and CINAHL databases and Cochrane Library were searched using the following key words alone and in various combinations: preoperative, information, health literacy, timing, delivery method and knowledge retention. Reference lists were reviewed and appropriate articles retrieved and critically appraised using CASP appraisal tools.

Results. This literature identified positive outcomes for patients who receive written preoperative information. Benefits included: increased knowledge, decreased anxiety, improved ability to self care and decreased postoperative pain. Such benefits are seen when the information is provided alongside verbal explanation during the preoperative stage rather than at the time of admission to hospital.

Conclusion
There are a large number of descriptive studies in the literature discussing information provision for the preoperative patient. Positive effects of patient information are commonly reported but the evidence on when to provide the information is less robust.

Implications for practice. This review has identified the benefits of providing written information to patients prior to undergoing major surgery. Patients undergoing major gastrointestinal surgery at Peter MacCallum Cancer Centre do not currently receive written information to accompany the verbal explanation. Patient information sheets on oesophageal and liver surgery are being developed with extensive consumer consultation.

Timing of information provision, content and format will be evaluated.

O-303 SYMPTOM DISTRESS: VALIDATION OF A MEASURE IN BRAZIL
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Gathering symptom–related data to improve patients’ daily lives cannot be neglected by oncology nurses. The assessment of symptom distress allows nurses to design and evaluate interventions to relieve the symptom burden caused by cancer and its treatment. Nurses in Brazil encounter a lack of valid and reliable instruments to assess symptom distress. Aiming filling this gap this study was designed to validate the Breast Cancer Treatment Response Inventory (BCTRI). This tool conceptualizes and operationalizes severity of symptoms and amount of distress experienced, allowing interventions which can be toward specific concerns that patients report. The BCTRI was translated using a forward–backward method. A team of experts evaluated the content, semantic, technical, criterion and conceptual equivalence, for cross-cultural validation. The tool was used to collect data from a sample of 91 breast cancer patients. Reliability was evident in Cronbach alpha coefficients of .89 for the total tool, and of .79 and .80 for the dimensions ‘severity’ and ‘distress’, respectively. The women’s age ranged from 32 to 84 years (M=53.5). Nearly half was married and had at least 1 child. Education was predominantly low (0 to 10 years). The majority worked as house cleaners or cooks (90%), had the tumor classified as stage IIA or more advanced (80%), had radical mastectomy (54%), and did not have breast reconstruction (80%). All underwent lymphadenectomy and were receiving radio (40.2%), chemo (39.3%), or hormone (43.2%) therapy. Using the BCTRI, the researchers privately interviewed each woman. The most prevalent symptom complained by the respondents was shoulder/arm discomfort (n=69, 76.7%), followed by pain (n=60, 66.7%), difficulty sleeping (n=58, 64.4%), difficulty concentrating (n=56, 62.2%) and emotionally upset (n=55, 61.3%). Severity of symptoms and level of distress were marked in a 3 point Likert-type scale. The most severe symptoms were temperature fluctuation (M=2.8, SD=4.1), difficulty sleeping (M=2.4, SD=0.7), loss of appetite (M=2.3, SD=1.5), fatigue (M=2.2, SD=0.8) and poor wound healing (M=2.2, SD=1.1). Levels of distress were higher for infection (M=2.5, SD=0.5), pain (M=2.3, SD=3.7), emotionally upset (M=2.2, SD=1.0) and difficulty sleeping (M=2.2, SD=1.0). The women did not show difficulties in understanding and answering the BCTRI, thus providing important data for nurses who work with this population. Results indicated that the translated version of the BCTRI is a valid and reliable method to determine and monitor symptom distress experienced by Brazilian breast cancer patients.
O-304 A DESCRIPTIVE STUDY OF BEDSIDE COMPANION USE
Angela Adjeyoe, RN, MPH, MA, FAACM, Bridgette Thom, MS, Nancy Kline, PhD, RN, CPNP, FAAN.
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This project identifies and explores the factors, conditions, and variables contributing to companion assignment within the inpatient units of comprehensive cancer center. The goal is to develop criteria to aide in the assignment and monitoring of patient companions hospital-wide as well as in a large general hospital with oncology/haematology clinics in the east of Taiwan.

Nurse leaders and/or Clinical Nurse Specialists assign a patient to a companion, or one-to-one sitter, for a variety of reasons, including high risk for falls, confusion, disorientation, and substance abuse. The companion is often a Nursing Assistant (NA) or a Patient Care Technician (PCT); as such, a companion assignment can lead to fewer support staff members available to assist nursing staff in a given shift. Currently, there are no standard criteria in existence at this institution for the assignment of companions. As the use of companions presents significant financial and staffing burdens, it is important to review and assess the determinants and outcomes of companion use.

This descriptive study seeks to answer the following questions:
1) What are the most common variables used to identify patients who need companions?
2) What is the relationship between companion assignment and clinical outcomes and nursing-sensitive quality indicators?

From January 2007 to December 2008, over 3800 companion order sets were put in place for 1978 unique patient visits. A limited waiver of authorization was obtained to review these medical records, and a random sample of 11 percent of the cases (n=418) was selected for this review. Variables of interest include reason(s) for companion assignment and, as applicable, discharge; clinical assessments prior to and during companion use; and circumstances related to patient discharge. Patient factors, such as disease and disease status and co-morbidities, are also being collected. Descriptive statistics will be used to analyze the data. It is hoped that the findings from this review, in collaboration with current literature, will be used to develop an evidence-based guideline for the assignment and monitoring of companion use. This will ideally lead to a more uniform method of assignment so that patients can continue to receive quality care without compromising staff resources.

O-305 PREDICTORS OF QUALITY OF LIFE IN TAIWANESE WOMEN WITH BREAST CANCER
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Objectives
To identify and describe the predictors of quality of life (QOL) among Taiwanese women with breast cancer.

Methods: A predictive cross-sectional survey was used to identify interrelationships amongst independent variables (e.g. demographic and medical characteristic, symptom distress, anxiety and depression, internal health locus control, and use of coping strategy), and QOL in Taiwanese women with breast cancer. A convenience sample of outpatients was recruited from a large general hospital with oncology/haematology clinics in the east of Taiwan. The data were collected by face-to-face survey interview. Descriptive statistics were used to summarise sample characteristics, clinical data, scale results, and reliability for scales. The standard multiple regression was used to analyse the unique contribution of each of the potential predictors on the QOL scale.

Results: In total, 196 women completed the survey administered by face-to-face interview, resulting in a response rate of 81.7%. The majority were high school educated, married, Buddhists not currently employed, and with a mean age of 53 years. The time since diagnosis ranged from 25 months to 36 months with a mean of 28 months. Most women were diagnosed with Stage II, had had a mastectomy and had no recurrence of the disease. Women’s perceived QOL were predicted by various independent variables in the study. Three independent variables in relation to symptom distress, anxiety and depression were most influential in the prediction of QOL. Additionally, use of coping strategies including planning coping, denial, humor, venting, and self-distraction made statistically significant contributions in the predictions of various aspects of QOL. This combination of independent variables predicted all aspects of QOL as outcome variables from a low of 5.7% of the outcome variance (nausea and vomiting) to a high of 43.8% of the variance (emotional function).

Conclusions: In terms of survivorship, the current results emphasize that in the short-term breast cancer survivors had good QOL. However, women’s perceived QOL was more influenced by physical factors (i.e. symptom distress), psychological factors (i.e. anxiety, depression) and use of coping strategies rather than demographic and clinical factors. This study provides important information for nursing professionals to target the specific need of women with breast cancer and to develop interventions for improving the QOL of breast cancer patients, as well as enhancing the quality care.

O-306 THE LIVED EXPERIENCE OF VENOUS ACCESS.
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Aim
The aim of the study presented in this paper is to bring forth the voice of the oncology patients who have undergone venous access/cannulation, as there is a paucity of literature regarding this topic. This qualitative study used phenomenology to explore the lived experiences of participants in order to better understand the impact of repeated cannulation on the cancer journey from the patients’ perspective.

Method: This phenomenological study explored the participants’ “lived experience” of being cannulated. Two rural oncology units in New South Wales, Australia, were chosen to recruit participants. Fifteen participants were recruited who had either completed a course of chemotherapy or were currently being treated. During individual interviews the participants were asked to discuss what it is like to be repeatedly cannulated. Individual interviews were audiorecorded and the transcripts analysed using a thematic approach.

Result
The themes that emerged as preliminary findings revealed that the patients’ choices about how, when and where to be cannulated was limited and they felt that a “holistic” approach to care was often absent. Examples of patient vulnerability and medical paternalism are demonstrated via direct quotes from the participants. Adjunct to these findings, participants’ also discussed how the experiences of cannulation broadly impacted on their cancer journey and on their experiences seeking further health care. It is anticipated that the outcomes of this study will improve understanding of the experience of being cannulated from the patients’ perspective, which may contribute to best-practice and improved patient outcomes.

O-307 DEVELOPING AND IMPLEMENTING A PATIENT EXPERIENCE SURVEY ACROSS A CANCER NETWORK: LESSONS LEARNED AND RESULTS
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The Sussex Cancer Network Partnership Group developed 5 surveys for cancer patients: referral to diagnosis, treatment (chemotherapy, radiotherapy and surgery) and follow up. The referral to diagnosis survey was completed in June 2009. 552 urology, breast, colorectal, haematology, head and neck, Upper GI, lung, gynaecology and Central Nervous System patients responded with a 52% response rate.

The results have been extremely positive with:
- patients receiving information they understood about investigations (84%), treatment options (90%), and possible side effects (88%)
- 90% of patients told their diagnosis in a sensitive way
The largest NCI-designated comprehensive cancer center continues to proudly pioneer cutting-edge technology in the field of chemotherapy and Computerized Physician Order Entry (CPOE). Accurate dose calculation and communication of chemotherapy orders are critical challenges in achieving a safe, effective medication management cycle. CPOE systems reduce medication errors, promote quality care and patient safety by offering best practice guidelines. In combining complete cycles of chemotherapy treatment into a single workflow, this institution maximizes its Eclipsys technology for chemotherapy order management. By utilizing the Electronic Adult Treatment Order (eATO), in our continual pursuit of quality related to chemotherapy ordering, documentation, and administration, we recently embarked on the design of an Electronic Medication Administration Record (eMAR) that would safely reflect the unique workflow processes involved in administering chemotherapy in the inpatient setting. A multidisciplinary team consisting of Nursing Informatics, Information Systems, Nursing Leadership, Physicians, Pharmacy Leadership, Hospital Administration, and frontline nursing and pharmacy staff helped create such a workflow and the eMAR.

The challenges included: 1) Changing both pharmacy and nursing’s way of verifying and ‘releasing’ chemotherapy orders; 2) Securely documenting two-practitioner chemotherapy safety checks (co-signature); 3) Defining frequencies unique to chemotherapy; 4) Creating new nurse documenting workflows; and 5) Performing end-to-end testing of the application and workflow.

This presentation will discuss: 1) The weekly multidisciplinary team meetings for mapping out workflows; 2) Nursing Informatics involvement with Eclipsys to create a custom co-signature feature for eMAR to accommodate nursing practice; 3) Nursing Informatics and Information Systems collaboration to create special frequencies that worked with the eATO, eMAR, and nursing practice; and 4) The joint Nursing Informatics and Nursing Leadership’s creation of a train-the-trainer program for nurses and unit assistants.

Although the hospital has not yet quantified patient outcomes related to care, as a result of this teamwork, quality of patient care has been improved through increased efficiency in order entry and time to treatment and through elimination of transcription errors. After successfully designing and implementing electronic chemotherapy documentation in the inpatient setting, work has begun to bring this template to the outpatient setting with the additional goal of providing efficient coding capabilities of ambulatory chemotherapy administration.

**O-309 IMPROVED CALL LIGHT RESPONSE ENHANCES PATIENT CARE.**
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In reviewing the most recent 2008 Patient Satisfaction Survey for our surgical oncology unit it was noted that our score for responding to patient call lights has not improved in comparison to previous surveys. The most recent score indicated that 33% of patients were dissatisfied with the waiting time after initiating the call light. It is well documented that patients’ satisfaction increases when call lights are responded to promptly and when nurses are unavailable patients uncertainty increases (Woodard, 2009).

Reasons for delays in nurses’ response needed to be explored. One of the first steps would be to identify the reasons for calls as it is the nurses’ belief that if the reasons for calls are identified, recommendations could be initiated to reduce the need for most calls. Anecdotal accounts from the nurses on this unit provided several reasons for patients’ call light use. A group of oncology nurses conducted a survey as a Quality Improvement Project to determine the reasons and frequency of the call light use. The results have prompted two changes: The potential needs of the patients were addressed and regular rounding was initiated. Before leaving the patient’s room, the nurse ensured the patient did not need to be toileted and that their other care needs were met.

The need for toileting and intravenous issues were among the most common reasons reported for the call light use; rounding regularly has been recommended to increase patients’ satisfaction and safety. Meade et al. (2006). Evaluation of these changes in practice will be revealed through patient responses in our next patient satisfaction survey. However anecdotal evidence has revealed that call light use has been reduced.

**O-310 CREATING A SEAMLESS CONTINUUM OF CARE: A NAVIGATIONAL TOOL FOR PATIENTS WITH LOCALLY ADVANCED RECTAL CANCER**
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Sunnybrook Health Sciences Centre/ Odette Cancer Centre, Toronto, ON, Canada.

It is estimated in Canada that 22,000 people will be diagnosed with colorectal cancer with 9,100 dying from the disease. (Canadian Cancer Society, 2009) In the United States, estimates of new cases for colon cancer are projected to be 106,100 and an additional 40,870 people diagnosed with rectal cancer. (National Cancer Institute, 2009)

The diagnosis of cancer often comes as a shock to individuals and their family members. The need to understand the complexity of their condition and ensure follow up appointments occur keeps treatment on track. The need to understand the complexity of their condition and ensures follow up appointments occur. At a regional cancer centre in Toronto, Ontario a navigational tool was created for patients diagnosed with gastrointestinal malignancies. The tool was initially developed for patients diagnosed with locally advanced rectal cancer.

The tool was designed as a communication vehicle between the primary nurse and the patient and is provided at their initial appointment and reviewed at subsequent follow up visits by various members of the health care team. Patients are able to keep track of who is involved in their care including the oncologists they will be seeing and other members of the team who will be accessible to them such as social workers, dieticians and psychiatrists/psychologists. In addition to serving as a record for keeping care team contact information it also allows the patient to keep track of the various diagnostic test/imaging/procedures required, highlights patient information/resources available to enhance their understanding of their condition and ensures follow up appointments occur with the appropriate surveillance tests and timing of these tests outlined.

This presentation will provide participants with an opportunity to:

- Discuss the development process of the navigational tool and its format
- Understand the impact of using a navigational tool by oncology nurses in an ambulatory setting
- Review patient feedback about the usefulness of a navigational tool during their patient journey
Interest in cancer nursing and specialized care of cancer patients is on the rise as the worldwide incidence of cancer is predicted to increase substantially over the next decade. Seventy percent of the new cases will be in countries with middle to low resources. Nurses have a key role to play in prevention, screening, encouraging early diagnosis, and in the care and comfort of patients during and after treatment in these countries. In addition, given the stage at which many cancers are diagnosed in these countries (i.e., 3rd and 4th stage), knowledge and skill in palliative care is incredibly important for nurses in these countries. However, access to education remains a challenge for nurses in middle to low resource countries.

The Nursing Department of the Aga Khan University Hospital in Nairobi and the Nursing Division of the Odette Cancer Centre in Toronto have embarked on a partnership initiative aimed toward developing the capacity of nurses in Kenya to prepare for the upcoming challenges in providing cancer care. Working collaboratively with local teams from each setting, the first initiative was successfully held—a 5 day chemotherapy course. The course was organized as an introductory course related to chemotherapy administration and cancer nursing as a specialty. A train the trainer model was incorporated. Seventy practicing nurses participated in the course and committed to returning to their clinical setting armed with new knowledge about caring for cancer patients. Data were gathered before, during, and after the course to assess attitudes and knowledge. A six-month follow-up was organized to determine how the nurses had utilized the new learning.

This presentation will describe the program development, delivery, and follow-up findings. The approach and the lessons learned during the process of organizing and offering the program will be of interest to other agencies or settings where needs exist for cancer nursing development and chemotherapy instruction.

Symptom management is a priority concern for patients with cancer and their families while undergoing chemotherapy and/or radiation treatment. Complex treatment regimens and disease progression precipitate the presentation of variable symptomatology for individuals with cancer. Understanding and addressing priority symptoms from the patient perspective is a significant role for oncology care providers. Cancer Care Ontario (CCO) is the governing body of all cancer centers in the province of Ontario. CCO has identified that symptoms in patients with cancer are often under-reported and poorly controlled. As a result, CCO developed a quality care initiative to provide every cancer patient the opportunity to share with their health care professional any symptoms which the patient was experiencing. The broad goal is for all patients in cancer centers throughout the province to be offered the opportunity to complete, the Edmonton Symptom Management score (ESAS), a validated tool used to address symptom management. The tool allows the patient to rate their symptoms on a scale from 0 to 10 based on "no symptoms" to "worse possible symptom". Initial implementation of this tool into clinical practice, has allowed patients to play a more active role in their care and control of their symptoms. Specialized oncology care providers perform enhanced assessments based on the priority symptoms identified by the patient. Evidence-based interventions for key symptoms outlined in the ESAS have shaped the interactions with each patient to improve symptom control. This oral presentation will take you through the roll out of the tools, the development of algorithms, the priority symptoms identified by patients at an urban regional cancer center in SouthWestern Ontario, and the evidenced based interventions that have been incorporated into clinical practice.
poster ABSTRACTS
P-01 IMPLEMENTING THE EDCan LEARNING RESOURCES: SUCCESSES AND CHALLENGES.
Sanchea Aranda, Prof1; Kylie Ash2; Gemma Connelly2; Linda Devitr2; Cathie Pigott1; Patsy Yates, Prof2; 1Peter MacCallum Cancer Centre, Melbourne, Australia, 2Queensland University of Technology, Kelvin Grove, Australia, 3University of Sydney, Sydney, Australia.

The aim of the National Cancer Nursing Education (EDCan) project was to increase the capacity of the cancer nursing workforce in Australia. The project involved defining a National Professional Development Framework for Cancer Nursing that included capabilities outlining role expectations of nurses working in cancer control. Learning resources to assist nurses acquire these capabilities were also developed. The purpose of this paper is to review outcomes from a series of pilot projects that sought to implement the EdCan Framework and associated learning resources in various education and practice contexts.

Fourteen implementation pilots were undertaken between November 2008 and June 2009, in rural/regional and metropolitan health-care and tertiary settings, involving nurses with various levels of experience in cancer control. Projects included curriculum mapping, and design and delivery of professional development and educational activities. Outcomes of projects were evaluated using surveys of project team members and nurse participants, and analysis of reports submitted from each implementation team. Data reflected a high level of participant satisfaction with activities that involved interactive workshops or discussions. Use of evidence-based case studies, supported by videos, was well received. Greatest success was observed in projects with clear objectives linked with the Framework, and where learning resources were adapted to participant learning needs.

Challenges reported included finding time, obtaining backfill to participate in the project, and many identified the need for advice and mentoring to utilise the Framework when designing educational activities. There were also lower levels of participation in the implementation project which involved on-line delivery of learning resources.

Professional development frameworks are important to guide the design and delivery of educational activities for nurses. The implementation projects identified various strategies to assist educators to use the framework, and highlighted the need for ongoing development of the nursing education workforce to optimise learning experiences and outcomes for nurses.

P-02 HUMAN RESOURCES FOR HEALTH: WORKFORCE & WORKPLACE, ESSENTIAL FOR CANCER CARE
Bethoney Thorne, PhD1; Mark Smith, BScN1; Keryn Tipper, BScN1; Carole Pitch, BScN1; National Organisation of Nurses and Midwives of Malawi, LIONGWE, Malawi.

Healthy Workforce and Workplace is essential for Cancer Care. Globally and locally especially in developing countries, critical shortage of nurses and specialists for cancer care entails limited focus on preventive, treatment and care management of cancer.

Efforts are been mobilised amongst stakeholders in the health sector to deal with the shortage of health professionals. Advocacy and implementation of comprehensive treat, train, and retain strategies will help to achieve deal with the shortage of health professionals. Advocacy and implementation of comprehensive treat, train, and retain strategies will help to achieve deal with the shortage of health professionals. Advocacy and implementation of comprehensive treat, train, and retain strategies will help to achieve deal with the shortage of health professionals. Advocacy and implementation of comprehensive treat, train, and retain strategies will help to achieve deal with the shortage of health professionals. Advocacy and implementation of comprehensive treat, train, and retain strategies will help to achieve deal with the shortage of health professionals. 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A new work schedule model for nurses can be an effective way of reducing waiting times and maintain good patient satisfaction for cancer patients and also to improve workplace environment and reduce staff turnover.

P-05 PREVENTING FROM OCCUPATIONAL EXPOSURE OF ANTI NEOPLASTIC DRUGS IN JAPAN: APPROACH BY SPECIAL INTEREST GROUP OF CHEMOTHERAPY

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3Gunma University Hospital, Maebashi, Japan

We will introduce our approach to prevent from occupational exposure of antineoplastic agents in Japan as Special Interest Group (SIG) of chemotherapy in Japanese Society of Cancer Nursing. Many researchers have shown that not only the cytotoxic drugs themselves but also patients undergoing treatment with these drugs become a source of exposure to healthcare workers, and suggested systematic approach to prevent from occupational exposure is necessary. Though Japan Pharmaceutical Association published the guideline about the handling of antineoplastic drug in hospital in 1999 and Japanese Nursing Association presented the guideline of occupational safety and health in workplace of nursing in 2004, they don’t have legislative force in Japan. Recently, outpatients receiving chemotherapy are remarkably increasing and nurses face more opportunities at risk of exposure. But concerning occupational exposure and its prevention, little is educated in basic nursing education. It depends on the education of each medical institution and the contents are not consistent by institutions. SIG, which consists of nurses who specialize in chemotherapy all over Japan, regards the spread of knowledge and awareness of occupational safety as an urgent problem to such current state, and started from 2007. First of all, we surveyed the prevalence of safety handling of antineoplastic agents in 17 institutions which SIG members are belonging to. It revealed that nurses mostly prepare antineoplastic drugs in the table not specific at nurse station. Though they mostly use gloves and gown and goggles as personal protective equipment (PPE), it is not the way recommended. We discussed based on these results, and then we developed questionnaire to grasp each nurses’ status of knowledge and skills to prevent from occupational exposure. We also developed educational tools and had workshops about safety handling of antineoplastic agents by using them. We are going to expand our approach all over Japan. At the same time, we also aim to promote the legislation to protect healthcare workers from occupational exposure.

P-06 IMPLEMENTATION OF A CANCER NURSING STRATEGY IN THE SUSSEX CANCER NETWORK

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A strategy is defined as a plan, method, or series of manoeuvres or strategies for obtaining a specific goal or result. The plan of our cancer nursing strategy was to get the basics right while embarking on developing and implementing our plans for the development of cancer nursing in the future. So what was our starting point? What patients valued about cancer nursing now and where they felt cancer nursing should develop in the future. Key messages, such as "We want more expert support in the community but not at the expense of having expert support when we are told our diagnosis" were incorporated into the strategy.

The resulting 20 key recommendations covering: patient/carer involvement, informing and supporting the patient and their family, professional and personal development, service improvement, skill mix, research and audit were the back-bone of the plan. This presentation will summarise progress on implementing the strategy. For example, we had subjective data on the availability of Clinical Nurse Specialists (CNS) when patients were told their diagnosis, despite the NICE Supportive and Palliative Care Guidance making it quite clear that this service should be available for all patients. All Clinical Nurse Specialists were required to complete a minimum dataset on an electronic record system, which provided robust data for the first time on inequities across tumour types and organisations. The resulting implementation plans included the prioritisation of new CNS recruitment, skills mix reviews, administration support and service improvement (ensuring that CNS would be not running at the same time). Performance monitoring of availability is presented to our Executive Board, Partnership Group and commissioners on a 6 monthly basis and has been instrumental in delivering an equitable, high quality service for all patients.
P-09 QUALITY OF LIFE OF CANCER PATIENTS IN CHEMOTHERAPY TREATMENT

Namie O. Sawada, Nurse, PhD, Associate Professor1, Adriano C. Nicolussi, Nurse, MS, PhD student1, Liyoko Okino, Doctor2, Fernanda M. C. Cardozo, Nurse, MS student1, Múrcia M. F. Zago, Nurse, PhD, Associate Professor1.
1University of São Paulo, Ribeirão Preto/SP, Brazil, 2Acupuncture Specialized Clinic, Ribeirão Preto/SP, Brazil.

Cancer is a disease that affects people in the whole world and may bring some impacts to patients and families’ lives in different ways, since the diagnosis and the knowledge until the treatment choice, its process, and the rehabilitation. The evaluation of Quality of Life (QoL) of oncologic patient is an important pointer of the patient reply to the cancer and the treatment in the own patient perspective. This is a descriptive, exploratory and cross-sectional study, which aim was to evaluate the quality of life of cancer patients who were receiving chemotherapy. The Quality of Life Core–30–Questionnaire (QLQ-C30) instrument was used to measure Quality of Life. The sample consisted of 30 cancer patients who were receiving chemotherapy at Oncology Specialized Center in Ribeirão Preto, São Paulo, Brazil, between April 2006 and November 2007. The QLQ-C30 instrument showed that, for Physical, Cognitive, Social and Role functioning, mean scores ranged from 71.26 to 75.12, demonstrating a satisfactory level. In the Emotional functioning, the mean score was low (55.46). On the symptoms scales, there were a predominance of insomnia, pain and fatigue. We concluded that Quality of Life was satisfactory in all domains except for the Emotional functioning, which scored low demonstrating that the side effects of chemotherapy exert a negative influence on quality of life of cancer patients. Descriptors: quality of life; neoplasms; oncologic nursing; drug therapy.

P-10 DEVELOPMENT OF A CREDENTIALLING FRAMEWORK FOR NURSING

Denise A. Spencer, Wendy Wood.
Peter MacCallum Cancer Centre, Melbourne Victoria, Australia.

Peter MacCallum Cancer Centre (Peter Mac) in Melbourne, Australia, like other oncology facilities around the world, is facing a rising demand for accountability in the provision of safe and efficient services. One available risk–management strategy is the establishment and maintenance of processes that credential or verify the knowledge and skills of health care employees. Within the Peter Mac Nursing Service, these processes form an essential part of recruitment and performance management measures. Following appointment at Peter Mac, the Nursing Service provides for additional and ongoing specific professional development needs and/or study leave to assist in further, related education and training. The Nursing Service Credentialling Framework, developed by the Manager of the Department of Nursing Education, distinguishes three levels to report to the Nursing Executive Committee as Key Performance Indicators (KPI). The framework is used to identify and guide the development of safe nursing practice at PeterMac.

Level 1 – Registration to Practice
Employment requires that nurses in Australia are registered with their State Nurses Board. All Peter Mac nurses are required to be registered by the Nurses Board of Victoria (NBV) and must have their registration to practice status checked annually.

Level 2 – Post Graduate Education, Continuing Education and Professional Development
Formal education, training and professional development courses focus on the acquisition or consolidation of requisite knowledge, attitudes and skills that enable nurses to meet current and future needs of our patient population. Course completion and student retention rates as well as attendance and program evaluation data contribute to ongoing planning for the level 2 KPI.

Level 3 – Competency Program
Since 2002, nurses at Peter Mac have undertaken a range of self-directed Learning and Competency Assessment packages that focus on skill and knowledge development for safe practice. The completion rate for the packages has been tracked from program inception and compliance with essential requirements is reported to the Nursing Executive Committee annually against a target of 80%.

P-11 TRENDS OF RESEARCH ON OCCUPATIONAL EXPOSURES TO ANTEOPLASTIC AGENTS IN JAPAN

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1Akita University, Akita, Japan, 2Gunma University, Maebashi, Japan.

The organization that administers antineoplastic agents by the outpatient in these ten years increases, too and the chance to handle anti–cancer drug antineoplastic agents increases in Japan. Then, the purpose of this research is to clarify future tasks to analyze the original paper to antineoplastic agents in Japan in the occupational exposure, and to avoid the exposure by antineoplastic agents.

A research was carried out using “Japana Centra Revuo Medicina” with “antineoplastic agents”, “exposure” and “handling” as key words, original papers published between 1983 and June 2009. As a result, there were 46 papers, and after 2005, 67% was published. It was concerned the danger of the occupational expoiiate and the guideline of handling in the 1990’s, the number of papers concerning handling and the working environment and the recognition of the handlers increased after 2000, and the papers concerning the approach with each hospital was seen in recent years. Additionally, there ware research on remedial measures to handle it appropriately.

There are the realities from which antineoplastic agents is not appropriately handled in each hospital though the guideline was presented in 1991. It is possible to have to spend a lot of labors on the improvement of equipment and the system besides the recognition of occupation exposure of the antineoplastic agents of people who work in the medical institution is low as the factor. It is necessary to improve the recognition of occupation exposure of the people’s antineoplastic agents as future tasks. And, it is thought that the systems approach is important because the improvement of the working environment in each hospital is attempted.

P-12 A PROJECT FOR IMPROVING THE SAFETY OF CHEMOTHERAPY ADMINISTRATION IN NURSES

Wenping Ya, a Master’s degree, vice-director, Chu-Fang Wu, Y.C. Ye, C.W. Hung, M.Y. Li, Chang-Gung Memorial Hospital, Taoyuan, Taiwan.

Objective
This project aimed to promote the safety of chemotherapy administration for nursing professionals. Analysis of the current administration of chemotherapy showed that safety-related problems of chemotherapy administration included three dimensions: knowledge of chemotherapy precautions, chemotherapy execution, and use of protective equipments. Statistical analysis of surveys on nurses showed an 81.75% of accuracy on knowledge of chemotherapy precaution, 52.59% of accuracy on chemotherapy execution, and 66.67% of accuracy on use of protective equipments.

Methods
These low rates of accuracy are mainly due to insufficient standard guidelines and regiments, and lack of in-service educations and trainings. Some nurses did not wear protective gown because they felt it was time-consuming to wear a gown. The oncology ward could not function properly due to insufficient protective equipments. Based on the survey results and literature review in November and December 2007, the procedures taken to improve safety of chemotherapy administration included first, revising “standard guidelines for chemotherapy administration and handling,” second, providing education on “standard guidelines for safety of chemotherapy,” third, unifying protective equipments for chemotherapy on wards.

Results
After all the above interventions, nurses had higher accuracy on knowledge of chemotherapy precautions, accurate chemotherapy execution, and use of chemotherapy protective equipments (93.65%, 91.5%, and 100%, respectively).

Conclusions
This project set an example for hospitals to improve their practice environment to increase safety of chemotherapy administration.

P-13 DEALING WITH TAXOTERE® SIDE EFFECTS ON HAIR LOSS AND HAND-FOOT SYNDROME

Mu-Ming Chang, Bieng-Yi Chang, Hsing-Ju Liang. Tri-Service General Hospital, Taipei, Taiwan.

Taxotere® (docetaxel) is one of the chemotherapeutic agents in taxoid class. It is gaining a reputation in western countries and is claimed to be an alternative to traditional chemotherapy. In Taiwan, average 80% of patients experience a NCI–CTC grade III to IV side effects including hair loss and hand–foot syndrome, a condition marked by pain, swelling, numbness, tingling, or redness of the hands or feet within two to four weeks following the Taxotere® chemotherapy. Hypothermia cap, gloves and slippers were given to patients 15 minutes before the chemotherapy started and took off until 15 minutes after the chemotherapy. Severity of side effects was recorded by the patients themselves one week later when the next chemotherapy course began. Hair growth in the hand–foot syndrome experienced in 32 patients were all graded NCI–CTC grade 0–I.
Introduction

Death from cancer continues to be the primary cause of top ten mortality rate in Taiwan population. Breast cancer is the most common cancer in women with 5-year survival rate about 82%. Improving patients’ quality of life is just as important as increasing their overall survival rate and functional status. This research was initiated to study and evaluate quality of life of post-operative breast cancer patients at the first, third and sixth months respectively after operation at a medical center in north Taiwan.

Materials and Methods

Based on a longitudinal, prospective design, this study adopted a purposive sampling method to select 60 breast cancer patients. QLQ-C30 and QLQ-BR23 questionnaire were developed by European organization for research and treatment of cancer (EORTC) in Chinese version were used to collect data by case manager from Oct. 2006 to Oct. 2008. The Linear Mixed Model was used to explore the differences at above-mentioned three time points.

Results: Patients had a mean age of 53.82 (SD = 12.29) years. The most frequent symptoms of breast cancer patients were insomnia, fatigue and pain during six months follow-up. The scores of sexual function were highest at 3 months after surgery. Longitudinal study showed that nausea/vomiting (1 month: 8.19 vs. 6 month: 3.35, p = .042), dyspnea (9.59 vs. 3.30, p = .021), appetite loss (13.67 vs. 6.30, p = .043) and physical function (89.91 vs. 94.97, p = .026) were improved significantly over time. Patients had positive perspectives on cancer in future (62.29 vs. 75.44, p = .026) and less side effects of systemic therapy (14.86 vs. 10.41, p = .012) at 6 months than the time at first month.

Conclusion

This finding suggested that nurses should pay more attention to the special needs of the breast cancer patients during different postoperative periods, and it could result in better care in these patients and to improve their quality of life.

Keywords

Breast Cancer, Quality of life, Linear Mixed Model analysis

P-15

ORAL MANAGEMENT FOR RADIATED PATIENTS IN HEAD AND NECK CANCER

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Introduction

Radiotherapy for cancer of head and neck is a mean for increasing the survival rate and providing the possible needs for patient who is unable to receive surgery. However, there are still risks associate with radiotherapy. Adverse effects from radiotherapy can lead to complications within the oral cavity. Dental caries, xerostomia, and reduced bone and tissue healing rates are the common adverse effects. One of the most serious sequelae is osteoradionecrosis (ORN). The purpose of this paper is to discuss the measurements for preventing or reducing the sequelae before radiotherapy.

Methods

We collect and review issues regarding to patients’ oral management prior to their head and neck radiotherapy in our hospital’s dental department. The gathered information is to be analyzed, and then is used to set up as a protocol for our dentists and dental hygienists.

Results

Our recommendation correlates with the study done by Regezi et al (1976). From the study, 49 patients received dental extractions at least 10 to 14 days before receiving radiotherapy. The result showed that only one case of ORN was observed among 311 extractions performed. When comparing the time intervals before radiotherapy with other more recent studies, this study appears to have the shortest time interval before radiotherapy. Upon patients’ first dental appointment, we will assess the overall dental health status. The teeth with non-restorable or with poor prognosis will be extracted in time. At this time, we then take the impression for making individual fluoride tray for each patient. Next appointment, the task of dental department is to teach each patient how to use fluoride tray with fluoride gel (AF, 1.23% Fluoride ion) in the home setting. We will suggest mouthwash (povidone iodine gargle solution) for them in order to prevent candida infection. Finally, we need to give instructions to patients on maintaining a good oral hygiene, check on new dental caries, and if there is any oral infection.

Conclusion

Thorough oral management and treatment should be done prior to radiotherapy and ongoing assessments are also required even after radiotherapy. Any teeth extractions and surgeries should be performed, at least 10−14 days before initiating radiotherapy, in order to reduce the risk of ORN. Dental caries can be prevented by fluoride supplement and frequent dental examinations.

The risk of oral infection can be reduced by good care of oral hygiene care and regular use of mouthwash. All the dental treatment should not interrupt and delay the radiotherapy treatment. The dental evaluation must be done, and preferably as soon as possible, prior to the scheduled radiotherapy.

P-16

NURSING CARE OF INTRAVENOUS/VASCULAR CONNECTORS BASED ON CONNECTOR TYPE

Cynthia Chennecky, PhD1, Lindsey Casella, MSN2, Denise Macklin, BSN3.

Medical College of Georgia, Augusta, GA, USA, 1University Hospital, Augusta, GA, USA, 2Professional Learning Systems, Inc, Marietta, GA, USA.

Introduction

Nursing care of IV/Vascular connectors based on connector type. Significance and Background: Intravenous and vascular access connectors are important in oncology nursing practice as they are used in administering fluids, blood products, medications and chemotherapy. Connectors can also cause patient problems due to blood backup into the connector causing partial or complete occlusions and/or catheter related bloodstream infections (CRBSIs). We have developed a basic chart related to 3 major types of connectors (positive, negative, neutral pressures) used in the clinical setting and staffing nursing maintenance guidelines based on the literature that proper disconnect care may decrease or avoid occlusions and CRBSIs. By using different types of connector, we can make sure there are different types of connectors and 30% believed the maintenance was the same for all types. The guides are available for use from the authors.

Evaluation: The nursing staff and intravenous teams of local hospitals found the guide easy to use and effective in implementing bedside care. The guide can be posted on medication carts, in medication rooms, in IV supply areas and in community and home health bags. The type of connector(s) used can be highlighted on the guide so the maintenance care during disconnect is easily identified for specific institutions or nursing units.

Discussion

The maintenance of multiple manufacturer connectors should be based on guidelines that are connector technology specific. Involvement of the end user, staff nurses, is imperative to optimal cancer patient care. This small intervention may be a major step in decreasing infections and occlusions in oncology patients requiring intravenous and vascular access.

Connector Maintenance IV/Vascular Access

Purpose

The goal was to develop a basic maintenance care guide on disconnection for cancer nurses who use connectors in patient care. The setting can be in-patient, out-patient, or community care. The avenue of connector use can be intravenous or vascular access. Oncology nurses utilize connectors multiple times, every day, on each patient and need to base their care related to disconnection on the type of connector used. Interventions: A pocket guide was developed based on previous research that revealed 78% of staff nurses did not know there were different types of connectors and 30% believed the maintenance was the same for all types.

Methods

We collect and review issues regarding to patients’ oral management prior to their head and neck radiotherapy in our hospital’s dental department. The gathered information is to be analyzed, and then is used to set up as a protocol for our dentists and dental hygienists.

Results

Our recommendation correlates with the study done by Regezi et al (1976). From the study, 49 patients received dental extractions at least 10 to 14 days before receiving radiotherapy. The result showed that only one case of ORN was observed among 311 extractions performed. When comparing the time intervals before radiotherapy with other more recent studies, this study appears to have the shortest time interval before radiotherapy. Upon patients’ first dental appointment, we will assess the overall dental health status. The teeth with non-restorable or with poor prognosis will be extracted in time. At this time, we then take the impression for making individual fluoride tray for each patient. Next appointment, the task of dental department is to teach each patient how to use fluoride tray with fluoride gel (AF, 1.23% Fluoride ion) in the home setting. We will suggest mouthwash (povidone iodine gargle solution) for them in order to prevent candida infection. Finally, we need to give instructions to patients on maintaining a good oral hygiene, check on new dental caries, and if there is any oral infection.

Conclusion

Thorough oral management and treatment should be done prior to radiotherapy and ongoing assessments are also required even after radiotherapy. Any teeth extractions and surgeries should be performed, at least 10−14 days before initiating radiotherapy, in order to reduce the risk of ORN. Dental caries can be prevented by fluoride supplement and frequent dental examinations.

The risk of oral infection can be reduced by good care of oral hygiene care and regular use of mouthwash. All the dental treatment should not interrupt and delay the radiotherapy treatment. The dental evaluation must be done, and preferably as soon as possible, prior to the scheduled radiotherapy.
P-18 
QUALITY WIG SERVICES FOR CANCER PATIENTS - IT ALL DEPENDS ON COMMISSIONING AND CUSTOMISING! 
Ann Fox, B.Sc (Hons) Nursing, M.A. Advancing Practice, North of England Cancer Network, Gateshead, United Kingdom.

It had become evident through patient feedback that there were huge differences surrounding the quality of wigs and level of services provided. Now however, patients who are living with cancer in the North of England are able to access free personalised high quality wigs from local hair salons thanks to a new initiative. They are able to choose their own wig from a number of participating salons and have their wig customised, which will be paid for by the local NHS as part of the patients treatment.

The service has been launched by the North of England Cancer Network (NECN) in collaboration with the Northern Orthotic Contracting Board (NOCB), who represents the orthotic services provided throughout the North East of England, and Procurement North East (PRO-NE).

Trevor Sorbie (MBE), celebrity hairdresser and founder of the My New Hair (UK Charity) which inspired the new North East project – met with the team and used criteria to score the quality of wigs which will be provided. The patients themselves also carried out their own assessments of potential salons who tendered to provide the service. Many of the North East hairdressers offering the wig service through the NECN have been trained by Trevor, through My New Hair.

The NECN Patient and Carer Group have carried out research into what services are currently available and how they can be improved locally and nationally. The NECN and Carers Network have achieved a collaborative patient focused procurement process. From the beginning, patients and carers have been a central part of the process and have reviewed each step for quality of product, service and the patient experience.

Since the launch of this service in the North of England a national NHS Toolkit for England has been developed and launched to ensure that any person affected by cancer should have the same level of service regardless of where they live in England. This procurement and commissioning project with patients central to every step of the process will improve the quality of wig provision for thousands of patients in the North of England and tens of thousands of patients across England.

Due to the training of hairdressers in customising wigs led by Trevor Sorbie and My New Hair charity the costs of the service have not increased as expensive real hair wigs are not necessary, monofilament wigs once customised provide and excellent ‘new hair’ feel for patients and therefore improving patient experience and treating an increasing number of patients. It has led to less specification of service and improved patient experience within existing resources.

NB This presentation if accepted could include a live demonstration from Trevor Sorbie to show the difference customising a wig can make.

P-19 
A COST EFFECTIVE COMPREHENSIVE EDUCATION PROGRAM FOR ONCOLOGY NURSES 
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Emory Healthcare, Atlanta, GA, USA.

Continuing Nursing Education is viewed as a important way of providing information about evidence based nursing interventions. Many state regulatory agencies and professional organizations require the successful completion of continuing education programs for licensing, professional credentialing and for nursing certifications.

The cost of providing funds for staff to attend off-site continuing education programs has risen significantly over the past few years just as the funds for sponsorship of these endeavors began to diminish. The average cost of a 2–3 day off site seminar is approximately $1200 per person.

The Emory Winship Cancer Institute (WCI) is located on the campus of Emory University in Atlanta, Georgia. We have approximately 200 registered nurses working in our outpatient clinics and on our inpatient units. We also about 30 advanced practice providers (nurse practitioners and physician assistants). 35% of these nurses are certified oncology nurses. If we were to provide hands on advanced practice providers (who conduct workshops and give these programs) an excellent opportunity for professional development and for improving their public speaking skills.

A Nursing Journal Club, an Oncology Nurse Residency Program, and a Cemo-Biotherapy Certification Course are ongoing. These programs offer continuing nursing education to Emory staff free of charge. Through the coordination of all nursing education under the WCI Nursing Leadership team we are able to offer cost effective alternatives for the provision of continuing education programs for staff and offer staff an opportunity for professional development.

P-20 
PREVENTION AND TREATMENT OF ORAL MUCOSITIS 
Isabelle P. Gomes, Master1, Flavia M. Gondim, Specialist2, Flavia Firmino, Master2, Paula E. D. Reis, Doctor3, Jean E L. Pereira, Specialist3, Jael R. S. Franca, Master1, UFPR, João Pessoa, Brazil, UNCA, Rio de Janeiro, Brazil, UNIRIO, Rio de Janeiro, Brazil, UNEFURB, Brasilia, Brazil, Napoleão Laureano Hospital, João Pessoa, Brazil.

Oral Mucositis is undesirable effect that stands out after the therapeutic antineoplastic. This work aimed identified evidences on actions of prevention and treatment for oral mucositis induced by chemotherapy and / or radiotherapy. The most effective treatment is the lasing of low power (23%) and chlorhexidine gluconate 0,12% (20%). Mucositis requires active participation of nurses in the pre-treatment, preventing and preparing the patient through an individualized approach based on evidences.

P-21 
DEVELOPING QUALITY - CHALLENGES AND OPPORTUNITIES - ADDRESSING THE ISSUE OF QUALITY IN ONE CANCER INSTITUTE IN A LOW-RESOURCE COUNTRY 
Virginia A. Cumley.
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This presentation will describe the challenges and opportunities faced in developing Quality Standards in the Nursing Division. Shaukat Khanum Memorial Cancer Hospital & Research Centre is a state-of-the-art cancer institute. Nursing Quality Assurance developed in tandem with the development of ISO 9001: 2000 and certification was achieved in December 2001. Early in 2002 it was recognized that in order for Nursing Quality Assurance to develop within the Nursing Division a Clinical Nurse Manager for Nursing Quality Assurance was required. A suitable person was recruited and sent to the Royal Marsden Hospital, London to study alongside personnel in the Quality Assurance Department. Throughout 2003 – 2007 many initiatives in Nursing Quality Assurance were developed and Internal and External Audits took place. The Nursing Division achieved the annual re-certification each year. A Gap Analysis tool was utilized to identify weak and problematic areas and in subsequently preparing the ground work for JCA (Joint Commission International Accreditation) Preparation has continues over the past 2 years. A Nursing Quality Assurance Framework was developed which includes Nursing Risk Management, Audit, Standards and Clinical Indicators.

The challenges have been numerous and the workload great. There is no price tag on quality – ultimately a “climate of quality” has to be developed – continual improvement is the only road.

Rachel Melia.

P-22 
DISTRESS IN CANCER PATIENTS 
Kathey R. Huey1, Lynn R. Marzinsky, RN, MSN, AOCN1, Lynne Connelly, PhD, RN2.
1. University of Kansas Cancer Center, Westwood, KS, USA, 2.University of Kansas School of Nursing, Kansas City, KS, USA.

The National Comprehensive Cancer Network has found that distress is a growing concern with this population of patients and has developed guidelines regarding distress. The goal of this retrospective descriptive correlation
P-24

COM Passion Fatigue: Can Oncology Nurses Live Happily Ever After?
Jennie Kenderski, RN, BSN.
The James Cancer Hospital & Solove Research Institute, Columbus, OH, USA.

The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet. -Naomi Remen, 1986.

We grow up listening, reading, and watching movies about princesses and princes who have fairy godmothers and live happily ever after. Is this ideal something nurses can aspire to while continuing to care and have compassion for others. Unfortunately there has been little emphasis on the potential health consequences for nurses providing care but there is some research that is assessing nurse characteristics that may help to predict the risk for developing compassion fatigue. The goal for treating nurses recovering from compassion fatigue are: increasing your self awareness about what is going on in your life, identifying what you can change, developing a self care plan and deciding to fully continuing to care and have compassion for others.

P-25

THE NURSING EXPERIENCE FOR A PATIENT OF REPRODUCTION CELL CANCER IN ADOLESCENCE
Chou-Shu Lan, RN, Chen-Pei Jang, RN.
Taiwan Lin Kuou Chang Gung Memorial Hospital, Taiwa n Lin Kuou, Taiwan.

The article investigates how an 18-year-old male with germ cell tumor adapted to physiological discomfort, separation from peers, disruption to his studies, and treatment process during admission. During the nursing care period from 26th February to 26th March 2007, the author used the Roy Adaptation Model of Nursing to evaluate his health problems through interviews, observation and physical assessment. From the objective and subjective information, the author understood the stresses the patient faced during admission, and confirmed that his nursing problems included ineffective breathing pattern, change in role and function, social isolation, etc. The author mobilized the medical team to relieve the patient’s respiratory difficulty, integrated related resources from his school and the social work department, used empathy and communication skills to guide the patient to voice his thoughts and feelings, readjusted his expectations toward the role of a student, encouraged him to actively interact with others, and continuously provided psychological support and encouragement. Through fully developing the roles of nurses as carers, nursing instructors and counselors, the author assisted the patient in coping with the stresses from his illness and adolescent development, while at the same time, learnt about the effects of cancer on the psychosocial development of teenage patients. The author hopes to share her experiences with her nursing colleagues and improve the quality of nursing care.

P-26

THE TIMING OF DENTAL CONSULTATION IN HEAD AND NECK RADIATED PATIENT
Jia-Lin Li, Dr.
Changhua Christian Hospital, Changhua, Taiwan.

Purpose of the study
Radiotherapy can increase cure rates, but the patient accepted the radiotherapy in head and neck is unavoidable to the complications that include mucositis, loss of taste, microvascular alterations and xerostomia. Dental caries and osteoradionecrosis(ORN) which were resulted from alterations in the salivary gland & dental structure and extraction respectively can be avoided. Fluoride application can prevent dental caries before and after radiotherapy. Because of the most severe example of sequela is ORN, this abstract will discuss the timing of the dental treatment relative to ORN for radiated patient, especially dental extraction.

Methods
We collect and review topics regarding to dental extractions and irradiated patients from 1980 to 2003.

Results
According to the literatures, the results regarding to extraction prior or posterior radiotherapy related to the rates of ORN are conflicting. Most papers showed higher rates of ORN when extraction performed after radiotherapy.Ho- riot et al (1981) demonstrated 0% and 4.5% ORN rates in non–radiated area and radiated area respectively, and Epstein et al (1987) obtained 5.4% and 7.1% ORN rates respectively. Thron et al (2000) obtained 45% ORN rates to extractions after radiotherapy and 10% to extractions before radiotherapy; and Renther et al (2003) observed 24% and 26% ORN rates, respectively. Renther et al (2003) observed 24% and 26% ORN rates, respectively. Regarding to the time interval between exodontias and the beginning of radiotherapy, Renther et al (1976) demonstrated 0% and 4.5% ORN rates in 313 extractions performed after radiotherapy and 49 patients at the interval 10 to 14 days before radiotherapy. Other paper showed a longer time interval between extraction and the beginning of radio-

P-23

PAIN, SLEEP, AND FUNCTIONAL STATUS IN MINORITY CANCER PATIENTS.
Robert Kaplow, RN, Ph.D.
Emory University Hospital, Atlanta, GA, USA.

Purpose/Objectives
To describe the nature and extent of pain and sleep disturbances in minority patients with cancer. The influence of socioeconomic status (SES) in terms of pain intensity, pain interference, overall sleep quality, and daytime sleepiness; to describe the relationships among pain intensity, pain interference, sleep quality, and daytime sleepiness; and to examine the influence of pain intensity and interference, sleep disturbance and daytime sleepiness, and their interactions on functional status.

Design
Descriptive and correlational.

Sample
74 patients of ethnic minority with lower SES who were undergoing outpatient cancer treatment and were at least one week status post hospital discharge.

Methods
While waiting for an appointment, patients completed a demographic form and four questionnaires: the Pittsburgh Sleep Quality Index, Epworth Sleepiness Scale, Brief Pain Inventory, and Functional Status Questionnaire.

Main Research Variables: Pain, sleep, and functional status
Findings: There was a moderate correlation between pain intensity and pain interference. In addition, the data revealed a weak correlation between sleep quality and pain intensity and a weak correlation between sleep quality and pain interference.

Conclusions
Pain and sleep difficulties interfered with social function. Pain interfered with physical, psychological, and social function. Sleep interfered with social function and ability to perform intermediate ADLs.

Implications for Nursing
The importance of assessing for sleep disturbances in patients with cancer needs to be emphasized. Questions about sleep should be added to all patient assessments. Healthcare providers ought to encourage nurses and other healthcare workers to ascertain the effects of distress in cancer patients receiving treatment or follow-up. The findings may lead to ideas for further research to include interventions to improve overall outcomes for this population of patients.

I believe that nurses are able to live happily ever after while working in such an environment. Will nurses be able to tolerate the demands of the job while continuing to care for their patients or will they face exhaustion, decreased empathy, cynicism, and loss of enjoyment, which can eventually turn to depression, secondary traumatic stress and stress-related illnesses? The goal for treating nurses recovering from compassion fatigue are: increasing your self awareness about what is going on in your life, identifying what you can change, developing a self care plan and deciding to fully continuing to care and have compassion for others. Is this ideal a real one? We grow up listening, reading, and watching movies about princesses and princes who have fairy godmothers and live happily ever after. Is this ideal something nurses can aspire to while continuing to care and have compassion for others.
therapy, and the ORN rates are all below 5%. Beumer et al(1983) showed one case of ORN in 62 patients in the median of 25.3 days; Epstein et al (1987) showed 5 cases of ORN in 52 patients in the median of 26 days; Sulaiman et al(2003) showed 2.6% in the median of 26.2 days.

Conclusion

Patients who have hand and neck cancer and are considering treat by radiotherapy should undergo a proper dental evaluation prior to their radiation therapy. It is preferred to extract teeth which are non-restorable or questionable prognosis before radiotherapy. Therefore, nursing of radiated patients in head and neck cancer should include consultation of dental care team.

P-27  CLINICAL INDICATOR: REDESIGN OF THE CANCER PATIENT SATISFACTION INSTRUMENT

Tsai Li Yuan, Chen Shin-Chia, Liu Ching-Ping, Li In-Fun. Mackay Memorial Hospital, Taipei, Taiwan.

Abstract

The aims of this present study were to develop and test an instrument for measuring cancer patients’ satisfaction of the nursing services. The study was divided into two phases, developing the instrument and testing validity and reliability. In phase one, the tool established according to literature review contains three sections: structure, process and outcome. These sections were in turn categorized to six domains which were physical environment, technical skill, availability, caring, explanation, continuity of care, and overall quality, totally 25 questions. Six experts reviewed the instrument for the content validity and the CVI were 0.70. In phase two, the instrument then applied to 264 cancer hospitalized patients. The principal components analysis with equamax rotation tested the content validity. Two extracting components were named as “general service”, and “guidance and continuity of care”. The cumulative percent of variance of 2 factors was 63.56%. The internal consistency reliability and split half reliability was accepted as Cronbach’s alpha value 0.957 and Spearman-Brown reliability 0.94. The results showed that the instrument had a satisfactory internal validity and reliability.

Keywords

Quality indicator, cancer, patient satisfaction.

P-28  ONCOLOGY RISKS CLASSIFICATION FUNDAMENTED ON THE NORTH AMERICAN NURSING DIAGNOSIS ASSOCIATION (NANDA) AND NURSING INTERVENTIONS CLASSIFICATION (NIC) TAXONOMY


The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) aims to increase the quality of healthcare preventing the risks for the security of patients. This work describes the process of identifying and classifying low risks related to oncological patients to the construction of an intervention plan. The work was developed by a team of a oncological reference hospital in Brazil. The first stage consisted of characterizing the risk from the nursing, psychology, physiotherapy, social work, pharmacy and medicine teams perspective. We classified two types of risk: the potential and the installed, and we grouped and categorized the risks. The NANDA taxonomy was used as a reference for denominating the risks, and the NIC taxonomy was also used, but for the intervention plan proposition. The following potential risks were characterized: infection risk related to immunosuppression due to antineoplastic therapy; acute confusion risk due to neurological changes, drug addiction, obstinence from psychoactive substances and psychotic symptoms; social isolation risk related to a not established residence (homless people), living in distant city and/or unstructured family; the use of potentially dangerous and highly monitored drugs risk when it comes to prescribing, preparing and administrating them; modified respiratory function risk related to excessive thick secretions, immobility, sedative drugs effect, pain, fear and anxiety; dysfunctional ventilatory weaning response risk in the hospital ward related to muscle weakness and fatigue, poorly controlled pain and/or patient’s poor knowledge of the weaning process; thromboembolic disorders risk related to neoplastic disease; bleeding risk related to antineoplastic chemotherapy, impaired skin integrity related to antineoplastic therapy; nutritional risk related to significant or severe history of body weight loss, reduction and change in food intake and the presence of factors which are able to affect the nutritional status in a negative way, and the suicide risk related to hopelessness, terminal illness,abandonment, loneliness, family rifts and loosing significant people ties. The identified installed risks were: No civil documentation, medullary compression syndrome, hemoediasis, infection, presence of co-morbidities; presence of catheter for enteral nutrition, parenteral therapies, and patients in context of malnutrition. Through the multidisciplinary work it was possible to verify the theoretical consistence and practice of nursing taxonomies expanding its use to other fields of knowledge and contributing to the consolidation of scientificity and social recognition of the profession.

P-29  IMPLEMENTING A PRACTICE DEVELOPMENT AND RESEARCH UNIT IN A REGIONAL CANCER CENTRE

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The Practice Development and Research Unit (PDRU) is an initiative that encourages and promotes evidence-based practice amongst all ward staff across all grades. The inpatient Radiotherapy ward is currently the pilot site for the Trust’s PDRU. The aim of the PDRU is to develop and implement projects which make a positive improvement to patient care and professional practice. Staff take ownership of good ideas and are instrumental in taking them forward and patients benefit from care based on a culture of excellence in practice where patients needs guide the process of care. The PDRU has been approved by both the local University board and the Trust respectively and the pilot phase began in June 2008. Staff will benefit from the PDRU as their working environment embraces innovative ideas and they feel empowered to make a difference. Staff are rewarded by seeing the positive impact their ideas and changes can make both in their own working practice and in meeting the needs of their patients. Clearly this promotes job satisfaction and encourages staff to want to work in this environment.

The PDRU is based upon the theoretical principles of how people learn and how people learn best, for example, through supportive environments and opportunities to advance, achieve and assume responsibility. A toolkit was developed and is based around three theories of learning (Benners’ Novice to Expert, Maslow’s Hierarchy of Needs and Herzberg’s Motivators & Hygiene factors). This toolkit can be accessed on line by staff. To improve awareness of the PDRU an area of the ward was set up with an information board. This depicts projects from start to finish and progress along the way. Staff decided on a visually effective theme of frogs jumping across a series of lily pads. A number of project proposals were submitted from ward staff. Three projects were selected for the pilot. Team leaders were allocated and documentation completed by each team to discuss proposed projects.
P-32 INTEGRATING EVIDENCE-BASED CLINICAL EDUCATION WITH THE LEADERSHIP TOOLS NEEDED TO BRING ABOUT CHANGES IN PRACTICE
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Globally, oncology nurses play an integral role in the transformation of cancer care, and recent advancements made in oncology indicate that leadership training is essential to implementing changes in practice. With this knowledge and evidence, an important component of a professional cancer nursing organization's global involvement has been to develop collaborative programs that integrate leadership development with clinical education to support and advance educational, professional, and research endeavors internationally.

In December 2007, this organization partnered with another professional cancer nursing organization and a consortium of Middle Eastern countries’ cancer centers to develop a leadership course for nurses from five Middle Eastern countries. Topics such as value identification, practices of exemplary leadership, effective communication, and patient advocacy equipped the participants to implement individually proposed projects that focused on improving healthcare in their regions.

The partnerships started June 2008 and continued with the initiative by combining clinical and leadership content to prepare nurses to advocate for their patients and transform their country’s healthcare. The collaborative conference on symptom management focused on implementing evidence-based interventions to manage cancer symptoms and the side effects of cancer treatments. However, in order to enact the necessary changes to improve patient care, the participants had to first be equipped to act as change agents within their institutions and community. Integral to the effectiveness of the ongoing discussion is the beginning discussion on strategic leadership and patient advocacy, which was personalized through the final projects that the participants developed as take-away implementation plans.

In a region of the world where “leadership development” is not a common practice and open discussion among the represented countries is not always a comfortable endeavor, the delegates worked together in both programs, developing their values, priorities, and self-awareness, and identifying their common challenges. Post-conference reports from participants showed tangible ways that participants influenced change in their respective institutions and regions. Ultimately, their efforts will lead to measureable improvements in patient care and education, community service, and clinical research.

P-33 DECISION AIDS FOR SURGICAL TREATMENT OF EARLY STAGE BREAST CANCER: SYSTEMATIC REVIEW OF THE EVIDENCE
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Purpose
To examine the state-of-the-science related to decision aids for women who are actually facing surgical treatment of early stage breast cancer.

Methods
Critical review, based on the literature published between 1998 and 2009 that report on studies designed to evaluate decision aids for women who are facing surgical treatment of early stage breast cancer. MEDLINE, CINAHL, EMBASE, Cochrane Database of Systematic Reviews, Google scholar, Psychinfo, PubMed and National Cancer Institute (NCI) databases were searched. The Quality Health Outcomes Model (QHOM) was used as the framework for reviewing the literature.

Results
Eleven reports of eight unique studies were included. Final treatment decision, patient’s knowledge of treatment options, patient’s anxiety and decisional conflict, and patient’s satisfaction and quality of life were the most frequently measured outcomes. Studies varied in design, measures used to assess effectiveness, format of the aids, patients’ populations and clinical settings, and have yielded mixed results.

Conclusion
There were mixed findings of the studies, however, there is some support for the use of decision aids with women diagnosed with early stage breast cancer. Implementation strategies that utilize clinical practice tools that require practitioners aware of and skilled in using them, environmental structures that support their use and access to the interventions. It is important that future studies of decision aids include both proximal and distal outcomes, compare effectiveness of different formats of the aids and evaluate their effectiveness when used as adjunct to patient’s counseling and coaching in the decision process.

P-34 TRAINING EXPERIENCE FOR RESEARCH IN THE CLASSROOM
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This paper is based on research by teaching in the classroom to develop an investigative attitude in students to specialize in oncology nursing, for optimizing nursing care of cancer patients through the construction and appropriation of knowledge from their clinical practice. The teacher is a researcher who uses the guidelines of action research to motivate students to transform the care of oncology nursing, improve and ensure the best possible quality of life for patients with cancer.

Specific objectives proposed were: Motivate students to research to nursing from unresolved issues to transform the care of oncology nursing, and facilitate interaction with others. Specific cancer conditions related to the presence of foul smell were identified: gynecological tumors, lung—infected tumors, some head and neck as nasopharyngeal cancer, halitosis by tongue cancer...
cer, tumors exophytic, infected, necrotic and ulcerated, and mucositis sec-
ondary to the administration of chemotherapy. Problems with the bad smell
were identified as changes in body image, altered self-concept or low self-
estee, social isolation, depression, hopelessness and ineffective individual
coping.
A recommendation is to conduct research studies on the impact of the odor
car caused by some tumors in the patient and those around him, and about use-
ful strategies for solving the problem because eliminating or reducing the
odor provides comfort to the patient.

P-35
EFFECTS OF PAIN EDUCATION WITH EXERCISE TRAINING ON CANCER PATIENTS’ PAIN AND FATIGUE EXPERIENCE
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Since 1982, cancer has been the leading cause of death in Taiwan. Pain recognized as one of the most severe problems for these patients. Pain was experienced by 30.9–85% of cancer patients in Taiwan. These findings suggest that cancer pain has not yet been controlled in Taiwan, and we need to find a method to alleviate cancer patients’ pain.

The purpose of this quasi–experimental pilot study was to assess the effects of pain education with exercise training on patients with cancer pain. Patients were recruited from an inpatient medical oncology ward at a medical center in Taipei. Eligible patients were cancer patients who (1) were adults (>18 years of age), (2) were aware of their cancer diagnosis, (3) had cancer related pain during the 2-week study period, (4) could communicate verbally, and (5) agreed to participate in the study. Patients who had surgery during the 2-week study period were excluded from the study because of the different characteristics of surgical and cancer pain. A quasi–experimental design with pre- and post-test was used for this study. The total participants were 20. Participants were randomly assigned to two groups: including(1) 15 minutes of education followed by 15 min-
utes exercise training for 3 consecutive days (Experimental group, n=10), and (2) those who received 30 minutes of care as usual ward routine (Control group, n=10). The Brief Pain Inventory Short Form – Taiwanese(BPI-T), Pain and Opioid Analgesic Beliefs Scale – Cancer (POABS-CA), Hospital Anxiety and Depression Scale–Taiwanese, and VAS were used to evaluate the effects of these interventions on pain intensity, pain interferences, mood status and fatigue.

The data were analyzed using descriptive statistics, t-test, and paired t-test. The results showed that (1) the worst and average pain intensity, pain inter-
ferring with sleep and general activity, and negative effect of pain belief were significantly reduced in patients receiving the pain education plus exercise training compared to the control group (p<0.05); (2) level of anxiety, depression and fatigue were significantly reduced in patients receiving pain education plus exercise training within experimental group (p<0.05). Our results suggest that pain education plus exercise training can effectively reduce cancer patients’ pain problem. Few participants included make results may not be generalized to all patients with pain due to the nature of pilot test.

P-36
COMPLEMENTARY THERAPIES TO CONSTIPATION IN PATIENTS WITH CANCER: A REVIEW
Paula Elaine Diniz dos Reis1, Thays Andreza Vale Fonseca Sacramento2. 1Universidade de Brasília (UnB), Brasília, Brazil, 2Hospital Alvorada, Brasilia, Brazil.

The constipation in cancer patients is one of the major disturbance caused by the progress of the illness and opioid treatments. This study aimed to identify which non-pharmacological interventions are being used in preven-
tion and treatment of intestinal constipation. A narrative literature review was made. Eight research article presents complementary therapies which were categorized by the themes: nutritional therapeutic, physical activity, natural complements and interventions – the utilization and efficacy of these kinds of therapeutic was discussed. The authors found few clinical re-
searches, suggesting the necessity of new clinical studies to test the real ef-
ficacy of these treatments and evidences of better ways to treat this population.

P-37
SEEKING PATIENT FEEDBACK: AN IMPORTANT DIMENSION OF QUALITY IN CANCER CARE
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A quality improvement study was conducted to measure ambulatory pa-
tients’ satisfaction with care and service delivery within a Cancer Care Centre. The sample consisted of 276 ambulatory patients with an almost equal rep-
resentation of men (n=136, 49.28%) and women (n=128, 46.38%). Average satisfaction on all survey items was high at 89.25% and the vast majority of patients selected that they would recommend the center to family and friends (98.71%). The areas of lowest satisfaction included the length of time of the wait experience as well as the ability to contact someone by telephone who could answer questions regarding a health problem. A trend between patient satisfaction and assignment of a nurse navigator was noted. Quality improvement initiatives will be designed to improve the quality and length of the wait time, and improve the availability of someone who could answer questions regarding a health problem by telephone.

P-38
INCIDENCE OF COMPLICATIONS ASSOCIATED WITH PERIPHERALLY INSERTED CENTRAL CATHETERS USING A NORMAL SALINE PROTOCOL TO MAINTAIN PATENCY
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Purpose
The purpose of this study was to measure the incidence of catheter occlusion with Peripherally Inserted Central Catheters (PICC) in medical/oncology patients.

Background
PICCs are routinely inserted to provide venous access for patients who require complex or prolonged intravenous therapy. Complications include infection, thrombosis, and venous stenosis. Occlusion is a significant prob-
lem that may result in delayed treatment or the need for catheter replace-
ment. The incidence of venous thrombosis has been estimated from 1–4% in studies relying on clinical signs and symptoms for diagnosis, and 38–40% in studies using venography for detection. Routine flushing with either heparin solution or saline is used to prevent clogging in the catheter. Multiple studies have compared the effectiveness of saline and heparin solutions as well as different flush volumes, with inconclusive results.

Methods
Data were collected on 40 patients who had a PICC inserted while admitted to the Medical/Oncology Unit. The protocol used to maintain catheters in-
cluded a twice daily flush with 10 ml of normal saline and a 20 ml saline flush after blood was drawn from the line or blood products were adminis-
tered. Nurses maintained a daily log to record the times a catheter was flushed, whether the catheter flushed easily, and the condition of the insertion site.

Results
Subjects were 70% female and ranged in age from 23 to 93, with a mean age of 59 years (± 20). Catheters were maintained on the unit for a range of 1–23 days, with a mean of 4.7 days (± 4.8). Only one subject had a problem with catheter patency. This occurred in one lumen of a double–lumen catheter and occurred on the 3rd day after the catheter was placed. Another subject experienced swelling distal to the insertion site, and two subjects experienced pain and swelling around the insertion site.

Conclusions
There was one catheter occlusion in this sample and it is not known whether the occlusion was due to venous thrombosis. The rate of occlusion was 2.5%, which is consistent with the rates of venous thrombosis reported in the liter-
ature. Normal saline is cheaper than heparin flush solutions and does not put the patient at risk for complications related to heparin administration. We conclude that our normal saline protocol for catheter flushing is adequate. Future research should focus on the methods used for site care and the incidence of infection or inflammation at the site.

P-39
FEBRILE NEUTROPENIC TRIAGE PROTOCOL AUDIT.
Kathlene Robson1, Colleen Kirkwood2. 1The Canberra Hospital, Garran ACT, Australia, 2The Canberra Hospital, Garran, ACT, Australia.

Aim
To evaluate and review evidence of the impact of a newly implemented febrile neutropenic protocol, based on time interval between a febrile neu-
 tropenic patient’s presentation to the Accident and Emergency department and receipt of initial antibiotic dose.
The 16th ICCN presents an exciting opportunity for us to globally show case to oncology health care professionals and researchers the invaluable contribution of the MBTB to ongoing breast cancer research. Plans are to highlight the role and functioning processes of the MBTB. In addition, we will be including information on research projects supported via MBTB and voluntary opportunities with tumour banking.

A poster presentation format will briefly capture the history, objectives, and goals (present and near future) of the MBTB. It is our hope that through a poster presentation the audience will have gained a better understanding of the role of MBTB in ongoing breast cancer research.

P-42
THE PURSUIT OF QUALITY
Marion Skipper, BSN, Patricia Marshall, MS, Roswell Park Cancer Institute, Buffalo, NY, USA.

Roswell Park Cancer Institute (RPCI) America’s first cancer center was founded in 1898 by Dr. Roswell Park and is designated as a “comprehensive cancer center”. In 2005, RPCI embarked upon its journey toward a comprehensive Electronic Medical Record (EMR) with its implementation commencing in May of 2006. RPCI is composed of a 100 bed in–patient hospital with a large out–patient population of approximately 700 visits daily. Currently there is a complete electronic medical record for the in–patient population with progress towards incorporation of the out patient services.

Evidence based medicine is essential in the development of good clinical practices and Hospital policies and procedures. Compliance with Hospital policies and procedures can be insured and standardized through the use of order sets and documentation. By structuring our electronic clinical documentation and orders sets to reflect our policies and procedures, and good clinical practices quality improvement (patient safety, excellent patient care) can be achieved.

Objectives
1. Use of information technology to provide the infrastructure to support the following of hospital policy and procedure.
2. Review the benefits of electronic documentation utilizing structured notes and flow sheets to heighten the compliance of the Hospital policies and procedures (i.e. legibility, accessibility, accuracy, privacy, reimbursement requirements, and compliance with National and State Regulations).

Methods
1. Continually reviewing Hospital policies and procedures within a multidisciplinary group and incorporating approved changes into the order sets, flow sheets, and clinical documentation to maintain consistent verbiage and structure. Incorporating the health care providers and service departments in the development of the order sets with a final review prior to activation in production.
2. With analytics and tracking staff has been alerted to potential infractions of Hospital policy.

Outcomes
Continued development and progress of a fully functional EMR in which incorporates Hospital policies and procedure into the management, coordination and documentation of care.

Program implementation has resulted in the following:
1. Order sets and documentation are constantly reviewed to reflect evidence based practice.
2. Increase ability to obtain financial reimbursement.
3. Enhanced communication and patient satisfaction.
4. The aim of the protocol was to aid in the identification and timely treatment of febrile neutropenic patients.

The Febrile neutropenic in cancer patients is a potentially life threatening complication. Prompt administration of antibiotics is necessary. An evidence based interdisciplinary protocol was developed and implemented to improve diagnosing and treating febrile neutropenia in the triage setting of the Accident and Emergency Department.

The aim of the protocol was to aid in the identification and timely treatment of febrile neutropenic patients. The Emergency Network Standard Operating Protocol (ACT Heath) is used in the Accident and Emergency Department. It uses preset guidelines to determine the patient’s category at presentation.

The triage medical staff can be guided by the febrile neutropenic protocol as to whether the patient is High/Low risk for febrile neutropenia and categorise them appropriately. The guided assessment outcome should result in the High Risk patient been treated within 10–30 minutes of presentation with intravenous antibiotics.

The audit will include 6 month pre–protocol implementation data and 6 month post protocol implementation data.

The audit was conducted to assess:
• The effects of the protocol and its impact on patient outcomes.
• Accident and Emergency medical staff can easily follow the protocol and whether it is easily achievable to routine practice and the streamlining of patient care.

Conclusion
The Febrile neutropenia data audit to provide evidence whether the protocol has had a positive impact on cancer patient outcome by easily guiding triage medical staff in categorising High/ Low risk cancer resulting in suitable treatment in an appropriate time frame.

P-40
EXTRAVASATION MENTORSHIP - TRAIN THE TRAINER PROGRAMME IN THE UNITED KINGDOM
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Northumbria University Hospitals NHS Trust, Carlisle & Whitehaven, United Kingdom.

The author was a member of the task force who produced the European Oncology Nursing Society (EONS) extravasation toolkit including management guidelines, and was also involved with the development of the United Kingdom Oncology Nursing Society (UKONS) bridged documents.

Following these documents she was a members of the multiprofessional group who provides a train the trainer extravasation program throughout the United Kingdom for key professional groups who provide a chemotherapy service within a variety of settings, including nurses, pharmacists and academics.

The interactive program was delivered to key clinical staff working within chemotherapy delivery services and provided an overview of extravasations in terms of pathophysiology, prevention and ways of minimising the risk, detection, treatment options and possible consequences, discussed patient case studies and published EONS guidelines, along with time for discussion and sharing experiences from clinical practice.

Evaluation by attendees was very positive, the attendees felt the program was very good/excellent and fully met their expectations and importantly they all agree to disseminate the information by delivering the sessions locally to their colleagues, which would raise their awareness and ultimately benefit patient care. Following the evaluation of the initial program a further program is currently being delivered.

Based on our experience in the United Kingdom this method of delivering education and presenting evidence based guidelines could be utilised in other countries to benefit both professionals providing the care and patients receiving the care.

These sessions are developed and delivered by members of UKONS and BOPA and are supported by an education grant provided by Topotarget.

P-41
MANITOBA BREAST TUMOUR BANK
Kendra-Ann J. Seenandan, BN, RN.
CancerCare Manitoba / Manitoba Institute of Cell Biology - Manitoba Tumour Bank, Winnipeg, MB, Canada.

The Manitoba Breast Tumour Bank (MBTB) is co-directed by Dr. Peter Watson and Dr. Leigh Murphy. The bank has supported bench research in the areas of breast health and breast cancer locally, nationally, and internationally since its inception in 1993. Most recently the bank has expanded to include Chronic Lymphocytic Leukemia, Head & Neck, Lung and Prostate.

The MBTB continues to grow in size as it provides samples and information to over 700 researchers and healthcare professionals in 12 countries to benefit both professionals providing the care and patients receiving the care.

The bank has supported bench research in the areas of breast health and breast cancer locally, nationally, and internationally since its inception in 1993. Most recently the bank has expanded to include Chronic Lymphocytic Leukemia, Head & Neck, Lung and Prostate.

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and who were attending the oncology out-patient clinic of that hospital during the period of data collection. Of the 477 eligible participants approached, 372 had been completed the questionnaire, giving a response rate of 78%.

Measurements: A self-administered survey consists of 4 parts was used: (a) the demographic data; (b) Sources of information; (c) Information Needs Questionnaire (INQ)–Chinese version; (d) Patient’s satisfactory level with information provided by health care professionals.

Results
The top three priorities were information about the likelihood of cure, information about how advanced the disease was and how far it had spread, and information about the different types of treatments. The majority obtained information from healthcare professionals, physician and nurses (≥ 90%) in particular. The three mostly satisfied information sources by rank were: nurses in wards/clinics, general practitioners and support groups.

Conclusion
Results of the study provided useful information about what the patients really want to know. This can be a basis for developing more effective models to deliver information and support breast cancer women. Identification of the actual needs for this patient population can enhance better resources allocation and provide health services more efficiently to meet those needs.

P-44
SUBCONSCIOUS AWARENESS OF POSITIONING CHANGE FOR PATIENTS IN A TERMINAL STAGE
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Objective
Many patients with cancer in the terminal stage have self-care deficiencies in various situations for lack of movements they had in their healthy conditions. We do not have a clear rule about how much we should move patients in the terminal stage. It is not clear about real clinical situations. The aim of this study is to make it clear about real care situations of positioning change for patients in a terminal stage. Besides we will clarify what is subconscious awareness for medical staffs to positioning change for patients in a terminal stage.

Method
Under ethical informed consent, 127 medical staffs filled out a questionnaire. Answer meant an agreement to this study. Each questionnaire was collected by boxes. The questionnaire was made by researchers based on research papers and a small pilot study. The questionnaire had 12 questions about a job, age, institute, positioning changes’ aim and time and reasons. Besides the questionnaire has medical staffs’ awareness about mattress and positioning change.

Results
Respondents were 76.4% nurses and 5.5% care givers. 19.7% were 20’s, 33.9% were 30’s, 24.4% were 40’s, 18.1% were 50’s, 1.6% were 60’s. Main aim to do positioning change were prevention of a pressure ulcer in 66.1%, prevention of a mental complication in 3.9%, prevention of a contracture in 19.7%, 68.5% answered that usual positioning change interval was each 2 hours. 11.8% were 3 hours. 43.3% answered that the reason of care came from a basic education at school. 10.3% believed that they will be able to do less positioning changes for patients using air mattress. 16.6% believed that it is better for patients in a terminal stage to extend positioning change interval. Their top priority was to give patients comfort. 11.8% answered that the maximum interval of positioning change was nothing in day time.

Discussion
Many medical staff’s interest about the bed sore prevention is high. They keep knowledge from the basic nursing education. Their top priority was comfort for patients in the end period. It is not clear about the relationship between positioning change interval and comfort. However medical staffs may have subconscious awareness that movement is not comfort.

Conclusion
Medical staffs have various subconscious awareness to positioning change. Their top priority was comfort and prevent to pressure ulcers. Parts of medical staffs have subconscious awareness that frequent movements are not comfort for them and air mattress is useful for less positioning change. The parts of them did not do positioning change for patients in a terminal stage.

P-45
ASSOCIATION BETWEEN ADVERSE EVENTS AND ADHERENCE OF PATIENTS WITH GASTRIC CANCER WHO UNDERWENT GASTRECTOMY AND ADJUVANT CHEMOTHERAPY WITH AN ORAL FLUOROPYRIMIDINE.
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Background
Patients with gastric cancer undergo gastrectomy and minimally 1-year ad-juvant chemotherapy with an oral fluoropyrimidine, S-1. Such patients may frequently experience gastric symptoms after surgery and severe adverse events from S-1, resulting in approximately 35% withdrawal rate.

Purpose
This study aimed at identifying predictors and correlates of self-reported adherence and burdensome feeling of patients with gastric cancer under-going postoperative adjuvant chemotherapy with S-1.

Methods
Patients at a metropolitan general hospital in Japan were invited for partici-pation if they were diagnosed as having gastric cancer and underwent gas-trectomy with D1 or D2 lymph–node dissection followed by adjuvant therapy with S-1. The participating patients were interviewed to respond to a ques-tionnaire, including authors–developed 25–item self-report adherence and the 14–item hospital anxiety and depression scale (HADS). Demographic and laboratory data were collected through chart reviews. Eight–item adverse events and grades were identified via interview and validated via chart as defined by the Common Toxicity Criteria of the National Cancer Institute. Statistical analyses including multiple regressions were performed via SPSS.

The study hospital’s IRB approval and patients’ written consent were ob-tained before the data collection.

Results
A total of 35 patients (mean age=66.9, SD=11.8, 28 males and 7 females) participated the study. The length of adjuvant therapy was about 1 year (mean=10.2 months, SD=6.1 months). They experienced moderate levels of depressive symptoms and anxiety (mean HADS=7.6, SD=6.2). Adverse events of grades 2 or 3 were common, including fatigue (27%), stomatitis (27%), diarrhea (22%), nausea (15%) and anorexia (11%). Their self-reported “burden” (a composite score of Likert-type scales of “have always make sure to take S-1,” “keep a written record to take S-1,” and “take S-1 exactly as prescribed”) was significantly predicted only by their older age (R-square=.528, p<.001). The degree of patients’ “burdensome feeling about taking S-1 regularly” was significantly predicted by their younger age (beta=-.423, p<.001), a higher composite score of adverse events (beta=.531, p<.001), and a higher score of HADS (beta=.251, p=.049) (Adjusted R-square=.575).

Implications
Symptoms of adverse events, depressive symptoms, and anxiety may increase patients’ burdensome feeling to adjuvant therapy, depending on their age. Nursing intervention should target identifying such patients’ needs to provide necessary support in outpatient setting and to individualize their sense of symptom control and better quality of life to continue long–term treatment.

P-46
MINIMUM DISCARD VOLUME TO AVOID FLUSH CONTAMINATION WITH CENTRAL VENOUS CATHETER BLOOD DRAWS
Sheri Wyant, RN-BC, MSN, OCNS1; Rachael Crickman, RN, MN, AOCNS2; 1University of Washington Medical Center Seattle, WA, USA, 2Virginia Mason Medical Center, Seattle, WA, USA.

Background
A major university medical center experienced a higher than expected rate of RN blood re-draws from central venous catheters (CVC). Discord method and vacutainer method of blood draw were preferred with exception; syringe method was used for PICC lines. A quality improvement project demonstrated a lack of standardization in discard volume (5-15 mL) and blood sampling technique. A review of the literature suggested that nursing research in adults is equivocal regarding volume of blood discard needed to avoid flush contamination. Oncology patients often require multiple blood draws to manage their conditions and frequently have central venous catheters from which specimens are obtained. Repetitive blood sampling may contribute to iatrogenic anemia.

Purpose: To determine within 3 mL increments the minimum discard volume to avoid flush contamination of blood samples drawn from CVCs. Cohorts evaluated: implanted ports (IP), tunneled lines (TL), and non-tunneled lines (NT).

Methods
An IRB approved repeated measures study with subjects as their own control during the period of data collection. Of the 477 eligible participants approached, 372 had been completed the questionnaire, giving a response rate of 78%.

Measurements: A self-administered survey consists of 4 parts was used: (a) the demographic data; (b) Sources of information; (c) Information Needs Questionnaire (INQ)–Chinese version; (d) Patient’s satisfactory level with information provided by health care professionals.

Results
The top three priorities were information about the likelihood of cure, information about how advanced the disease was and how far it had spread, and information about the different types of treatments. The majority obtained information from healthcare professionals, physician and nurses (≥ 90%) in particular. The three mostly satisfied information sources by rank were: nurses in wards/clinics, general practitioners and support groups.

Conclusion
Results of the study provided useful information about what the patients really want to know. This can be a basis for developing more effective models to deliver information and support breast cancer women. Identification of the actual needs for this patient population can enhance better resources allocation and provide health services more efficiently to meet those needs.
The purpose of this study was to develop a dissemination model for cancer treatment and nursing care for cancer patients. The dissemination model of the EBN guidelines in clinical practice will be developed based on the barriers and issues identified in this study.

**Result**

4.38 mg/dL, 2 points outside LOA. Clinical significance analysis (> 5% difference): IP: 6/33; TL: 2/30; NT = 95% LOA: -2.72 to 4.38 mg/dL, 2 points outside LOA. Clinical significance analysis (> 5% difference): IP: 6/33; TL: 2/30; NT = 1/30.

**Conclusion**

There were multifaceted and complex gaps between the EBN guidelines and clinical practice for cancer patients. These were the personal factor (knowledge, technique, recognition, attitude, and motivation), the interpersonal factor among the health care professionals (power balance, interpersonal relationship, expectation of other people and dependence on others) and organizational (culture and authority) dimensions. The evidence-based care guidelines assist with clinical decision making for nurses, promote cancer nursing knowledge base, and decrease interventions that have little effect in cancer treatment and nursing care for cancer patients. The dissemination model of the EBN guidelines in clinical practice will be developed based on the barriers and issues identified in this study.

**Purpose**

The aim of this study was to: (a) Identify the factors that influence customer’s satisfaction, (b) Determine role of leaders and managers to achieve customer’s satisfaction and (c) Discuss the importance of customer’s satisfaction for an organization.

**Method**

An integrated review of theoretical literature.

**Result**

A number of factors like quality standards, reasonable pricing, communication and behavior of service providers influence customer satisfaction. Leaders of an organization can imply several strategies to achieve customer satisfaction, like utilizing resources effectively, having customer service policy, maintaining quality standards and having system of evaluation and monitoring. Customer satisfaction plays an important role in the success of an organization. It increases customer intimacy, loyalty and retention and consequently has a positive effect on the profitability of the business.

**Conclusion**

A customer is the most important person for an organization, yet in many companies he is viewed as a nuisance. A customer is a person who brings us his wants. It is our job to handle them profitably to him and to ourselves. Customer satisfaction is the impression that a customer has of a product, service or physical asset. The recognition of determinants of customer satisfaction must be made an essential concern for management.

**Purpose**

To explore oncology nurses’ knowledge and practice behaviors in the assessment of chemotherapy-induced peripheral neuropathy (CIPN) using a new questionnaire.
Research Questions

What is oncology nurses’ knowledge specific to CIPN?
What are the practice behaviors and CIPN assessment skills of oncology nurses?
What is the reliability of the piloted questionnaire?

Significance: Detecting early symptoms of CIPN may prevent patient injury, minimize functional impairment, and alleviate patient anxiety during chemotherapy treatments. Neuropathic pain may be a consequence of CIPN but is seldom assessed as a unique component of the chemotherapy experience. Because neuropathic pain is often included under general pain assessment, evaluating oncology nurses’ knowledge and practice behaviors specific to the assessment of CIPN may provide groundwork for the development of feasible practice guidelines.

Design/Setting

Cross-sectional, exploratory study piloting a new questionnaire in two hospital-based outpatient chemotherapy infusion clinics

Sample/Methods: Convenience sample of 39 oncology nurses completed the piloted questionnaire that was developed by the principal investigator of this study. The tool consists of 16 knowledge, 11 practice behavior items, 10–item demographic survey and items relating to skills and previous CIPN instruction.

Outcome measures

CIPN knowledge measured as a percentage of correct responses; Assessment frequency and CIPN assessment practice behaviors measured by a 4–point Likert scale.

Internal consistency reliability evaluated using Cronbach’s coefficient alpha.
Results: Questionnaire scores indicated adequate nursing knowledge pertaining to CIPN (mean=12.6 out of total 16). Practice behavior responses revealed that nurses utilize basic assessment skills and practices more frequently than advanced objective skills. All of respondents indicated that CIPN assessment is essential in their oncology role but 75% rated their CIPN assessment skills as fair to poor. Although 82% believe that CIPN is a significant patient problem, 84.6% indicated no previous instruction in assessing CIPN. The calculated Cronbach’s alpha for the questionnaire is 0.84.

Practice Implications: Currently, no guidelines exist for nursing assessment of CIPN. Basic CIPN assessment skills and practices may be most appropriate and practical for oncology nurses. Efficient, practical CIPN nursing practice guidelines are needed to improve detection of functional changes that impact ADLs, to educate patients in recognizing signs/symptoms of CIPN, and to assist patients in developing adaptive mechanisms to promote safety. Future research utilizing the piloted questionnaire is essential in establishing reliability of the newly developed instrument.

P-51 NARRATIVE APPROACH FOR BREAST CANCER SURVIVORS RECEIVING OUTPATIENT CHEMOTHERAPY

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Objective

Cancer chemotherapy in Japan has shifted greatly from hospitalization-based to outpatient-based treatment due to the effects of medical policies such as comprehensive medicine and the outpatient chemotherapy point system. While the number of breast cancer survivors receiving long-term outpatient chemotherapy has increased, outpatient interventions that address their various concerns are clearly lacking. In the present study, we used a narrative approach to elucidate changes in the narratives of breast cancer survivors receiving outpatient chemotherapy (hereafter, “survivors”).

Methods

The present study was a practical nursing study that combined nursing practice with research, and used a qualitative and inductive design. After obtaining approval from the ethics review boards of the Nursing Department of University A and the cooperating facility, oral and written consent was obtained from the ethics review boards of the Nursing Department of University A and the cooperating facility, oral and written consent was obtained from the principal investigator of this study. All of respondents indicated that CIPN assessment is essential in their oncology role but 75% rated their CIPN assessment skills as fair to poor. Although 82% believe that CIPN is a significant patient problem, 84.6% indicated no previous instruction in assessing CIPN. The calculated Cronbach’s alpha for the questionnaire is 0.84.

Practice Implications: Currently, no guidelines exist for nursing assessment of CIPN. Basic CIPN assessment skills and practices may be most appropriate and practical for oncology nurses. Efficient, practical CIPN nursing practice guidelines are needed to improve detection of functional changes that impact ADLs, to educate patients in recognizing signs/symptoms of CIPN, and to assist patients in developing adaptive mechanisms to promote safety. Future research utilizing the piloted questionnaire is essential in establishing reliability of the newly developed instrument.

P-52 IMPLEMENTATION AND EVALUATION OF SUPPORT PROGRAMS FOR PREVENTION OF Lymphedema IN SURGICALLY TREATED BREAST CANCER PATIENTS

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1Gunma Cancer Center, Gunma, Japan, 2Gunma University School of Health Sciences, Gunma, Japan, 3Gunma Prefectural College of Health Sciences, Gunma, Japan.

Objectives

Psychological and educational intervention was provided to breast cancer patients for 6 months after surgery involving dissection of axillary lymph nodes, and the efficacy of this intervention in prevention of lymphedema was evaluated.

Methods

1) Subjects: Twenty patients who underwent the first operation for breast cancer (including axillary lymph node dissection). 2) Method of intervention: (1) Timing: 5 or 6 days after surgery and 2, 4 and 6 months after surgery. (2) Method: Home–made materials (leaflet, DVD, etc.) containing information about the necessity of self-care, methods and contraindications to self–lymph drainage (SLD), precautions in daily life, etc. were used for the intervention. (3) Evaluation: The preventive effect was evaluated by assessment of edema on a three–grade scale according to arm circumference laterality (the difference in arm circumference of between the baseline and the diseased limb): (1) 0.5 cm or less (edema palpable), (2) 0.6–1.0 cm and (3) 1.1 cm or over. 4) Ethics: Approval for the study was first obtained from the ethics committee of the medical facility managing each patient. Then, each candidate patient was informed as to the study design both in writing and orally, and their consents to participate in the study were obtained.

Results

Four patients (20%) were free of edema. Signs of edema were noted in 16 patients (80%). Self-awareness of edema was absent in 5 patients in whom arm circumference laterality was 0.5 cm or less but edema was palpable by the nurse. These 5 patients were instructed to touch the edematous area themselves to ascertain the state of edema. At the same time, these patients were instructed to self–confirm changes in the edematous area after drainage as compared to the pre–drainage state. In this way, SLD was implemented continuously and none of the 5 patients showed exacerbation of edema. In 7 patients (35%), arm circumference laterality between 0.6 and 1.0 cm was noted. All of these patients were aware of edema. Because these patients had experienced alleviation of symptoms following SLD, they practiced SLD whenever they felt ill. Thus, these patients noted the edema–reducing effect of SLD. As a result, exacerbation of symptoms was avoided.

Conclusion

Although continuous intervention was provided, beginning immediately after surgery, edema developed in 80% of our study group when early edema not perceivable by the patient was also counted as edema. This result suggests the importance of prophylactic intervention. The results of this study suggest that if nurses intervene in a continuous and supportive manner, allowing patients to experience edema–reducing effects, self–efficacy will be more strongly achieved through practicing self–care and such patients will continue receiving the care they need.

P-53 TO ENHANCE THE CORRECTING RATE OF OUTPATIENT’S COGNITION FOR CHEMOTHERAPY BY MULTIMEDIA NURSING GUIDE

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The purpose of this study is to enhance cancer patients on chemotherapy cognitive accuracy to enhance the home self–care ability. Clinical findings of out-patient cancer patients receiving long-term chemotherapy treatments. Neuropathic pain may be a consequence of CIPN but is seldom assessed as a unique component of the chemotherapy experience. Because neuropathic pain is often included under general pain assessment, evaluating oncology nurses’ knowledge and practice behaviors specific to the assessment of CIPN may provide groundwork for the development of feasible practice guidelines.
nursing education incomplete. Second, the patient areas: older, are illiterate, only to understand Taiwanese. Three, tools areas: health education in small monotonous card content design, fonts, small, less than the type; solution for one. Playback States Taiwanese nursing instruction multimedia CD–ROM 2. Borrow Taiwanese nursing teaching tape version 3. To provide health education plan Carpenter. To improve after the implementation of ad hoc, out-patient cancer patients on chemotherapy, the correct recognition rate up to 86%. So, the ad hoc implementation of cancer patients for home self-care ability has its benefits.

P-54 UPDATE OF THE BONE METASTASES PATIENT INFORMATION BOOKLET
Phyliz Goh, BSc, BScN(C), Margaret Fitch, RN, PhD, Edward Chow MBBS, Sunnybrook Odette Cancer Centre, Toronto, ON, Canada.

Purpose
To update an existing publication, Bone Metastases Patient Information Booklet (2004) so as to better meet the information and support needs of patients diagnosed with bone metastases (BM).

Methods & Materials: An on-line survey was created and distributed to health care professionals (HCPs) who treat patients with BM at hospitals and cancer centres throughout Canada. Patients were asked for their feedback about the content and format of the publication as well as the use of the book. Additionally, ideas were taken from reviewing other cancer patient information booklets currently being distributed to patients. Each chapter was revised and reviewed by an expert in the particular topics. Standards of patient education were followed in preparing the final version.

Results
Input from HCPs, patients, and other information sources were summarized and sorted to update and create the new BM Patient Information Booklet. The content includes facts about BM and the complications that may stem from metastatic spread. It also includes information on means of investigation; possible systemic treatments such as bisphosphonates, radiation, chemotherapy, surgery; and medications with their side effects and tips on how to control them. Complementary therapies, coping strategies, and community resources are just some of the other topics that have been updated in this booklet.

Conclusion: Through patients’ and health care professional’s input, we were able to update, publish and distribute the new updated BM Patient Information Booklet to centres across Canada and internationally that treat patients with BM. This new booklet will assist patients by helping them understand and better cope with their diagnosis.

P-55 INCREASING THE COMPLETENESS OF COLOSTOMY CARE TECHNIQUE BY PATIENTS AND CAREGIVERS
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Tri-Service General Hospital, Taipei, Taiwan.

Background
In Taiwan, colon cancer has become the third leading cause of cancer mortality in 2008. Evidence revealed that 50–60% of patients who received colostomy and their caregivers are not familiar with colostomy care after discharge due to lack for practice during hospitalization. Presentation contain: Patients who received colostomy and their main care givers were recruited in this project. As was stated above, 80% to 90% of patients and their caregivers were worried about taking care of colostomy after discharge! We found the completeness of colostomy care technique were 57.5% in patients and caregivers.

A Quality Control Circle (QCC) was conducted to improve the patients’ and caregivers’ ability of colostomy care. The following four strategies were adopted: multimedia approach of colostomy care, establishing instruction pamphlets, arranging education schedule for practice and reply to technique questions. After the intervention, the completeness of colostomy care technique was increased from 57.5% to 85.4%.

Conclusions
A comprehensive education of care for patients before discharge benefits their self-care.

P-56 ENHANCE ONCOLOGY NURSING STAFF COMPLETE DOCUMENTED OF CANCER PAIN ASSESSMENT IN THE CENTRAL HOSPITAL CENTER OF TAIWAN
Su-Ling Chuang, Pi-Hui Chen, Chin-Yu Lin, Chin-Chin Lin, Lin-Nu Shu, Wan-Chen Yeh, China Medical University & Hospital, Taichung City, Taiwan.

Optimal outcomes in pain management are only now beginning to be defined and more research is needed. When possible, pain should be prevented and controlled to a degree that facilitates function and quality of life. Pain treatment and goals must be tailored to the needs, desires, and circumstances of individual patients. Goals for pain management should be written in the plan of care. The purpose of this study is in the survey found that oncological nursing staff in the daily cancer pain assessment documented complete rate only 43.2%(n=53). The current situation according to the results of the analysis found that the reasons for incomplete writing: 1. Oncology nurses inadequate education and training in pain management. 2. Poor design of cancer pain assessment record form. 3. Cancer Pain record without monitoring systems.

The study method was increase the monitoring frequency and Methods, establishment of Nursing education, and Simplify processes of assessment records, Development e-record assessment form. Fifty-three nurses were interviewed in this study. The result showed that pain assessment documented completely from 43.2%(n=53) increased to 100%(n=53).

The findings of this study can uncover the problems and pressure that oncological nurses came across when they interacted with cancer pain assessment, implementation the assessment of cancer pain and disposal capacity and integrity of the records immediately, so that doctors can quickly access a patient pain-related information so that patients receive effective pain control. This report can be designed as a template of the associated courses for other specific topics.

P-57 A PROJECT TO IMPROVE THE NURSING CARE OF PAIN IN CANCER PATIENTS
Wen-Chuan Hwu, Head Nurse, Shuyin Su, Head Nurse, Hungying Lu, Chang Gung Memorial Hospital, Taipei, Taiwan.

Cancer is the leading cause of death. According to 2005 the Department of Health, Executive Yuan statistical results, has 43,000 new diagnosis cancer patients approximately every year, and statistical demonstration cancer has 20–50% in the diagnosis initial period, the contract 30–40%, the terminal stage is higher than 55–90% patients to withstand the pain attack. The pain is one of symptoms which cancer patient most common and also most disturbing.

However, the present situation medical stuff to the pain processing specialized knowledge, skill and the complete assessment being insufficiently experienced. According to the result of this project we found a solution to relieve patient’s pain and got completely experience of pain evaluation cause by cancers. It induced cancer patient to be brave in expressing pain and improve living quality. In terms of survey we found that stuff had no standard clinically measurement to evaluate patient’s pain. Therefore, we concluded four key points as below. Staff had no unification standard and sheet for pain evaluation. It only reached 48.55% of target. We didn’t get any aid tool for pain indicator. We found the most symptoms, pain which disturbed cancer patient and had 70% incidence. The score was 7. The pain symptom also can influence can the patient’s emotion, the daily activities, the sleep and the joys of life score amounts to 7.1. We draw up the strategy implementation to be as follows: 1. conducts the pain professional training; 2. Uses PQRST to be the nursing routine and 5th vital signs; 3. Made a board for patient pain self-assessment –VAS, including the mood assessment and nursing instruction to put in each bedside.

Concept that the staffs carry out the assessment pain performing standard uniformity from 48.75% to 90%; 2. cancer patients common symptom disturbance, the average pain scale of severity reduces to 3 points by 7 points; 3. the pain symptom disturbance creates average score 7.1 and so on mood, daily activities, sleep and joys of life reduce to 3 points. The pain symptom can distress the mood, the daily activities, the sleep and the joys of life score amounts to 7.1. We expected the project can be apply the clinical continuously, assists the nursing staffs to utilize the knowledge and skill to handle the patient’s pain and related symptoms. Patients can also assess pain severity and dares to say the pain, achieves the medical team comprehension to put in each bedside.

Key word: pain, symptom disturbance degree, visual analog scale

P-58 THE NURSING THERAPEUTIC IMPROVEMENT PROJECT OF CANCER PAINS
Lu Pei Chien, III, RN, Kuo Chia Yu, RN, Hou Mei Jau, RN, Taiwan Chai yi Chang Gung Hospital, Taiwan Chai yi, Taiwan.

Generally, the pains occupy 81% of terminal cancer symptoms. The appropriate pain control can ease the patients’ pains. The failure to relieve the cancer pains triggers the research motivation. This project aims at advancing the nursing therapeutic improvement pain and pain improvement degrees of cancer pains. As to realize the status quo of the implementation, through the observation and examination of the nursing records, the integrity sums up 66.7%; therein, the use of pain assessment tools totals 43% as the lowest; the pain assessment completed in 24 hours after the hospitalization sums...
up 50.2% as secondarily lowest; the ability to record pain assessment results in nursing records sum up 70.4%; the ability to draft pain nursing plans sums up 70.4%. Through the analysis, the cause are the failure to offer the assessment tools, the lack of clear prescriptions that define the pain assessment for cancer patients within hospitalized time limit, the deficiency of nursing therapeutic standard categories, the unfamiliarity of employing nursing therapeutic standard categories along with templates of computer operating flow, and the negligence of drafting nursing therapeutic plans. According to the preceding findings, the improvement project is drafted as: 1. to offer nurses pain assessment tools, 2. to post a pain scale on the head of the patient’s bed, 3. to order pain assessment standard flow, 4. to define pain nursing therapeutic standard categories along with templates of computer operating flow, and 5. to monitor nurses’ pain assessment and computer operating accuracy. After the improvement, the integrity of nurses’ pain assessment and nursing therapeutic execution sums up 98%. There are 52 patients (65.2%) from medium to heavy (pain index 5–7 points), 10 patients (12.2%) from heavy to light (pain index 1–4 point) and 40 patients (48.8%) from medium to light, indicating that the project has advanced effectively the nurses’ nursing therapeutic integrity and improved the cancer patients.

P-59 EXPLORING THE ADAPTING PROCESS OF CANCER PATIENTS’ WHEN THEY UNDERGOING RADIATION THERAPY. Ya Huan Chao1, Cindy Wang2, 1Kuang Tien General Hospital, Taichung, Taiwan, 2School of Nursing Hungkuan University, Taichung, Taiwan.

Over the last few decades, malignant tumor has become the leading cause of death in Taiwan. The expenditure of the hospitalization due to cancer has exceeded 30 billion every year. Approximately 60% of all cancer patients accept radiation therapy in their cancer treatment journey. In clinical practice, in order to cure and control cancer, even to prevent cancer recurrence, radiation therapy will be used alongside with surgery and chemotherapy. Because of the development of technology for radiation therapy, it gradually decreases injury in normal tissue. However, there may still have some serious side effects for some specific parts of the body due to radiation therapy. Because cancer patients need to make the decision to do radiation therapy in a short time, this situation puts a lot of pressure on patients. During radiation therapy, patient’s work and body may be interfered during the treatment. In Taiwan, regarding cancer patients’ adapting process when they undergoing radiation therapy, there are no similar studies explored in depth. Therefore, it becomes very essential to explore the process of adaptation for cancer patients’ when they undergoing radiation therapy. The purpose of this research is to explore cancer patients’ adapting process when they undergoing radiotherapy. Using grounded theory approach, this study sought to explore cancer patients’ understanding of radiotherapy and adapting process when they undergoing the treatment. The findings of the study demonstrate that the interactions between cancer patients’ understanding and their adapting process to radiotherapy are complex. Through this study, health care professionals are able to have better understandings regarding cancer patients’ adapting process when they undergoing radiotherapy. Therefore, these findings may be useful for health care professionals’ understanding regarding cancer patients’ adapting process with which they engage. Furthermore, suggestions to health care professionals regarding clinical care for patient’s undergoing radiotherapy are also provided.

P-60 A NATIONAL STRATEGY FOR THE EFFECTIVE INTRODUCTION OF ADVANCED PRACTICE NURSING ROLES IN CANCER CONTROL. Denise E. Bryant-Lukosius1,2, Sanchez Aranda, RN, PhD3,4, Debra Bakker, RN, PhD5, Jessica Comer RN, PhD6,7, Creta Cummings, RN, PhD8, Esther Green, MSc (T)5,9, Jennifer Ranford, MA10, Jennifer Wiernikowski, RN, MN2.

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The Canadian Centre of Excellence in Oncology Advanced Practice Nursing (OAPN) in Hamilton, Ontario represents the first nursing research unit to be established by a cancer centre in Canada. The goal of OAPN is to improve the health of individuals affected by cancer through the effective development and implementation of innovative advanced practice nursing roles in the delivery of cancer services. International research demonstrates that well-designed APN roles in oncology and other specialties have a positive impact on patient, provider and health system outcomes. While the number of advanced practice nursing (APN) roles is increasing, Canada has yet to realize the full potential of these roles in the delivery of cancer services. There is significant need for innovation to improve timely and equitable access to high quality cancer services. Better human resource planning and new models of care that maximize the use of health care provider roles, expertise and scopes of practice, including the expanded introduction of APNs, will be important strategies to meet increasing demand for cancer services. This presentation will describe OAPN’s goal to provide a comprehensive national program designed to strengthen the contribution of APN roles in cancer care through a three-pronged approach: research, education and mentorship and knowledge translation. We will share how OAPN: a) engages and supports APNs in developing and evaluating their roles; b) demonstrates the added value of APN roles for improving patient health and their cancer experience; c) promotes the development of patient centred models of care to address health needs that are important to patients; d) promotes evidence-based practice among oncology APNs; and b) builds capacity to conduct APN-related research that generates new knowledge to support oncology APN role implementation and evaluation and will highlight how OAPN has collaborated and partnered with key stakeholders and national and international researchers relevant to oncology APN roles. This presentation will be relevant to advanced practice nurses, health care administrators, educators and researchers interested in the development and evaluation of oncology advanced practice nurse roles.

P-61 VELCADE® TEAM AT HEMATOLOGY CARE UNIT IN JAPAN. Mai Hosokawa, RN, Machiko Hoshino, RN, Akihiro MANAKA, Atsushi ISODA, MD, PhD. National Hospital Organization Nishigunna National Hospital, gunma, Japan.

Purpose
Multiple myeloma remains a refractory hemopoietic tumor despite advances in chemotherapy. In December 2006, bortezomib (Velcade®) was approved for the treatment of therapy resistant multiple myeloma in Japan. Velcade® team was started to investigate the safe handling and management of side effects due to bortezomib.

Activity Report
1. Training nurses who administer bortezomib
Velcade® team trained the floor nurses in the administration and side effects of bortezomib. Nurses trained to perform venous injection of bortezomib were floor nurses with clinical experience of two years or more.
2. Developing a clinical path and teaching materials
A check sheet for the clinical path was made so that all nurses would be able to similarly observe the side effects of bortezomib, and provide original materials documenting the treatment day and the day any side effects of bortezomib appeared, side effects were described clearly in the patient education materials.
3. Evaluation and intervention of peripheral neuropathy
The evaluation of neuropathy, which is an important side effect of bortezomib, was regularly evaluated (once/3weeks) using FACT-GOG (NTx) and a novel neuropathy evaluation table developed for this purpose. The neurotransmission speed and vibration sense were also measured. Moreover, an intervention standard for neuropathy was developed, and when symptoms appeared, prompt intervention was performed. To promote treatment of bortezomib without disruption, the team staff holds regular conferences.

Conclusion
Bortezomib is a proteasome inhibitor that has recently been approved in Japan, and there are various side effects of treatment. There was one case in which appeared neuropathy after bortezomib treatment had completed. Therefore, evaluation and intervention must continue during follow up.

P-62 COMMUNICATION SKILLS OF STUDENTS TRAINING IN CANCER MANGING IN JAPAN. Keiko Iino1, Yurie Koyama2, Shigeki Watanuki3, Mayumi Sukeyoshi4, Chikako Suzuki2, Youko Kato5, Naoko Nishikimi6, Ayako Chikama7, Yayoi Suhara8, Youko Hisada9.

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Aim
Cancer patients have been increase in Japan. Nurses play an important role in cancer care because various issues are involved. It is important to clear about cancer nursing educational program. Especially, communication training is very important for nurses in cancer care, which is known to be difficult in previous studies. The purpose of this study was to identify the students’ experience of communication skill training among cancer nursing practicum.
Methods
Before nursing practicum, student studied about communication skills with cancer patients. And cancer nursing practicum held for two weeks. The end of the first week we held the conference about communication. In conference, students and teachers discussed difficulties in cancer nursing practice. After practicum, group interviews were conducted with a convenience sample of 10 students who were asked to their cancer nursing practicum experience. The interviews were tape-recorded, transcribed in full, and they were analyzed using qualitative methods to develop meaning units and themes. The study protocol for this survey was accepted by the Research facilities Research Ethics Committee. The participants’ agreement to participate in this survey was confirmed in writing.

Results
The three categories were extracted of [Lack of knowledge of cancer nursing], [Anxiety can be met with a poor prognosis patients], [Fear that may hurt patients].

Conclusion
The teachers, as well as compensate for the lack of knowledge of students, understands the anxiety and fear that students need to promote learning.

P-63 THE COLLABORATIVE PARTNERSHIP BETWEEN A PERIOPERATIVE HEAD AND NECK CANCER PATIENT AND A NURSE
Tsuyuki Kitamura. Jichi Medical University, Shimotsuke, Japan.

Background
With shortening of the hospitalization, it is urgent business recently to develop nursing support to the patient in the shift period for the discharge from the periodic phase.

Purpose
In this study, a head and neck cancer patient and a researcher made cooperative partnership for the periodic phase and were aimed at clarifying a fact of the approach by the partnership of a process and the collaboration that both traced.

Patient and Methods
For patient who received supracricoid laryngectomy with CHEP, 60’s man 1, researcher interviewed it. Researcher clarified it with a patient, and, by the interview, practice evaluated the problem that a patient of the periodic phase held for life after the discharge from all over the hospitalization.

Results
A patient and a nurse made cooperative partnership, and the patient carried out a problem while wish clarification / the practice of the problem evaluated rolling of the reception, object understanding, mutual understanding, the construction of the relationship of mutual trust, the maintenance of patient – nurse relations in the process when mutual relations of both changed, and both went ahead through the stage of five these.

Conclusion
Approach and the result that became clear supported imperative construct of 5 of the cooperative partnership in this study, and researcher was concerned with a way of thinking about the partnership of the collaboration, and it was suggested that interaction by the partnership of the collaboration was brought about by consciousness.

P-64 THE COLLABORATIVE PARTNERSHIP BETWEEN A PATIENT WITH PARIOPERATIVE HEAD AND NECK CANCER AND A NURSE
Tsuyuki Kitamura; Hideko Minegishi. Jichi Medical University, Tochigi, Japan, Kitasato University, Kanagawa, Japan.

Background
With shortening of the hospitalization, it is urgent to develop nursing support to the patients who are in the transition from the perioperative stage and get discharged.

Purpose
In this study, a patient with head and neck cancer and a nurse agreed to have a "collaborative partnership", in order to achieve their treatment goals and meet the patient’s needs including after a discharge. The purpose of this study is to describe the process how their relationship changes, also their approach to have a successful "collaborative partnership".

Subject & Method
A male patient in his 60’s who has received supracricoid laryngectomy with CHEP was interviewed. A nurse discussed and evaluated the concerns that the patient advanced toward his discharge in the interview.

Result
A patient and a nurse made collaborative partnership. The patient carried out a problem while needed clarification and evaluated his concerns. These processes were “uncertainty of the collaborative partnership,” “difficulty of accepting each other’s values,” “mutual understanding,” “the construction of the relationship,” and “the maintenance of patient–nurse relations.” In addition, there were three approaches that became clear “a patient confront independently the problem,” “a patient with a nurse confront the problem,” “a patient needs coordination of nurse to confront the problem” in that.

Conclusion
It was suggested that collaborative partnership brought about interaction by being aware of making partnership. Thus, collaborative partnership led a patient to be able to clarify a problem by oneself, and to confront the problem.

P-65 EVIDENCE-BASED NURSING OF CANCER CARE IN JAPAN: A LITERATURE REVIEW
Reiko Makabe. Fukushima Medical University. Fukushima, Japan.

Purpose
The purpose of this study was to review of Japanese articles of evidence-based nursing (EBN) related to cancer care and to identify some issues of EBN and cancer care in Japan.

Methods
A literature search was performed by using Igaku-Chuou Zasshi, one of Japanese health literature databases. Methods of a “KEYWORD” and “AND” literature searches were performed by using two terms, “EBN” and “cancer nursing.” Selecting and reviewing related articles were followed.

Results
As the first step, “KEYWORD” literature search of “EBN” resulted in 647 articles and of “cancer nursing” resulted in 9621 articles. Then, as the next step, “AND” literature search was performed by using the two terms, “EBN” and “cancer nursing.” Finally, 25 articles were selected and determined to be relevant articles in this study (performed at the end of January, 2009). Reviewing the 25 articles, types of articles (e.g., research study, case study, literature review, and anecdotal/commentary), publication years, authors, authors’ institutions, and the others were summarized. The publication years of these articles were from 2001 to 2008. The types of the articles were 1) case study (n=2), 2) literature review (n=3), 3) commentary/anecdotal articles (n=16), and 4) the others (n=4), such as articles from conferences. Numbers of authors were ranged from one to three. The authors were nurses, and their working places were hospitals, nursing schools, or universities. The two case study articles were about providing nursing care for cancer patients who were receiving chemotherapy. The 16 articles were commentary/anecdotal, and the articles were introducing and emphasizing importance of EBN in cancer nursing. Moreover, there were no databases related to EBN and cancer nursing care in Japanese articles, as an example database, “Putting Evidence into Practice (PEP),” published by Oncology Nursing Society in 2009 (Eaton & Tippton, 2009).

Conclusion
This literature review of EBN of cancer nursing care in Japanese articles identified some important issues: 1) the articles have been published since 2001, and 2) the most of them were non-research articles, and 3) there were no databases related to EBN and cancer nursing. This literature review suggested that Japanese nurses need to be aware of EBN in cancer nursing care. Further research studies of EBN on cancer nursing were proposed.

P-66 TRANSFUSION REACTIONS IN ONCOHEMATOLOGICAL PATIENTS: NURSING CARE
Paula E. D. Reis; Isabelle Pimentel Gomes. University of Brasilia, Brasilia, Brazil, “Federal University of Paraíba, João Pessoa, Brazil.

Transfusion therapy is constantly associated with the treatment of malign neoplasms. However, it is estimated that 20% of transfusions end up entailing some kind of adverse effect for the receiver. Transfusion reactions can be classified as acute or delayed, both of which require an efficient intervention by the nursing team, recognizing the main signs and specific symptoms for each reaction type, with a view to preventing and controlling adverse effects. This study aims to describe the main acute reactions resulting from transfusion therapy in oncohematological patients, as well as the necessary behavior to deliver adequate nursing care in these situations. Thus, a literature review was accomplished, dealing with the main nursing team interventions in accordance with the kind of reaction that occurred.
P-67

COMPARISON OF CHEMOTHERAPY TOXICITY ASSESSMENTS MADE BY CONSULTANT ONCOLOGIST AND CONSULTANT CANCER NURSE

Helen Roe, BSc (Hons).
North Cumbria University Hospitals NHS Trust, Carlisle & Whitehaven, United Kingdom.

As a consultant cancer nurse the author provides a nurse led service including review of patients receiving chemotherapy and needed to assess her practice in terms of effectiveness, rather than just from the patient perspective. As part of the other evidence looks at patient satisfaction and does not discuss patient safety. Also consultant nurses are an example of the development of nursing roles and the blurring of professional boundaries in the Health Service in the United Kingdom, as well as there often being comparisons made between consultant nurses and consultants.

The study used a qualitative design using a triangulation of interviews and transcripts. The patient group was adjuvant breast cancer patients who are received chemotherapy in the outpatient setting. The patients were selected so half were reviewed by the consultant oncologist and half by the consultant cancer nurse.

Analysis involved cross over analysis by both the consultant oncologist and the consultant cancer nurse who reviewed initial information provided by the patient prior to their consultation, the transcripts of the consultation and medical notes to determine if their management was appropriate and effective.

Results of the study demonstrated that the consultant cancer nurse review was as effective as that provided by the consultant oncologist in terms of detecting side effects, offering management strategies and monitoring outcomes of previous interventions.

The conclusion of the study was that patient care was not compromised by them being reviewed by the consulting cancer nurse.

P-68

ACTION OF ASCORBIC ACID IN FIBRINOLYSIS IN VITRO

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The long-term central venous catheter is a device indicated, in some circumstances, for patients under chemotherapy use, which can, by its turn, require frequent hemotransfusions. However, this device can present occlusions due to thrombi. The thrombotic agent of choice for recuperation of the catheter functioning is the Streptokinasis, that presents risks and delayed costs. For more than 10 years, nurses utilize the Vitamin C empirically in these catheters disconnection, with positive results. The objective of this research was to analyze the vitamin C action on the blood thrombi, establishing a model in vitro of coagulation and fibrinolysis. The methodology used an experimental design in vitro (approved by the Ethics Committee on Research of the Faculdade de Medicina e do Hospital Universitário Antônio Pedro/HUAP, under number 153/07), that utilized total blood of 10 healthy volunteers treated in vitro with citrated plasmas. The results revealed reduction in the D-Dimer values with statistical significance when treated with vitamin C before the clot formation, and also, in the first and second hours, after occurring the clot formation process. In the studies using pool of plasmas, significant difference was only observed when treated with vitamin C before the clot formation process, while with the pool there was not significant difference. The clot morphology treated with vitamin C showed intense autolysis in the peripheral region forming a species similar to a capsule surrounding of the structure and small amount of fibrin in the central region, while the clot treated with saline solution presented moderate amount of fibrin in the whole observed area. It concludes that the vitamin C actuates with more intensity in the clot pre-formation, altering its structure. In the clot just formed, the reduction in the Dimer-D generation until the second hour suggests a fibrinolytic process inhibition but, while the ascorbic acid loose its activity, these values equalize to the control. Even having need of more studies about its action mechanism, these results showed that the vitamin C interfere in the clot process, that explain its activity in the venous catheters disobliterations.

P-69

ROLE OF SPECIALIST ONCOLOGY NURSING IN AN EXTERNAL CONSULTATION. EXPERIENCE IN A SPECIALIZED CENTER OF ONCOLOGY IN CENTRAL TAIWAN, TAIWAN.

Emilce Vargas Ramirez.
Centro Javeriano de oncología, Hospital Universitario San Ignacio, Bogotá, Colombia.

The most attractive workplaces for specialists in oncology nursing in Colombia are the wards of chemotherapy, while recognizing the work of teachers and of nurses to hospital inpatients, the consultation represents a special point, within the many areas where these specialists could work.

When there is no a nurse oncologist in charge of outpatient care of cancer patients in an institution, the implementation of this new position represents a challenge that necessarily gives the recognition of this specialist as a bridge of communication between the oncologist with the patient and his family. There are many activities that the specialist in oncology nursing assumes as protagonist in this field, which is increasingly demanding greater assistance and care for cancer patients. The roles are focused to protect patients’ rights, the proper handling of information, education and information for patients and family, solving administrative problems of the health system. These functions are fulfilled through a series of activities such as monitoring telephone, support during the medical consultation, education and listening and information, being part of the solution of administrative daily problems that patients and their families face with the health system among others.

Describes the work carried out over a year by a nurse oncologist who started this new position in an outpatient center specializing in oncology, which includes strategies, lines of action, achievements, difficulties, expectations, and commitments to balance future. Among the achievements highlighted the reduction in the allocation of time for first appointments and controls, monitoring phone of side effects of treatments, telephone calls for clarification of questions from patients and their families and remember scheduled appointments; guidance and assistance in solving administrative procedures that interfere with the timeliness of patient care, and referrals to other specialties interconsultation as palliative care, oral oncology and psycho-oncology, the motivation for patients to participate in educational programs offered by nursing professionals in the pharmaceutical industry, coordination with psycho-oncological for the admission of patients to a shop preparing to begin chemotherapy patients and coordination with the representative of the National Association of Industrialists – Colombia (ANDI) for admission to patients to its program of support to cancer patients’ look good, feel better.}

P-70

NURSING EXPERIENCE OF A PATIENT WITH TONGUE CANCER WITH HEMORRHAGE

Hien-Chu Wu, Yi-Chen Huang, Mei-chu Chen.
Changhua Christian Hospital, Changhua city, Taiwan, Taiwan.

Purpose
We reports the nursing experience of a 61-year-old male with tongue cancer presenting hemorrhage shock from right carotid artery rupture. The patient was intubated for ventilation support and receive intra-arterial embolization.

Methodology
Data were collected from March 1, 2009 to March 17, 2009 by observation, communication with the patient by writing, deep interviews with the patient and family, and reviewing medical record during the nursing process. The data were evaluated and analyzed according to Roy’s theory that includes physiological-physical function, self-concept-group identity, role function, and interdependence.

Results
The major health problems discovered were as follows: (1) Ineffective airway clearance (2) Deficient fluid volume (3) Risk for nephropathy (4) Malnutrition (5) Hopelessness. We provided holistic nursing care for the patient and family. Through problems focusing on nursing care, the major health problems were much improved hospitalization.

Conclusion
The nursing care should cover psychological problem as well as physiological problem. The feeling of fear and hopelessness of the patient can’t be improve without psychological support. The nursing staffs should receive more psychological training in continuing education to improve the quality nursing care.

P-71

CARCINOMA FOR LIVER TRANSPLANT WITH ROY ADAPTATION THEORY

Dong-Line Dai, Yi-Chen HUANG.
Changhua Christian Hospital, Changhua city, Taiwan, Taiwan.

Purpose
The purpose of this study is to explore the nursing experience of a patient with liver cancer, who was treated with Liver transplant in a medical center of central Taiwan. This patient is 65 years old, diagnosed with hepatocellular carcinoma in stage IV. The patient was treated with Liver transplant.

Methodology
Data were collected between 2007-09-20 and 2007-09-30, by observation, and deep interview during the nursing process. It was then evaluated and analyzed according to Roy’s theory that includes physiological physical function, self-concept-group identity, role function and inter-dependence.
Results
The assessment showed the main health problems of the patient as follows: ineffectiveness in breathing pattern, malnutrition, risk for infection, anxiety, etc. [Unsupported Character - &lt;65106.]] In care, the mutual trust was established between the patient, family, and nurses by holistic nursing care with empathy & sympathy. The discovered main health problem was much improved during the process-oriented nursing care. We helped the patient to recover his health with good social adaptation.

Conclusion
This holistic nursing care experience would be helpful for other nursing staffs in the clinical practice.

P-72 BUILDING PARTNERSHIP BETWEEN PORTUGUESE SPEAKING COMMUNITIES AND SETTLEMENT/HEALTH AGENCIES: EXPERIENCES WITH THE BREAST CANCER SURVIVORSHIP PROGRAM AT PRINCESS MARGARET HOSPITAL
Christine Maheu, RN, PhD; Gilbert Gallaher, RN, PhD; Margaret Zanchetta, RN, PhD; Sepali Garuge, RN, PhD; Scott Secord, MSW; Maritx Kirst, PhD; "University Health Network, Toronto, ON, Canada. 2Centre for Research on Inner City Health St. Michael's Hospital, Toronto, ON, Canada. 3Daphne Cockwell School of Nursing, Ryerson University, Toronto, ON, Canada. 4Princess Margaret Hospital, Toronto, ON, Canada. 5St. Michael's Hospital, Toronto, ON, Canada.

Purpose
To describe experiential learning of building research partnership between local cultural Portuguese speaking communities, the Breast Cancer Survivorship Program and interdisciplinary health care providers to enhance cultural sensitive patient-centered care.

Conceptualization of phenomenon
Community based cancer support programs and organizations in Toronto such as the Love and Live Life organizations and the Wellness Promotion Program at St. Stephen’s Community House have expressed a concern that greater numbers of Portuguese speaking women with breast cancer should be accessing and using important health services that would benefit them in the prevention and self-management of their condition. This study will be interested in knowing understanding the social and cultural capital of four Portuguese speaking communities living in Toronto and their influence on individual’s and group behaviors towards breast cancer prevention and self-management.

Proposed methodology
Design
This study is a critical ethnography study aiming to describe Portuguese speaking women’s social and cultural capitals networks and their challenges, barriers to use breast cancer prevention and self-management services. Data collection: Our mixed method data collection approach will involve focus groups with community members and organizations; individual interviews with breast cancer patients; population small scale survey the use of a Portuguese newspaper; and email interviews with health care providers. Analysis: The analysis will be done through two phases. Information collected through the development and pilot of the individual and focus group interview. We applied the comprehensive assessment to the case with Portuguese newspaper; and email interviews with health care providers. The analysis will be determined through thematic analysis to determine the cultural appropriateness of the questions asked and identify major themes. The validity of the analysis will be ensured by triangulation of the different sources of data by members of the project team, community partners, health care professionals and individual community members.

P-73 BLACK WOMEN & BREAST CANCER: THE KNOWLEDGE IS POWER CONFERENCE
Christine Maheu, RN, PhD; Gilbert Gallaher, RN, PhD; Ebony Smith, M.P.H.; Judy Frain, R.N.; M.S.N.; Cassandra Leggins, R.N.; M.S.N.; Vanessa Loyd, Ph.D.; St. Michael's Hospital, Toronto, ON, Canada.

Purpose
The purpose of this presentation is to present an overview of three different Black Women and Breast Cancer Conferences that have been developed by community and interdisciplinary health care providers to enhance cultural sensitive patient-centered care.

Background
Breast cancer is the most common form of cancer among women in the U.S. Despite the progress in cancer detection and control, black women bear a larger burden from this disease when compared to white women because although they experience a lower incidence, their death rate is higher (American Cancer Society, 2009). Studies have shown that early detection of breast cancer has been proven to reduce mortality rates of individuals who have been diagnosed with this disease. Unfortunately black women are being diagnosed with later stages of breast cancer which lead to higher mortality rates.

Goals and Activities
An ongoing community-based initiative called the Black Women Breast Cancer Survivor (BWBCS) Project is a participatory action research project. We conduct Afrocentric research and provide Afrocentric evidence-based programming guided by black women breast cancer survivors. The primary conference goal is to educate black women on the importance of breast health and how early detection can help prevent loss of life by increasing their awareness about breast cancer. The secondary conference goal is to build a coalition consisting of service providers, community organizations, and church leaders in order to determine breast cancer resources within the respective communities. The final goal is to establish a strong community involvement in the fight against breast cancer and stress the importance of strong community support systems.

Implications to Practice
This presentation will highlight the impact that a small group of community activists can make in the fight against breast cancer.

P-74 RELATIONSHIPS BETWEEN MIDDLE-AGED, FORMER BREAST CANCER PATIENTS AND THEIR PARTNERS IN JAPAN
Saana Aoki1; Kyoko Yamawaki1; Michiko Fujita2.
1Kochi University, Nankoku-shi, Japan, 2Fukuya Heisei University, Fukuyama-shi, Japan.

Aim
The purpose of this study was to examine middle-aged, former breast cancer patients, and discuss their recognition of relationships with their partners following the completion of treatment.

Methods
Subjects were nine women in their fifties and sixties who underwent breast cancer treatment. We performed a semi-structured interview, and conducted a qualitative, inductive analysis of the results.

Results
Relationships with their partners following cancer treatment were grouped into seven categories: “bonding to support each other”, “restoring their normal sexual life”, “continuous relationships even after losing their breasts”, “some difficulties in their sexual life due to changes to the wife’s body”, “both hesitating to speak their feelings”, “ambivalent feelings”, and “serving to meet physiological needs”.

Conclusion
Breast cancer patients and their partners continued to view their partners as an important person even after cancer treatment, although they had some difficulties regarding their sexual life. As the side effects of treatment became mild, they began to become more interested in each other, gradually returning to their normal sexual life. On the other hand, most couples hesitated to directly talk about the cancer, showing ambivalent feelings toward it.

P-75 CARING FOR A FOREIGN LABORER SUFFERING FROM TERMINAL STOMACH CANCER NURSING EXPERIENCE
Ying Hsing CHIANG, RN.
Changhua Christian Hospital, Changhua, Taiwan.

Purpose
This article explores the caring process of a foreign female laborer in Taiwan, who was found that the end stage of gastric cancer combined of colorectal metastasis after initial inspection. Due to cultural differences and language barriers, the case lacks of recognition of treatment, the case facing the multiple pressures of physical, mind, and spirit.

Method
The author collected information by using direct nursing care, observation, and interview. We applied the comprehensive assessment to the case with Roy’s adaptation model.

Results
We identified and established the nursing problems: fluid overload, anxiety, sleep pattern disturbance, anticipatory grief, and pain. We made care plans to help this case overcome the disease process. This case received total care guided by black women breast cancer survivors. The primary conference goal is to educate black women on the importance of breast health and how early detection can help prevent loss of life by increasing their awareness about breast cancer. The secondary conference goal is to build a coalition consisting of service providers, community organizations, and church leaders in order to determine breast cancer resources within the respective communities. The final goal is to establish a strong community involvement in the fight against breast cancer and stress the importance of strong community support systems.

Conclusion
Through this care experience, we hope to share with the readers, and to be a future reference for similar cases. Promoting the quality care should be continuous.

Keywords
Foreign laborer, gastric cancer, spiritual care.


**P-76 EVALUATION OF THE FICA SPIRITUAL ASSESSMENT TOOL**

Betty Farewell, PhD, FAAN, MA, FPCN; Tami Borneman, MSN, CNS, FPCN; Shitlety Otis-Green, MSW, ACSW, LCSW, OSW-C; Pam Baird, AS; Christina Buchalski, MD, MS, FACP.


The National Consensus Project for Quality Palliative Care includes spiritual care as one of the eight clinical practice domains. There are very few standardized spirituality assessment tools. The purpose of this pilot study was to provide psychometric evaluation for the FICA Spiritual Assessment Tool and to test its feasibility in clinical settings. Correlates between the FICA qualitative data and QOL quantitative data were examined. The framework of the FICA tool includes: belief, impact of spirituality, individual's spiritual community, and interventions to address spiritual needs. A prospective, cross-sectional design was used. Patients with solid tumors were recruited from ambulatory clinics of one comprehensive cancer center. Items assessing aspects of spirituality within FACT QOL tools were used, and all patients were assessed using the FICA. The sample (n=32) had a mean age of 64, and almost half were of diverse races. The majority of patients rated faith/belief as very important in their lives (X=3.8, 0-5 scale). FICA quantitative ratings and qualitative comments were closely correlated with items from the QOL tools assessing aspects of spirituality. Findings suggest that the FICA is a feasible tool for clinical assessment of spirituality, and correlations between existing spiritual well-being domains of QOL tools are promising avenues for addressing spiritual needs in clinical settings. This is critical in enhancing QOL. This evaluation provides preliminary validation of the FICA Spiritual Assessment Tool as a relevant tool for future research and clinical practice.

**P-77 RELATIONSHIP BETWEEN SPIRITUALITY AND PATIENTS’ PERSPECTIVE**

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1. University of São Paulo at Ribeirão Preto College of Nursing, Ribeirão Preto - São Paulo, Brazil; 2. Faculty of Medicine of São José Rio Preto, São José Rio Preto - São Paulo, Brazil.

WHO estimates that nine million people will die of cancer in 2015. Thus, health professionals have been constantly concerned about patients’ physical, emotional, social, cultural and spiritual wellbeing. This descriptive and qualitative study aimed to understand the relationship between spirituality and cancer under cancer patients’ perspective. In total, 14 patients diagnosed with malignant neoplasm, under chemotherapy treatment in a hospital in the interior of the state of São Paulo, were interviewed between February and March 2008. Interviewees’ reports were analyzed according to Inductive Thematic Content Analysis. Of the participants, 64% were female, between 23 and 72 years of age, 64% were married, 93% without monthly income, 71% lived with their families and 93% reported having a religion, 86% worshippers and 21% reported higher attendance to religious events after cancer diagnosis. Reports were organized into three categories: The Diagnosis of Cancer, The Search for Cancer Cure, and The Faith for Coping with Cancer. It was understood that Cancer Frightens and Spirituality Renews, once cancer patients searches spirituality as a way to cope with the disease, giving meanings to their life. The results revealed that the majority of cancer patients were female (61%), 47 years of age (average by median), length of stay before interviewing = 3–5 days. The mean scores of 2 aspects of spiritual needs fell within the high level (the importance and necessary level) that were the meaning /purpose and hope needs (mean ± S.D. = 20.0 ± 4.6 and 19 ± 6.9 respectively) but 1 aspect fell within the moderate level (fairly important in life) that was relationship need (mean ± S.D. = 20.0 ± 7.7). In spiritual support need from nurses, there were 2 aspects (the hope and the relationship needs) that fell within the moderate level (having need sometimes/means: S.D. = 10.5 ± 9.4 and 14.5 ± 16.0 respectively) and 1 aspect (the meaning need) fell within the low level (perceiving nurses’ limitation) (mean: S.D. = 8.1 ± 7.2). The spiritual needs inventory was tested by exploratory factor analysis. Extraction method was principal component analysis and oblique rotation method having 8 components (8 factors), each factor loading value > 0.5 and total variance explained = 70.0%. The internal consistency reliabilities (Cronbach’s alpha coefficient) = 0.8. The organization should pay attention on spiritual needs such as: having clinical practice guide-line for spiritual needs, spiritual needs project in clinic etc. Evaluation research in clinical education for any spiritual needs projects for supporting skill among nurses should be emergent. The spiritual needs inventory should be re-designed again with a appropriated sample size and creating more numbers of variables in each factor.

Keywords: Spiritual needs, spiritual supports need, spiritual needs inventory.

**P-78 SPIRITUAL CARE NEEDS FOR THE FAMILY OF THE TERMINAL CANCER PATIENTS ADMITTED TO PALLIATIVE CARE UNITS IN JAPAN.**

KOBUYASHI TAMAMI1, Adachi Kosei2, Murakami Yutaka2.

1. Osaka University Graduate School of Medicine, Suita, Osaka, Japan; 2. Kobe Adventist Hospital, Kobe, Japan.

Purpose

As for the importance of spiritual care to the patient in the end period of the cancer, a concept called “spiritual well-being” having been taken up other than the side of the society of the mind of the body for a conventional healthy definition in 1999, but fear to various death and uneasiness will be shocked by it being it for cancer whom of the family it is for and to test its feasibility in clinical settings. Correlates between the FICA qualitative data and QOL quantitative data were examined. The framework of the FICA tool includes: belief, impact of spirituality, individual’s spiritual community, and interventions to address spiritual needs. A prospective, cross-sectional design was used. Patients with solid tumors were recruited from ambulatory clinics of one comprehensive cancer center. Items assessing aspects of spirituality within FACT QOL tools were used, and all patients were assessed using the FICA. The sample (n=32) had a mean age of 64, and almost half were of diverse races. The majority of patients rated faith/belief as very important in their lives (X=3.8, 0-5 scale). FICA quantitative ratings and qualitative comments were closely correlated with items from the QOL tools assessing aspects of spirituality. Findings suggest that the FICA is a feasible tool for clinical assessment of spirituality, and correlations between existing spiritual well-being domains of QOL tools are promising avenues for addressing spiritual needs in clinical settings. This is critical in enhancing QOL. This evaluation provides preliminary validation of the FICA Spiritual Assessment Tool as a relevant tool for future research and clinical practice.

**P-90 SPIRITUAL NEEDS OF PATIENTS WITH METASTATIC PROSTATE CANCER DURING THE PROCESS OF APPROACHING THE TERMINAL PHASE**

Katomi -1, Mitsuhiro Sakurai, Ph.D.2,3.

1. Katsuras University Hospital, Sakagurama, Kanagawa, Japan; 2. Katsuras University School of Nursing, Sakagurama, Kanagawa, Japan.

Background

Overseas, it is understood that the importance of individual spiritual needs is which the family of the cancer patient held than word for word record for the end period, and collecting categorized similariy or a cord with the difference characteristics. I explained that it was a study purpose, a method, maintenance of the anonymity, the participation by the free will to a person of object and obtained its consent by a document.

Results

As a result of having analyzed interview contents, as for spiritual care needs which the family of the cancer patients held for the end period, nine categories of the [I spend calm time together] [I help with the departure to peaceful death] [I ask it the duty of the family] [I taste an atmosphere of the beginning of death] [I ask for a feeling of antagonism between the patient families] [I share the experience of the patient together] [in search of healing by words] [I give priority to the relaxation of the pain] [I fix the support system of the family] and 21 subcategories were found.

Discussion

As for the number of results, spiritual care needs which the family of the cancer patients sought for little only period become was. Becoming a memory with a suffering and the patient of family oneself with its suggesting a relationship with the patients and the death of the patients that look back, and that the relation that was conscious of the existence of the family who held a suffering or the wish that I showed in a category was important was suggested. I increase the number of the examples and want to clarify spiritual pain for the family of the cancer patients sequentially in future for the end period.
POSTER SESSION #2  
ATLANTA BALLROOM

MARCH 9, 2010—1:00PM – 2.30 PM

P-81  CANCER SURVIVORS’ INVOLVEMENT: CASE STUDY IN THE PHILIPPINES 
Maela Babate, MA Nursing, Notre Dame of Dadiangas University, General Santos City, Philippines.

This paper looked into cancer survivors’ active involvement in their cancer care. Interviews were made to six (6) cancer survivors. Results reveal a general tendency among the participants for active participation, a general desire to be involved in decision making and a strong preference for being informed about their cancer. Findings from this initial study contributed to the new understanding of cancer survivorship in the Philippine context.

P-82  THE DEVELOPMENT AND EVALUATION OF THE INTEGRATED LONG-TERM FOLLOW-UP PROGRAM FOR BREAST CANCER SURVIVORS 
Chun-Chiu Cheng, RN,MSN, Min-Chuan Chang, RN, MSN, Jir-Shiong Tsai, M.D., EA, C.P.  
San Yet-Sen Cancer Center, Taipei, Taiwan.

Advances in early diagnosis, cancer treatment and quality of medical care continue to increase the numbers of cancer survivors every year. Among cancer survivors, breast cancer survivors came out for the majority. The health care system and the public focus on cancer screening, cancer treatment and end–of–life care but pay a little attention on cancer survivors so as in Taiwan. According to clinical experiences, the oncologist visits of cancer survivors became less frequent and the long-term follow–up care lacked continuity. As we know, there is no any complete survivorship care program in Taiwan. Therefore, it is necessary to develop a long–term follow–up program and to provide high quality of follow–up care for breast cancer survivors.

P-83  A STUDY OF BREAST CANCER PATIENT’S COGNITIVE PROCESS OF CANCER 
Eiko Hagiyama.  
Yokohama City University, Yokohama, Japan.

Objective 
The purpose of this study is to elucidate the processes that breast cancer patients go through before cognitive that they have breast cancer and begin undergoing treatment.

Subjects and Methods: We conducted a semi–structured interview survey of 10 breast cancer patients from whom cooperation for the survey was obtained, using the modified grounded theory approach for the analysis.

Results 
The process of cognitive cancer was composed of 4 [core categories], 10 [categories], and 24 < concepts >. Against a background of [wishful thinking that they do not have cancer], breast cancer patients were following a process of [a convincing prognosis that they have cancer], [adjustment and consolidation of acknowledgment that they have cancer], and [living with cancer] while continuously experiencing and recovering from [confusion of cognition] to reach an cognition that they had cancer. When the patients noticed an abnormality in their breasts, they felt [shock and anxiety regarding the physical abnormality], gradually harbored a [suspicion that they have cancer based on personal knowledge], and visited a hospital. After visiting the hospital, a [conviction that they have cancer felt in association with receiving medical treatment] corroborated their suspicions and they experienced the phase of [a convincing prognosis that they have cancer]. Subsequently, they were informed that they had cancer and felt [shock and dismay that they had cancer caused by the notification of cancer] on the one hand, along with < satisfaction due to the primary physician’s notification of cancer > and newly experienced the phase of [adjustment and consolidation of cognition that they have cancer], at which time they feel [a conviction that they have cancer due to the notification]. Against the background of the patients’ strong [wishful thinking that they do not have cancer], these 2 phases both affected and were affected by the [confusion of cognition]. This was composed of the 3 mutually interacting crisis situations of [shock and anxiety regarding the physical abnormality], [assessment that they do not have cancer based on abnormality in their breasts, they felt [shock and anxiety regarding the physical abnormality]] which continued from the discovery of the abnormality. Finally, by using the notification of cancer as motivation to adjust and consolidate the cognition that they had cancer which they had harbored based on experience, the patients were able to then [face their cancer] and experienced the phase of [living with cancer], which led to [attempts toward restructuring lifestyle and life].

Conclusion 
It is important that nurses understand these types of processes of cognition and provide nursing support appropriate for each situation to enable the patient’s cognition to link with proactive efforts toward psychological adaptation.

P-84  THE EFFECTS OF A STRUCTURAL SELF-CARE SUPPORT PROGRAM FOR PATIENTS RECEIVING OUTPATIENT CANCER CHEMOTHERAPY 
Kiyoko Kanda, Professor, R.N,ACPh.D, D.A@ 1, Akemi Tagai, Assistant Professor, R.N,ACMHSc@ 1, 1Ruka Seyama, Assistant Professor, R.N,ACMHSc@ 1, Kazuko Ishida, R.N,ACMHSc@ 1, Kazuko Ishida, R.N,ACMHSc@ 1, Gunma University School of Health Sciences, maebashi, Japan, Guna University Hp, maebashi, Japan, Guna Prefectural College of Health, maebashi, Japan, Yokohama City University School of Medicine, Yokohama, Japan.

Purposes
The purpose of this study was to evaluate the effects of a structural self–care
support program with psychological and educational interventions on cancer patients receiving outpatient chemotherapy.

Methods
The educational intervention involved: 1) self-monitoring—based management of ADR-related symptoms, 2) pamphlet—based education, 3) video—viewing to learn measures against ADR, and 4) phone communication. The psychological intervention involved: 1) instruction on simple breathing methods and 6) active listening. Effect indicators such as i) concerns—rating scale, a self—efficacy—scale, and a QOL measure were employed for investigation, and ii) semi—structured interviews were held for subjective evaluation.

Results
The subjects were patients receiving their first cancer chemotherapy at A University Hospital on an outpatient basis, including 13 as a control and 13 as an intervention group. The types of chemotherapy and disease were largely uniformly between the groups, with breast and digestive cancers being predominant in both groups. The concerns—rating scores were decreased 3 months after compared to those before treatment in both groups. The self—efficacy scores were decreased after treatment in the control group, and increased after treatment in the intervention group. The QOL scores were increased after treatment in both groups. In the evaluation of the effects of intervention, variance analysis was performed in a repeated—measures, two—way layout design to detect any difference over time between the groups with and without intervention.

Conclusion
However, the effects of intervention could not be statistically demonstrated as no significant difference was found in each item. On the other hand, the subjective evaluation identified a category of the program phases through which patients had gradually built confidence in self—management by receiving feedback—based instructions and setting common goals, an indication of the effects of intervention.

P-85 ENHANCING SELF-EFFICACY: WILL IT IMPROVE QUALITY OF LIFE AND SELF-MANAGEMENT FOR PATIENTS WITH BREAST CANCER RELATED LYMPHEDEMA?
Cwen McGhan, RN
Pennsylvania State University, University Park, PA, USA.

Background
Current breast cancer treatments increase life expectancy, but they also affect quality of life. One after—effect of breast cancer treatment is lymphedema. As a chronic, incurable, and sometimes disfiguring condition, the effects of lymphedema take both a physical and psychological toll. Research estimates between 20—40% of women develop lymphedema after breast cancer treatment (Rampul et al., 2003, Sakorafas et al., 2006). The purpose of this small pilot study was to examine the influence of enhancing self—efficacy on breast cancer survivors’ lymphedema self—management and quality of life.

Theoretical Framework: Providing the theoretical framework to investigate the relationship between self—efficacy, quality of life, and symptom management is Bandura’s (1986) Social Cognitive Theory (SCT). In SCT, human functioning is viewed as the product of the relationship between personal, behavioral, and environmental factors. Self—efficacy evolved within SCT to better predict and explain the personal factors that provide the foundation for human motivation. According to Bandura (1997), self—efficacy beliefs influence health behaviors because people must believe they can initiate and adhere to health promoting habits to achieve change.

Findings
To enhance self—efficacy beliefs, the nursing intervention in this study targeted the four sources of self—efficacy: personal accomplishment, vicarious experience, verbal persuasion, and physiological states. Measurement tools included, the Strategies Used by People to Promote Health (SUPPH) and the Functional Assessment of Cancer Therapy – Breast (FACT—B+4) questionnaire and the Comparative Circumferential Measurement Method (CCMM). The quantitative data showed the scores for self—efficacy and quality of life trended up from baseline while the reduced level of lymphedema achieved during treatment was maintained. The qualitative data from the follow—up focus group revealed three themes: that of the survivor experience, the lymphedema experience, and the shared group experience.

Implications
Although this was only a small pilot study and further research is required, the results of this study highlight the importance of psychosocial interventions and how they can provide a basis for nurse researchers and clinicians in promoting improved self—management and quality of life for patients with breast cancer related lymphedema.

P-86 CANCER SURVIVORSHIP: NEEDS AND DISTRESS AMONG OLDER ADULTS IN A COMMUNITY CANCER CARE SETTING
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Given the increasing ranks of older adults and higher rates of cancer incidence in this group, survivorship care for this population will be a significant public health issue in the years ahead. A dearth of research exists on older adults and their survivorship experience and even less is understood about those receiving survivorship care in community care settings. Since age has been identified as a risk factor for elevated need among survivors, empirical evidence identifying the distinctive experiences and needs of older survivors in community settings is essential. Secondary analyses of survivor data from a comprehensive symposium of 1,900 older adults yielded a descriptive correlational design. Using the Survey of Needs, main research variables were survivor needs and associated distress by five subscales (19 physical effects, 10 social issues, 10 emotional aspects, 5 spiritual issues, and 6 other issues). Older survivors reported an average of 10 physical effects, 4 social issues, 5 emotional aspects, 1 spiritual issue, and 3 other issues. The needs most frequently experienced were fatigue (78.9%), fear of recurrence (73.2%), sleep disturbance (67.9%), balance/mobility/walking issues (64.2%), long-term effects of treatment (63.7%), and body changes (63.7%). Significant moderate to strong positive correlations were observed between number of physical needs experienced by older survivors and other aspects of cancer survivorship (i.e., well—being, long—term effects, stress, fear of recurrence, living with uncertainty, managing pain and managing difficult emotions). Similar significant relationships were observed between older adults’ physical distress scores and these same aspects of cancer survivorship. Older adults also reported interest in survivorship education, with 75% requesting education and information on physical effects common in cancer survivorship. Findings for survivors in this study are supported by existing literature describing the survivorship experience of older adults cared for across a variety of cancer care settings. Aspects of cancer survivorship like well—being and quality of life, have been linked back to physical symptoms or physical side effects associated with cancer and its treatment. Results in this study suggest assessment of older adult cancer survivors’ experiences related to physical symptoms, a focus on symptom management, and provision of client education targeting physical effects common to the survivorship experience. Documentation of the multidimensional impact of cancer survivorship on quality of life among older adult survivors in community cancer care settings may allow professionals working in a variety of community cancer center contexts to respond to older adults’ unique survivorship needs.

P-87 SELF DISCONTINUATION OF AN AMBULATORY CHEMOTHERAPY INFUSOR FROM A VENOUS ACCESS DEVICE: EMPOWERING PATIENTS BY PROMOTING QUALITY OF LIFE AND SURVIVORSHIP THROUGH EDUCATION.
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The approximate geographic boundary of 1600 square kilometers that surrounds our center creates physical, emotional and financial hardship for our patient. There are currently twenty-five protocols (24 present, 804 patients) that include ambulatory chemotherapy infusers. These treatments require the patient to have a venous access device. At present, in our centers, there is a policy in place that allows patients to self-discontinue from a Peripheral Inserted Central Catheter (PICC). However, there is no policy in place or research to support the safety of self-discontinuation from an Implanted Venous Access Device (IVAD). An initial study in 2008 showed significant benefit to the patients, however, due to the small study population, this study was reintroduced in 2009 to a larger population, with the goal of self discontinuation becoming a provincial standard.

Patients expressed a desire and were willing to be taught how to self disconnect their ambulatory chemotherapy infuser. Quality of life issues, safety related potential complications and maintenance of the lines were examined. Criteria were then developed for the selection of suitable patients.

In an entry questionnaire, fatigue, loss of control and lack of independence were motivating factors for patients. Patients were then followed for the duration of their treatment on quality of life as well as any complications with their IVAD. At completion of their treatment, patients are asked to complete an exit questionnaire to evaluate impact on their quality of life. The initial research showed a sense of increased control during their journey (63%), as well as increased independence (50%), with no increased incidence in regards to complications with the IVAD (3.6% required intervention). The current phase of this study is ongoing with plans to close accrual September 2009. Data will be analyzed early 2010.

Patients express benefit in terms of improvement in quality of life related to fatigue, increased independence and control over their lives, allowing patients to live with, through, and beyond their cancer experience into survivorship.
PATIENTS’ EXPERIENCES OF REINTEGRATING INTO THE COMMUNITY FOLLOWING A LARYNGECTOMY FOR RECURRENT CANCER: A QUALITATIVE DESCRIPTIVE STUDY

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Head and neck cancers have been described as the most emotionally traumatic of all cancers (Dropkin, 1989). Psychosocial problems may not become apparent until after discharge from the hospital. An individual’s voice is often associated with his or her personality. Loss of voice creates emotional and social changes that may result in withdrawal and depression (Maddalena, 2002; Happ et al, 2003).

Little has been studied or published regarding patients experiences during this challenging transition period after discharge, as they reintegrate into their communities. Most research has focused on the inpatient recovery process. Nurses have a critical role in assisting patients with laryngectomies to learn self-care behaviours and prepare for discharge from hospital (Clarke, 2002; Dropkin, 1999).

The purposes of this qualitative study are to describe patients’ perceptions and experiences as they reintegrate into the community following laryngectomy and identify their perceived supports and barriers for this often silent, marginalized population.

Thorne’s (1997) qualitative interpretive description method will be used to guide the study. Purposeful sampling was used to recruit nine participants from two large urban hospitals. In-depth, audiotaped interviews were conducted with 9 participants, 6-12 months following treatment. Giorgi’s analytic technique was used for analysis. Following data analysis, study findings were shared with 3 participants to verify that themes were reflective of the experience of the participants.

Enveloped under an overarching theme of a “Constant Accommodation to Life with a Laryngectomy” were three main themes: 1) Impact of Cancer Diagnosis, 2) Coping with Illness: Trying to Live Life like Before, and 3) Transitions in Recovery. Subthemes further illuminated the constant accommodation participants had to make following diagnosis of recurrence, surgery, and returning home.

This oral presentation will share participants’ experiences about learning to live with and accommodating to having a laryngectomy. Strategies and interventions are being developed for patients as well as the health care team to better support future patients for the treatment experience. Implications for practice, education and research will be identified.
P-92
EMOTIONAL FEELINGS WITH METASTATIC SPINAL CORD COMPRESSION AMONG LONG-TERM SURVIVAL CANCER PATIENTS
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Background
Many cancer patients have a risk of skeletal-related metastases. Especially, spinal metastasis caused pain and spinal cord compression at the root motion for the vulnerability and instability of the spine, and reduced activity of daily living, suddenly. Many metastatic patients do not understand their symptom and its treatment and health professionals do not typically verify patients’ understanding of information. Additionally, most patients do not seek timely medical attention, and confuse in their situation.

PURPOSE: The aim of this study was to determine the emotional feelings in patients diagnosed with spinal cord compression after 5 year post-treatment of the primary site.

Methods
Semi-structured interviews were conducted with cancer patients with metastatic spinal cord compression in the A Hospital in Japan. The interviews were analyzed with use of qualitative methods and content analysis techniques. Demographic and laboratory data were collected through chart reviews.

ETHICAL CONSIDERATIONS: The study protocol for this survey was accepted by the Ethics Committee of Tokyo Metropolitan Hospital.

Results
Five cancer patients participated in the study. The average the interview time was 55 minutes. The seven categories were identified that “Anxiety to ease the pain,” “Confusion due to bed rest”, “I do not think this can be explained scientifically,” “Not wanting to burden others,” “Burden on family caregivers”, “Early detection of bone metastases by medical staff”, “Collaboration with orthopedic surgeon and physicians in oncology.”

Implications
Many cancer patients are kept their ADL until the end of the life. However, spinal cord compression reduced activity of daily living, suddenly. It is important for patient to keep the bed rest period without confusion before and after operation. Patients are not accepting their situation with spinal cord compression caused primary cancer. It is necessary to understand the feelings of the patient care. And, the nurse identifies early detection of bone metastases, and help the patients choose their doctor. Even years later from treatment in primary cite, if pain and palsy occurs, the cancer patient needs to be taken to the hospital specializing in oncology and orthopedics. This opportunity, once again captures the problems of their cancer, try to adjust the environment to ensure we care what you do around them.

P-93
SUPPORT FOR COPING IN THE EARLY PHASE OF DIAGNOSIS OF GYNAECOLOGIC CANCER
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Background
Denmark has implemented several cancer schools that offer training and support for patients and relatives during the early diagnostic phase. The project started in April 2009 and the results from 1st phase of the project are expected in late August 2009. The results relate to the needs for support for patients and relatives in the early phase of diagnosis.

Method
The project is divided into three phases and includes both qualitative and quantitative research methods as well as development and implementation of a multidisciplinary support program.

Conclusion
The project started in April 2009 and the results from 1st phase of the project are expected in late August 2009. The results relate to the needs for support for patients and relatives in the early phase of diagnosis.

Implications for practice:
Our results may lead to a nursing practice with increased support and involvement of relatives and patients during the early diagnostic phase. The Support Program will not only be a part of the offers that the Department of Gynaecology and Obstetrics at Odense University Hospital gives the patients but will also be developed with focus on a high transferability of the concept to other cancer departments.

The project is supported by the Danish Cancer Society with 183,000 $.

P-94
DAY SURGERY AND RECOVERY IN WOMEN WITH A SUSPICIOUS BREAST LESION: EFFECTS OF A PSYCHOEDUCATIONAL NURSING INTERVENTION ON EMOTIONAL DISTRESS.
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Background
Breast cancer is the most frequently occurring cancer among women between the ages of 35 and 55 in Quebec, as in Canada; it accounts for 30% of all cancers in women, and 18% of all cancer deaths (National Canadian Cancer Institute, 2009). Day surgery is now the first treatment offered. This study assessed whether a telephone nursing intervention based on self-regulation theory, the Attentional Focus and Symptom Management Intervention (AFSMI) could help women enhance their functioning and reduce their emotional distress once they are discharged from the hospital.

Material and methods
The sample consisted of 117 patients with breast cancer who were outpatients and undergoing surgery as part of the initial treatment for their cancer. All subjects were interviewed at three different occasions (2–3 days, 9–10 days, and 16–17 days after surgery). The subjects were randomized into the experimental group (n=61) or the usual care group (control, n=56). The subjects in the experimental group received the AFSMI intervention based in self-regulation theory in two sessions, 3–4 days and 10–11 days after surgery. The outcomes were the subjects’ emotional distress and functional status.

Results
Results showed significant differences between the experimental and control group at post-test on total mood disturbance, confusion, tension, and disruption in home management activities scores. Change scores also indicated a moderate level of improvement in the experimental group, as hypothesized, in emotional distress and clinical functional status. The intervention had a small effect on mental fatigue, reduced motivation, and affective pain.

Conclusions: Findings from the present research demonstrated that a nursing intervention applied during the immediate surgical recovery period after breast cancer, is clinically relevant to reduce emotional distress and usual functioning. Self-regulation theory could effectively be used as a guide in the development of effective nursing interventions in clinical practice for patients with cancer undergoing day surgery. Future research should consider investigating longer individualized interventions using redirection in order to help these women be empowered, emotionally comfortable, and normally functioning. These interventions are needed especially for women at risk for depression, and having to undergo further treatments such as chemotherapy, radiation therapy or both.

P-95
UNDERSTANDING FOOD CHOICE AMONG CANCER PATIENTS USING ETHNOSCIENCE

Cancer patients often complain of chemosensory alterations and appetite loss, which in turn can lead to changes in food choice, decreased food intake and weight loss. Dietary patterns and caloric intake have previously been studied as a function of chemosensory complaints. But we lack knowledge and understanding of what underpins the food choice.

To: Further our understanding of cancer patients’ perceptions about the impact of chemosensory changes on food preferences and subsequent food choice.

Methods
Adult cancer patients who report chemosensory alterations are being invited to take part in this study. Beliefs, values and behaviors related to food preferences and food choice are being elucidated using techniques arising from ethnoscience. The key assumption of this method is that individuals construct meaning through the use of language. In this study we are learning more about the meaning of food preferences and food choice by studying the language used to describe these two phenomena. Data are collected using interviews and card sorts. Results will be organized in a taxonomic structure to show participants’ constructed meaning regarding food preferences and food choice.

Conclusions: Findings from the present research demonstrated that a psychosocial intervention (AFSMI) could help women enhance their functioning and reduce their emotional distress once they are discharged from the hospital.

Results
The data collection and analysis are ongoing; two participants have completed the study to date and we aim to recruit a total of about 20 participants by the end of 2009. These results will help health care staff, especially nurses and dieticians, increase their understanding of food preferences and food choice among cancer patients.
P-96 DEVELOPMENT OF AN INTERDISCIPLINARY SUPPORTIVE CARE PLAN FOR PATIENTS WITH LUNG CANCER
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Background
Lung cancer impacts all dimensions of physical, psychological, social, and spiritual well-being.

Objectives
This two phase study of QOL and symptoms in lung cancer included Phase I to determine usual care at a NCI designated comprehensive cancer center. Phase II gained input from patients regarding QOL concerns and pilot tested a palliative care intervention.

Methods
In Phase I, 100 patients were randomly selected by the tumor registry from 125 new lung cancer patients seen over a 12 month period. An audit tool reflecting aspects of quality care as described by the NCCN was developed, peer reviewed and tested to establish reliability. Care was audited for a 6 month period. In Phase II 10 patients completed 4 quantitative tools and participated in a tape-recorded interview. Data was summarized into a care plan and shared with the interdisciplinary team at a case conference whereupon the care plan incorporated the team’s suggestions. Follow-up with the participant occurred one and three months post conference to evaluate the impact of the intervention.

Results
Phase I data revealed 85% were stage III-IV, 82% had comorbidities, 81% received chemotherapy and 43% had radiation therapy. Thirty two percent received no supportive care services. Uncontrolled symptoms were reasons for outpatient visits and for 38% of hospital readmissions. Phase II data revealed 60% had stage III-IV with COPD/embolus and cardiac disease as common comorbidities. Symptom specific scores were moderate (X=20.6) as were overall scores for QOL using the FACT-L (X=87.8). Emotional well-being scores were the lowest (X=18.4) followed by functional (X=21.1), social/family (X=23.8), and physical (X=24.5). Supportive care services recommended included nutrition, psychology/psychiatry, social work, rehabilitation, and chaplaincy.

Conclusions
QOL/symptom concerns are often neglected in usual care in lung cancer. An interdisciplinary palliative care intervention can prospectively meet these needs.

P-97 DOES EMPATHY AND STIGMA DIFFER AMONG PATIENTS AND CAREGIVERS WITH SMOKING OR NON-SMOKING RELATED ILLNESSES?
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In Canada and the United States, changing attitudes towards cigarette smoking have resulted in a social stigma or ‘spoiled identity’ facing smokers and those with smoking-related illnesses such as lung cancer and Chronic Obstructive Pulmonary Disease (COPD). Many patients rely on family or other caregivers for their day-to-day care and empathic behavior is an essential component of effective communication to facilitate the caregiving relationship. This exploratory study examined whether there is an association between caregiver and patient stigma and empathic behaviour amongst patient/caregiver dyads with smoking-related illnesses compared to a colorectal cancer control group. Thirty-four patients (19 diagnosed with a smoking-related illness and 15 diagnosed with colorectal cancer) along with their caregivers were recruited to participate in this study. The four empathic behaviour scales utilized demonstrated good reliability with both diagnostic groups; however, the stigma scale used was shown to be reliable only with the colorectal cancer group. There were no differences found in either patient or caregiver stigma between diagnostic groups but there was a trend for patients to report more stigma than caregivers. Younger patients reported more stigma and when patients and caregivers reported no preference for religion, they reported more stigma. Empathic behavior was found to be positively related to patient and caregiver education, patient income, and negatively related to patient and caregiver smoking history. Patients diagnosed with smoking-related illnesses viewed their caregivers as less empathic than patients in the colorectal cancer group. Patients with a stigmatized illness and their caregivers may ultimately benefit from this research as empathic behavior has been shown to be potentially modifiable and interventions may be developed to ameliorate or prevent any identified detrimental effects of stigma that may impact optimal empathic behavior.

P-98 STRESS EXPERIENCED BY BREAST CANCER PATIENTS RECEIVING PREOPERATIVE CHEMOTHERAPY ON AN OUTPATIENT BASIS
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Purpose
To clarify physical, mental, and social stress experienced by breast cancer patients receiving preoperative chemotherapy on an outpatient basis, and explore nursing intervention for them.

Methods
Subjects: 12 breast cancer patients who received preoperative chemotherapy as outpatients.
Survey period: May to October 2007. Data collection: Interviews with subjects were held using a semi-structured questionnaire and interview guide. Data analysis: Qualitative inductive analysis. Ethical consideration: Approved by the ethics committee of A University Medical School. Subjects were fully informed of the study purpose and methods, their freedom to participate in and withdraw from the study, and protection of their privacy. Then, their written consent was obtained.

Results
The mean (±SD) age of the breast cancer patients who received preoperative chemotherapy as outpatients was 55.92 (±9.14) years. The types of preoperative outpatients chemotherapy were 4 courses of epirubicin/cyclophosphamide (EC) + 4 courses of docetaxel (DOX) in 11, and 4 courses of EC + 2 courses of DOX + 2 courses of paclitaxel (PTX) in 1.
Stress caused by preoperative outpatients chemotherapy was summarized into five sentences: “Fatigue and anxiety, in addition to pain from adverse reactions, accumulated as I became unable to play my roles in the family and society” “I had trouble with treatment as well as anxieties over it”; “I felt distress due to not being able to live as I wished”; “The treatment was expensive, becoming a financial burden”; and “Outpatient chemotherapy caused fatigue and pain, and limited my time.”

Conclusion
Breast cancer patients who received preoperative outpatient chemotherapy were found to have continued it while being subjected to various types of stress in terms of physical, mental, and social aspects. As nursing intervention for breast cancer patients receiving preoperative chemotherapy on an outpatient basis, 1) support for self-care, 2) promotion of self-value and self acceptance, 3) provision of information and encouragement to apply it, 4) improvement of environments for treatment, and 5) continuing to be able to play an effective role in the family and community are considered important for such patients to live their own lives while receiving preoperative outpatients chemotherapy through to completion.

P-99 THE PATIENTS’ EXPERIENCE AND APPRAISAL OF AN EXERCISE-BASED MULTIMODAL INTERVENTION DURING HEMATOPOIETIC STEM CELL TRANPLANTATION: A QUALITATIVE INQUIRY
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Background
Studies applying exercise, relaxation training and psychoeducation have each individually shown a positive impact on physical performance and/or psychological wellbeing in persons diagnosed with cancer. In hopes of a synergistic effect, this study applied all three components in a multimodal intervention in patients undergoing hematopoietic stem cell transplantation (HSCT) which resulted in physiological and psychological benefits. However, little is known about HSCT patients’ experience during exercise-based interventions while undergoing aggressive treatment.

Objective
The aim of the study is to explore the patients’ experience and appraisal of the multimodal intervention.

Design
42 patients (18 –65 years) undergoing myeloablative allogeneic hematopoietic stem cell transplantation (allo-HSCT) were randomized either to an intervention or a control group. The intervention group (n=7) received standard treatment and care; and a supervised 4–6 week, structured exercise program, progressive relaxation and psychoeducation during entire hospitalization, 1 hr. 5 days/wk. The control group (n=17) received standard treatment, care and physiotherapy.

Methods
Data were obtained though semistructured interviews of fifteen patients from the intervention group following the intervention period. Verbatim transcripts of tape-recorded, in–depth interviews were analysed for thematic content. Findings: Patients reported favourable evaluation of the multimodal intervention and would recommend it to future patients undergoing HSCT. These recommendations were based on the themes of ‘individual and social appraisal and experiences’ that supports the patients’ sense of purpose and control.
while living restrictively under potentially threatening conditions. Patients reported a heightened sense of physical and emotional awareness that was used as a catalyst for motivation.

**Conclusion**

The intervention succeeded in satisfying patients’ need for active participation in their own treatment and care. The patients’ accounts reflected the need to ‘normalize’ their situation with the goal of health maintenance.

Relevance to clinical practice: Exploring the multimodal intervention through the patients’ perspective supplements and contributes to the quantitative methods that found the intervention to be feasible and safe, shown to reduce the symptom burden with physiological and quality of life benefits. This qualitative inquiry suggests that patients are health seeking and motivated to be active participants even during rigorous treatments. These results have the potential to enhance the development of important strategies in the allo-HSCT regime for prevention, care, treatment and rehabilitation.

**P-100**

**SUPPORT AND CARE OF RELATIVES TO PATIENTS WITH BREAST CANCER.**

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**Introduction**

The study deals with care and support to relatives of patients who have recently been diagnosed with breast cancer. One in ten women in Denmark contract breast cancer. Annually, The Breast Cancer Center at Vejle Hospital undertakes diagnosis, preparation for, and follow-up of surgery and treatment for approximately 350 patients. Many studies focus on the cancer patient’s situation. Few studies concentrate on the relatives of breast cancer patients. The aim is to describe the relatives’ experience of the time of diagnosis. Relatives should be regarded as an important resource during the course of the illness.

**Aim**

The aim of the study is the wish to be able to provide the best possible care and support to relatives of newly diagnosed breast cancer patients.

**Research questions:**

- To investigate how relatives experience care and support.
- To investigate nurses’ perception of the care and support provided.
- To discuss how the results of the study are relevant to nursing practice at The Breast Cancer Center, Vejle Hospital.

**Materials and methods**

The research approach is qualitative, employing a phenomenological-hermeneutic theoretical framework. Six relatives and six nurses are included in the study. Data collection is conducted by focus group interviews with relatives and nurses, respectively. The interviews are digitally recorded and transcribed. The data are analyzed and interpreted using a method inspired by Ricoeur’s interpretation theory. The interpretation is carried out on four levels: naïve reading, structural analysis, and critical interpretation and discussion.

**Results**

The study showed that both relatives and nurses consider it essential that relatives are actively involved from the time of diagnosis, in order to be able to support the patient. During the meeting between nurses and relatives it is usual that relatives open up on thoughts and feelings about being unprepared, vulnerable and anxious, and also the feeling of physical unease. The meeting can be challenging, depending on whether the relative is quiet, reserved or outspoken. The way in which the relatives and nurses are present in the meeting, is of vital importance. For example, the significance of eye-contact is emphasized as important in developing a trusting relationship. The study also showed that support and care to relatives seldom is documented in nurse’s case records.

**Conclusion**

It can be concluded that mutual engagement and attention during the meeting is of major significance to how relatives experiences support and care, and to how nurses view the provision of support and care to the relatives. Extra awareness and dedication is called for when undertaking support and care to relatives in this vulnerable situation, where the person closest to them has just been diagnosed with breast cancer. The same attention is called for in documentation in nurse’s case records.

**P-101**

**MANAGEMENT OF HOT FLASHES IN PATIENTS UNDERGOING HORMONE SUPPRESSIVE THERAPIES.**

Lyn Kligman, MN ACNP (ANCC) 1,2


Hormone suppression therapies are used for the treatment of breast cancer in both the adjuvant and metastatic setting. However side effects, including hot flashes, are often frequently reported by patients as the cause of discontinuation of therapy. This presentation provides an overview of hormonal suppression therapies and the evidence based management options for hot flashes summarized in a suggested treatment algorithm.

**P-102**

**A STUDY ON RECOVERY PROCESS IN PATIENTS WITH PRIMARY BREAST CANCER AFTER BREAST-CONSERVING SURGERY: FOCUSING ON CHANGES IN THEIR BODY IMAGE -**

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**Purpose**

The purpose of this study was to clarify recovery process in Patients with Primary Breast Cancer after Breast-conserving Surgery. We examined how the notification of breast cancer, breast-conserving surgery, and preoperative/postoperative treatment affected their body image, and discussed nursing support for them.

**Methods**

Subjects were female patients with primary breast cancer in their forties and fifties who underwent breast-conserving surgery. We conducted semi-structured interviews (three times in total) between within 3-14 days and three months after the surgery regarding their thoughts and feelings their body conditions and breasts.

Empowering interaction and phenomenological approach, we performed a qualitative and inductive interview. Based on the content analysis, we categorized their responses and obtained 6 major semantic similarities as our findings. The present study was conducted with the approval of the ethics committee of the facility, and we obtained written informed consent from the subjects.

**Results**

The average age of the nine subjects was 50.7±6.5. At the time of diagnosis, one patient was at Disease Stage 0, three at Stage I, another three at Stage II, and there were two patients at Stage III. Four patients received preoperative systematic chemotherapy, seven patients under radiotherapy; another seven under hormonal therapy. In four patients, the side of their dominant hand was affected by cancer.

The 6 similarities about their changes in their body image were: 1) to imagine themselves by reflecting the talk of relatives and acquaintances who experienced cancer, 2) to concern the loss of the breasts after cancer notification and treatment, 3) to change their sensation to physical symptoms and a sense of discomfort, 4) to keep seeing the changes between from breast-conserving and anxiety for recurrence, 5) to assess their current physical conditions and daily behaviors by comparing with their former self and others, 6) to feel uncertainty about their future.

**Discussion**

The uncertainty impression was related to body image in patients with primary breast cancer after breast-conserving surgery. It was interpreted that recovery process had indicated producing new one’s own body and nurturing confidence again, while unifying the past and present. Nursing support requires understanding, promoting the patient’s recovery process.

**P-103**

**A CASE STUDY OF A GASTRIC CANCER PATIENT WITH END-STAGE.**

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More than 30,000 people die of cancer every year in Taiwan. In 2007, there are even 40,306 victims. Oncology nursing staffs have many chances to take care of end-stage cancer patients. In Taiwan, hospice shared care was impelled since 2004 to help end-stage cancer patients in general acute hospital ward and their families by the cooperation of the original medical treatment and nursing team.

This article describes the experience of caring for a 58 years old woman dying from gastric cancer. By the case study, we found that end-stage cancer patients often face: 1. nutritional status change/short in the bodily need; 2. fatigue; 3. depression; 4. to suffer pain; 5. to lose weight, suffer from physical, emotional, and social distress; 6) to feel uncertainty about their future.

We also observed that by means of accompanying, concerning, listening and empathy could encourage the case and the family members to express their thoughts and feeling. Finally, providing the nursing idea of “four entire care”: entire person, entire family, entire journey, entire team, as well as “three peace”: physical peace, mental peace, and peace of soul could help the case and the families accept the dying process confidently, peacefully and have no regrets.
P-104 CLEARING THE MIND: A NURSING ASSESSMENT TOOL FOR THE RECOGNITION AND MANAGEMENT OF DELIRIUM
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Background
Delirium affects up to 85% of patients with advanced cancer. The aim of this project was to review the literature and establish which was the most effective and accurate nursing delirium assessment tool for use in an inpatient cancer unit.

Methods
Medline, Cinahl, Pubmed and PsycINFO were all searched; twenty two articles were found and reviewed; thirteen articles were found to be relevant to the project and critically appraised. Reference lists of key articles were also hand searched and authors were contacted for clarification when required.

Results
Seven delirium assessment tools were identified in the literature. Six tools were not appropriate due to the time they took to complete, they did not accurately recognise all types of delirium and were more appropriate as a diagnostic tool rather than a screening tool. The Nu-DESC was found to be the most accurate, effective nursing assessment tool for diagnosis and for continuous monitoring of severity of symptoms associated with delirium.

Implications for practice
This tool will allow delirium to be recognised early and for interventions to be put in place in a timely fashion, thus improving the nursing care provided and the patient’s quality of life. Due to the lack of evidence surrounding the tool a six week trial has commenced in the Head, Neck and Lung Cancer unit using the Nu-DESC to gain a greater understanding of the benefits and appropriateness for in patients at Peter Mac.

P-105 CONCERNS FELT BY CANCER PATIENTS AND FAMILY MEMBERS AND PROVIDING OF HUMAN SUPPORT DURING TRANSITION TO OUTPATIENT CARE IN JAPAN
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Purpose
This study was conducted for the purpose of determining the contents of concerns felt by cancer patients and their family members and the actual state of human support provided during transition to outpatient care.

Method
Study period: August 2007 to March 2008
Subjects: Cancer patients (n = 188) currently hospitalized for cancer treatment at a general hospital and their family members (n = 175). The patients and their families were provided with an explanation of an overview of the study and their consent to participate in the study was obtained.

Data collection method: Self-administered survey forms were distributed to the subjects on the day of discharge, after which the subjects filled out the survey forms at home and returned them preferably on the 7th day following discharge.

Survey contents: Attributes of the patients and their family members as well as “current anxieties and concerns”, “presence of persons able to consult when troubled”, “presence of persons providing support when dealing with illness” and “expectations of nurses” of the patients and their family members.

Results
Replies were obtained from 97 of the 188 patients (valid response rate: 51.6%) and from 82 of the 175 family members (valid response rate: 46.9%). The average age of the patients was 64.0±11.6 years and that of the family members was 59.5±12.4 years. With respect to gender, the patients consisted of 58.9% men while the family members consisted of 46.9%). The average age of the patients was 64.0±11.6 years and that of the family members was 59.5±12.4 years. With respect to gender, the patients consisted of 58.9% men while the family members consisted of 46.9%.

1. “Current anxieties and concerns” among Patients and Family Members respectively “future outcome”: 78.4% and 90.2%, “symptoms”: 19.6% and 35.4%, “treatment”: 19.6% and 26.8%.
2. “Presence of persons able to consult when troubled” among Patients and Family Members “spouse”: 67.0% and 39.0%, “son”: 45.4% and 42.7%, “daughter”: 41.2% and 43.9%.
3. “Presence of persons providing support when dealing with illness” among Patients and Family Members “spouse”: 76.3% and 37.8%, “daughter”: 41.5% and 47.6%, “son”: 44.3% and 50.0%.
4. “Expectations of nurses” among Patients and Family Members “supplementing explanations from physicians”: 36.1% and 41.5%, “informing of effective methods for dealing with symptoms”: 34.0% and 35.4%, “no particular expectations”: 27.8% and 11.9%.

Discussion
Despite patients and their family members having numerous concerns regarding their illness and course of treatment after being discharged, consultations regarding those concerns and anxieties are had nearly entirely with family members consisting of spouses, sons and daughters, thus clearly demonstrating the situation in Japan in which illnesses are dealt with within the family.

P-106 A PILOT STUDY ON THE DEVELOPMENT OF A PRACTICAL SUPPORT PROGRAM PROMOTING ADAPTIVE BEHAVIORS IN CANCER PATIENTS AFTER SURGERY
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Purpose
The present study was conducted in order to develop a practical support program for post-surgical gastrointestinal cancer patients. The support program aimed to promote adaptive behaviors in these patients by providing support that facilitates the development of realistic perceptions of the event, positive perceptions of social support, and adequate coping mechanisms.

Methods
From October 2008 to February 2009, patients who underwent surgery for gastrointestinal cancer in a university hospital in Japan were presented at discharge with a booklet listing 14 common concerns/problems regarding their illness, and were invited to participate in this study. Participants who chose to participate in face-to-face sessions with a nurse in an outpatient unit for six months were asked to indicate from the 14 common concerns/problems listed in the booklet the issue that most concerned them before the first session. Participants in the study were the patients who chose to participate in the sessions. During the sessions, the patients discussed the issue with the nurse using a workbook for patients that was developed for this program.

Results
Among the 9 patients (mean age, 68.0 years; 5 men, 4 women; 5 with colorectal cancer, 4 with gastric cancer) who accepted the booklet, 2 patients (1 female with gastric cancer and 1 male with rectal cancer) made an appointment to take the first session. More female than male patients were interested in this program, while old and male patients tended to be least interested in taking a session. The primary reason for males not wanting to attend a session in an outpatient unit was that they only wanted to receive a booklet, while for females, the primary reason was that they could not make time to take a session out of regard for families. The issues chosen as the topic of the session were “change of self image” for the male patient with rectal cancer and “concerns about symptoms” for the female patient with gastric cancer.

Conclusion
An inadequate number of patients participated in the sessions. However, as gastrointestinal cancer occurs frequently in old males in Japan, it is necessary to develop a support program that better addresses the needs and attributes of those who will benefit most from it.

P-107 SUPPORT DESIRED BY CANCER PATIENTS AND FAMILY MEMBERS DURING TRANSITION TO OUTPATIENT CARE IN JAPAN
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Purpose
This study was conducted for the purpose of determining the contents of support desired by cancer patients and their family members when transferred to outpatient care.

Method
Study period: August 2007 to March 2008
Subjects: Cancer patients (n = 188) currently hospitalized for cancer treatment at a general hospital and their family members (n = 175). The patients and their families were provided with an explanation of an overview of the study and their consent to participate in the study was obtained.

Data collection method: Self-administered survey forms were distributed to the subjects on the day of discharge, after which the subjects filled out the survey forms at home and returned them preferably on the 7th day following discharge.

Survey contents: Attributes of the patients and their family members as well as “current anxieties and concerns”, “presence of persons able to consult when troubled”, “presence of persons providing support when dealing with illness” and “expectations of nurses” of the patients and their family members.

Results
Replies were obtained from 97 of the 188 patients (valid response rate: 51.6%) and from 82 of the 175 family members (valid response rate: 46.9%). The average age of the patients was 64.0±11.6 years and that of the family members was 59.5±12.4 years. With respect to gender, the patients consisted of 58.9% men while the family members consisted of 46.9% women.

1. “Current anxieties and concerns” among Patients and Family Members respectively “future outcome”: 78.4% and 90.2%, “symptoms”: 19.6% and 35.4%, “treatment”: 19.6% and 26.8%.
2. “Presence of persons able to consult when troubled” among Patients and Family Members “spouse”: 67.0% and 39.0%, “son”: 45.4% and 42.7%, “daughter”: 41.2% and 43.9%.
3. “Presence of persons providing support when dealing with illness” among Patients and Family Members “spouse”: 76.3% and 37.8%, “daughter”: 41.5% and 47.6%, “son”: 44.3% and 50.0%.
4. “Expectations of nurses” among Patients and Family Members “supplementing explanations from physicians”: 36.1% and 41.5%, “informing of effective methods for dealing with symptoms”: 34.0% and 35.4%, “no particular expectations”: 27.8% and 11.9%.
Survey contents: Attributes of the patients and their family members as well as "things they want to know about," "contents of desired support" and "specific contents of desired consultations" of the patients and their family members.

Results
Replies were obtained from 97 of the 188 patients (valid response rate: 51.6%) and from 82 of the 175 family members (valid response rate: 46.9%). The average age of the patients was 64.0±11.6 years and that of the family members was 59.5±12.4 years. With respect to gender, the patients consisted of 58.9% men while the family members consisted of 67.1% women. 1. "Things they want to know about" among Patients and Family Members respectively "relapse/metastasis": 52.6% and 51.2%, "daily life (diet)" : 27.6% and 25.6%, "course of illness": 26.8% and 41.5%. 2. "Contents of desired support" among Patients and Family Members "seek consultation": 49.5% and 45.1%, "providing of information through reference materials" :23.7% and 13.4%, "enhanced coordination between hospitals": 14.4% and 15.9%. 3. "Specific contents of desired consultations" among Patients and Family Members With respect to the location of consultation offices, "hospital consultation office" was indicated by 20.6% and 15.9%. With respect to the method for providing consultation, "direct consultation" was indicated by 37.1% and 36.6%, "telephone consultation" by 10.3% and 9.8%, and "e-mail" by 7.2% and 3.7%. With respect to the person with whom they desired to consult with, "physician" was indicated by 34.0% and 36.6%, "nurse" by 16.5% and 12.2%. With respect to the contents of consultations, "treatment" was indicated by 32.0% and 24.4%, "daily life" by 7.2% and 12.2%. [Discussion] Patients and family members soon after discharge were determined to desire information through reference materials and consultation services by which they can consult with doctors and nurses regarding their illness, treatment and daily life, and it is therefore necessary for us to promptly take the proper steps to accommodate these desires.

P-108
DEVELOPMENT OF THE SELF-CARE SUPPORT SYSTEM OF THE RADIOTHERAPY CANCER OUTPATIENTS
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Purpose
The outpatient is continuing medical treatment, holding the anxiety over medical treatment etc. Therefore, a patient needs physical, psychological and social self-care. Moreover, since medical staffs do not understand the state in the outside of a patient’s hospital, they cannot do sufficient patient’s support. In this reason, we develop the radiotherapy cancer outpatient’s self-care support system.

Method
A critical path function of radiotherapy, a vital data input/chart display function and subjective information “current state” function provide for the development system. The contents of critical path have item such as an irradiation treatment period, the treatment schedule day, screening, medication, disposal, progress, a consultation day, a nursing goal, a nursing care plan, nursing intervention and evaluation. From the many item, requirement items of each patient can be chosen and displayed at a personal critical path. In the system for medical staffs, it is able to evaluate the grade of an understanding of the self-care capability, the current feelings (“subject information”), a self-care situation, the situation of family support and medical treatment of a patient, etc. And the “subject information” function has the patient's physical, psychological, and social description. Furthermore, the inputted vital data can be presentation of graphical display.

Results
The display of a daily state of patient time series could execute. Moreover, in this function, since it can add and correct at any time, medical staffs were able to understand state and change of each patient. Moreover, on the system for medical staffs, assessment of a patient’s self-care capability could execute from a nursing goal and a nursing care plan, and nursing intervention could be complete and evaluate from the self-care system. Furthermore, medical staffs could share the new information of the outside of a patient’s hospital.

Consideration
We thought as follows. The medical staffs can do individual guidance for each patient and it is thought that the consciousness to a patient’s self-care is raised. Moreover, it is thought that the graphical representation of vital data leads to the temporal monitoring of a patient or medical staff. The patient was able to convey the physical, psychological and social opinion of the patients themselves to medical staffs using the “subject information” function.

Conclusion
The development system could support the self-care of outpatient other than the time of outpatient reception. And useful patient information could provide from medical staff. Further the “subject information” function became an effective communication tool of an outpatient and staff.

Acknowledgment
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P-109
SUPPORTIVE CARE AND CANCER
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Cancer is major cause of morbidity and mortality throughout the world, with nine million. People newly diagnosed each year and five million people dying from the disease. In Australia cancer is the second most common cause of death, accounting for approximately one quarter of all deaths. Approximately 55,000 cases of cancer are diagnosed each year, the most common being cancers of the breast, prostate, colon-rectum, lung, and melanoma. Due in part to the focus on early detection and improved clinical management of cancer, five-year survival rates indicate that more people are now living with cancer, and for longer periods of time. More treatment modalities are now available than ever before, and this has led to significant gains in terms of improving both life expectancy and cure rates. New treatment modalities will certainly become available in the future and hopefully one day cancer will be a disease that is not only treatable but curable in the majority of the cases. THE 10 AREAS OF NEED, EXPERIENCED IN THE PREVIOUS MONTH, RANKED HIGHEST TO LOWEST TO DISPLAY CHARACTER: #504)I)CH TAMENTS COMPLETING THE SUPPORTIVE CARE NEEDS SURVEY ACROSS ALL TREATMENT GROUPS AND CENTERS OF CARE
Item % of sample reporting a Domain
Moderate–high need
Fears about the cancer spreading 40 Psychological
Fears about the cancer returning 39 Psychological
Concerns about the worries of 38 Psychological
Those close to you
To be informed about the things 36 Health system
you can do to help yourself to get well information
Lack of energy and tiredness 33 Physical –daily living
Not being able to do the things you 33 Physical–daily living
Used to do Uncert

P-110
CONSIDERATION POINTS ON ADMINISTERING THE SUPPORT GROUP FOR THE RECURRENT BREAST CANCER PATIENT
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In Japan, the interest to support group arises as group approach for cancer patients to improve QOL. We think that needs of the recurrent breast cancer patient differ from needs of the initial breast cancer patient and hold a support group accordingly. An aim of the support group for the recurrent breast cancer patients is to raise problem solving ability of participant. We hold one course in four sessions. Each session consists of information time and discussion time. The purpose of this study is to determine consideration points on administering the support group for the recurrent breast cancer patient. Subjects are six nurses concerned with the administration of that support group. After having carried out two courses, group discussion about the purpose of this study was performed. Through qualitative inductive analysis, six consideration points became determined for consideration points on administering the support group for the recurrent breast cancer patient. 1. Because some hospitals hesitate to post the poster for the participant recruitment by the reason that patients receive a large shock by the word “reurrence”, it is necessary to talk out with a hospital about a method of the participant recruitment. 2. Because it is difficult for some participation applicants to participate by the progress of cancer, it is necessary to hear physical condition from a participation applicant on the telephone, and to judge the possibility of the participation. 3. Because some participants hold severe physical pain by metastases to bone and side effect of recurrence cancer treatment, it is necessary to prepare for the environment that participants can spend comfortably safely. 4. Because the flower reminds participants of a funeral and a graveyard depending on a type and a color of the flower, it is necessary to think about the meaning that the flower has in Japanese culture when we prepare for flower arrangement. 5. Because the course that the recurrent cancer patients followed and the sense of values formed that course are very various, it is necessary to explain repeatedly the discussion’s rule that we do not force one’s thought on for another person. 6. Because we do not have experience to express and discuss one’s principles very much in the Japanese culture and because the power that recurrent cancer patients protect from the opinion of another person is weak, it is necessary to observe whether a participant is not threatened by discussion and to support it individually at the time of the need. The findings of this study suggest that in administration of the support group for the recur-
rent breast cancer patient, it is necessary to consider the physical and psychological characteristics of the recurrent breast cancer patient, variety of the course and the sense of values that these patients have, and Japanese culture.

P-111
A METHODOLOGICAL EXPLORATION OF SYMPTOM CLUSTERS IN PATIENTS WITH INOPERABLE LUNG CANCER

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Aims
The objectives of the study were 1) to inductively explore the presence of symptom clusters in an homogeneous group of patients with inoperable lung cancer and 2) to explore if these symptom clusters are consistent when examined with different instruments and analytical methods.

Study design and methods: A cross–sectional study was conducted of 400 patients newly diagnosed with inoperable lung cancer, with a mean age of 64.5 years. Forty–eight percent of the participants were women. Data were analyzed from two questionnaires, European Organization for Research and Treatment of Cancer’s Quality of Life Questionnaire–C30 with the lung cancer specific module LC13; and the Symptom Distress Scale. Items in the questionnaires were adapted to increase their correspondence. Symptom clusters were analyzed using Pearson’s correlations, cluster analysis, factor analysis and Cronbach’s alpha.

Results
Three clusters were found to be notably consistent across instruments and analyses: 1) a non–tumor specific somatic cluster consisting of pain, nausea, bowel problems, appetite loss and fatigue; 2) a psychological cluster consisting of mood, outlook, concentration and insomnia; and 3) a tumor–specific respiratory cluster consisting of breathing and cough with fatigue and appetite loss closely related to more than one cluster in several analyses.

Conclusion
We found consistent symptom clusters for a large cohort of lung cancer patients at a comparable point in their cancer trajectory, across different measurement tools and statistical methods. This is important, as the relevance of symptom cluster research is questionable if there is a lack of consistency across data collection and analysis approaches. It is possible to achieve consistency in symptom cluster research across instruments and analysis methods, if instrument items are comparable. Fatigue and appetite loss were related to more than one cluster, indicating the need for further study of these symptoms, with consideration given clinical and not only statistical features.

P-112
WILL THE EXERCISE INTERVENTION PROGRAM REDUCE THE CANCER PATIENT’S FATIGUE LEVEL?

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Background
Fatigue is common distress of cancer patients. Without receiving appropriate treatment, the fatigue will affect the patient of the activities of daily living. How to improve patient fatigue level triggered author would like to further explore. The aims of this article are looking forward to empirical methods to evaluate whether the exercise intervention program can reduce the fatigue level of cancer patients.

Methods
We try to find the answers with empirical methods. We formed of a PICO question, and further searched the literatures by the database of ProQuest Nursing Journals, Ovid Medline and PubMed information. We entered keywords to find the evidence, and selected the RCT studies. Finally, we did the literature appraisal to find the good evidence.

Results
The study of Schwartz indicated that home exercise program applying in improving breast cancer patients showed significant differences in fatigue levels. The study of Barsevick found that “energy conservation activities” could reduce the fatigue level. The study of Berger pointed that there was a significant negative correlation of fatigue level and activity. The study of Barsevick pointed that “energy conservation activities” could reduce the fatigue level. The study of Berger pointed that there was a significant negative correlation of fatigue level and activity.

Conclusion
Comprehensive literatures shows that appropriate exercise intervention of cancer patients can effectively reduce the fatigue level. We look forward to providing the health care personnel for the reference to enhance the quality of life of cancer patients.

P-113
DEVELOPMENT OF SELF-MANAGEMENT SUPPORT SYSTEM FOR CANCER OUTPATIENTS

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Purpose
The number of cancer patients in Japan is increasing. Moreover, chemotherapy of cancer patients is shifting to outpatient–based therapy. Such outpatient therapy often results in a shortage of communication between the medical staff and patient, and may lead to an increase in uneasiness in the patient. We developed a support system that provides ouroutpatient cancer chemotherapy patients the same effect as those receiving inpatient cares. This system can also facilitate active participation of the patient in their own medical treatment.

Methods
The system includes a side effect self–diagnosis system, a patient community system, and an information service system. A social networking service (SNS) system was developed using the OpenPNE engine. Transmission and reception between patient and medical institutions are performed over the Internet.

Results
The side effect self–diagnostics system allows the patient to diagnose their own side effects. In advance, the patient and the medical staff can share the side effect data. The patient community system consists of a blog, community, and messaging functions. The information service system allows searching and inspection of information about medical treatment or side effects. Furthermore, contributions and edits of objective information (medical information) and subjective information (experience, etc.) are also possible. The usability test of this system was carried out with 28 men and women (age range, 21 – 57 years old; average, 38.5 years old). Although one subject required the manual to operate the system, task completion percentage was 100%. The system developed here can be used for patients in the age group unfamiliar with personal computers. With the continuing adoption of Internet usage, this system built using a web application framework will be well–received by patients.

Conclusions
The side effect self–diagnostics system and blog function allow both patients and medical staff to gain a detailed understanding of the patients’ side effects. Moreover, exchange of information between medical staff and patients is possible using the bulletin board system as part of the community function. Furthermore, the information service system was useful not only for information gathering about medical treatment or side effects, but also for conveying the experiences of the patients to others.

P-114
THE EXPERIENCE OF THE DEVELOPING OF THE ESOPHAGEAL SUPPORTING GROUP

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Purpose
The purposes of setting the esophageal supporting group are: 1) Helping esophageus disease patient to know medical treatment process. 2) Promoting the self care abilities of esophageus disease patients. 3) Improving the care skills of the families of the esophageus disease patients. 4) Providing the mental support and spiritual consulting of the esophageus patients and rebuilt the hope to walk out the shadow of disease. 5) Preventing the complications of the esophageus tumor, esophageus trauma, and esophageus corrosive injury. 6) Providing latest information for the families and patients by the web page.

Method
We built up the esophageal supporting group since 1999. The members of the group are including the esophageus patients, families, Dietitian,
operative patients with breast cancer and gynecological cancer. The lym-
phedema grades of them were stagel by the International Society of Lym-
phology (ISL). They underwent MLD once or twice monthly and received
health education for skin care, self-massage and exercise, and compression
stockings in accordance with the program. Assessment of the program in-
cluded measuring the limb circumference, life characteristics such as em-
ployment, family, and social activity affecting lymphedema.

Results
Eight female patients who had upper or lower limb lymphedema were en-
rolled in the study. Their average age was 59 years old. Three of them with
lower limb lymphedema had pain in walking and the limitation of their
sphere of activity. The pain among other participants with upper lym-
phedema obstructed their daily lives such as cooking and changing their
clothes. The mean period of the program was 16.5 months. The limb lym-
phedema circumference was reduced in the early stage of lymphedema by
taking CDP once to twice a month and doing self-care. However, it is difficult
to reduce lymphedema in the cases of having the tight situation for self-
care such as an advanced age, the consequences of cerebrovascular
accident, and a role of home care for an aged family.

Conclusion
The sample size was small, but the study suggested that the effectiveness of
the care program for lymphedema was made in cases with early stage of
lymphedema, stageland self-care. The improvements were made in mobil-
ity, subjective symptom, motivation to continue self-care by reducing the
limb lymphedema circumference. It is hard to apply the program in cases
having upper limb mobile limitation by the consequences of cerebrovascular
accident or orthopedic diseases, excessively using lymphedema limb, and
having difficulty to care by oneself due to lack of power of understanding.
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P-116
THE EFFICACY OF PROGRAM BASED ON COMPLEX DECONGESTIVE
PHYSIOTHERAPY FOR CANCER SURVIVORS WITH LYMPHEDEMA AT
AN OUTPATIENT SETTING IN JAPAN.

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2Kawasaki University of Medical Welfare, Kurashiki, Japan, 3Kobe City College of
Nursing, Kobe, Japan.

Background
Lymphedema is a chronic problem causing distress and loss of functions
and decreasing quality of life. Complex Decongestive Physiotherapy (CDP)
is a representative noninvasive treatment for lymphedema, conducted by con-
bining four kinds of physical therapies: skin care, manual lymph drainage
(MLD), compression bandage and exercise. CDP is considered a standard of
care in developed countries but has only recently been used in Japan for peo-
ple at outpatient settings.

Purpose
This prospective study assessed the efficacy of a care program based on CDP
for the woman’s cancer survivors with lymphedema. Methods: The care program for lymphedema was led by a group consisted
of a nurse who has a license of CDP therapist and certification of cancer clinical
urse, clinical nurses, and medical doctors. The participants were post-

P-117
SEXUALITY AFTER TREATMENT OF CANCER OF THE CERVIX IN KUMASI
- GHANA

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Background
A total of 2,278 new cancer cases were seen from January 2004 to December
2005 at the Oncology Directorate of KATH: 495 males and 1,780 females.
The mean ages are 50 and 54 years for males and females respectively. The
male to female ratio is 0.3 : 1 with female cancers forming 75%.
Cervical cancers account for 39% of all cancer types and it is the leading killer
of women between ages 40 and 60 in Ghana due to late presentation at di-
agnosis. 20% of these women lack financial and emotional support from their spouses
and threats of divorce, posing insecurity which affects their quality of lives.

Objective
To conduct a preliminary study to assess clients sexual life prior to
the disease and after treatment and whether it has affected their marital rela-
tionship.

Methodology
Years 2004 and 2005 patients were used in this study. 306 women with cancer of the cervix were treated with Radiotherapy and Chemotherapy dur-
ing this period. 133 were married, 50 out of these between ages 30 and 60,
with stage b2. b were free from the disease and leading normal lives, were
selected randomly and interviewed. A questionnaire was designed to carry out the study.

Results
• 15% had sexual activity once a week, 5% twice a week, 36% once a while
  and 44% not interested at all after treatment.
• The spouses of all the women knew about their diagnosis.
• 20% felt insecure due to lack of financial, emotional support and threats
  of divorce from their partners.
• 80% were afraid to have sex speculating a re-currence of the disease.

Conclusion
Based on the preliminary results, cancer of the cervix affects the sexual
activities and marital relationships of women. There is also the need for fur-
ther studies in our part of the world.

P-118
THE EFFECT OF INFORMATIONAL AND SUPPORTIVE CARE PROGRAM
COMBINED WITH PROGRESSIVE MUSCLE RELAXATION ON ANXIETY
AND QUALITY OF LIFE AMONG FAMILY CAREGIVERS OF PATIENTS WITH ADVANCED
CANCER.

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The purpose of this quasi–experimental study were to examine the effect of
using Informational and Supportive Care Program combined with Progressive
Muscle Relaxation (ISC-P–PMR) on anxiety among family caregivers of ad-

POSTER ABSTRACTS

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advanced cancer patients. Forty family caregivers of advanced cancer patients from inpatient of King Chulalongkorn Hospital were selected by matching the experimental group with the control group. The experimental group received routine nursing care, while the control group received the ISCP-PMR for 4 weeks from the researcher. The program based on Orem theory and relaxation concept. The collecting instrument was the State Anxiety Test from Y-1 of Spielberger et al (1983). The data were analyzed by using t-test. The finding reveal that the posttest anxiety of the experimental group was significantly lower than that of the control group (p <.05). The results suggest that ISCP-PMR could decrease anxiety of family caregivers of advanced cancer patients.

**Keyword**
INFORMATIONAL AND SUPPORT CARE PROGRAM/ PROGRESSIVE MUSCLE RELAXATION/ANXIETY/FAMILY CAREGIVERS/PATIENTS WITH ADVANCED CANCER
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P-119
SEXUALITY OF THE WOMAN WHO UNDERWENT A MASTECTOMY
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The study tried to investigate the aspects of sexuality in women who are carriers of breast cancer and who underwent a radical mastectomy surgery. It had as a starting point my assistance practice as a nurse in the gynecological unit. I noticed concealed questions both from the part of the women and from the part of the professionals related to discussing sexuality after a mastectomy. This investigation has been developed using Martin Heidegger philosophical approach and had the objective of revealing the meaning of sexual expressions in women who underwent mastectomy, in the ambulatory of a public hospital in Rio de Janeiro city (Brazil), phenomenological interviews were carried out consisting of two main questions: how the woman feels after a mastectomy and, also, how she feels in terms of sexuality after mastectomy. By a thorough reading of fifteen transcribed statements, it was possible to construct the units of significance. In a vague and average comprehension, the expression of sexuality was revealed through: heterosexual relationships, the necessity of a period of time to get accustomed to the mutilated body, the affectionate attention of husbands, the return to the daily activities, and the happiness to be alive and the recovery of the physical integrity. The interpretation, based on the view of Martin Heidegger, revealed that these women understand that it is possible to cope with the loss of their breast and to live sexually healthy and happy. They realize they can live well and the conclusion they are able to come to is, for us, professionals, an alert: it is a false perception to believe that the woman after a mastectomy surgery will definitely have her capacities and possibilities compromised. Moreover, health assistance must arise from the woman needs and not only include her as if she were a passive being.

P-120
THE HEAD NURSE IN ONCOLOGICAL UNITS: INTERVENTIONS OF SUBJECTIVITY IN THE ORGANIZATION OF HEALTHY WORKPLACES
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The practice of nursing in oncology puts professionals in close contact with situations of pain, ending and death, besides mutilations and hopelessness, as well as expectations of cure. The therapeutic aggressiveness and the required adjustments to the treatment process constitute stress generating elements for patients, relatives and the team. In this scenario the head nurses develop their practice, and conduct teamwork relationships. This work aims to discuss the interface of nursing leadership with its subjectivity and its intervention in the organization of healthy workplaces in oncological units. A descriptive study of qualitative approach. For theoretical basis, we adopted the Brazilian National Humanization Policy guidelines. Twelve head nurses working at a federal public institution agreed to participate in the research in order to produce data we used the focal group technique. Content analysis has shown the analytical category: the head nurse in oncological units – interventions of subjectivity in the organization of healthy workplaces; two other categories. The results indicate the need for a humanized managing practice, so as to favor a healthier environment for performance of the nursing team. One reaches the conclusion that head nurses can act as facilitators for humanized working relationships, as long as they can adopt strategies that embody autonomy, protagonism and co-responsibility of the individuals involved in the health production process, through the construction of new meeting spaces.

P-121
CAPACITY BUILDING: RESEARCH INFRASTRUCTURE IN AFRICA
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**Capacity Building: Research Infrastructure in Africa.

Background
The African Population and Health Research Center (APHRC) is a non-profit, non-governmental international organization committed to conducting high quality and policy-relevant research on population and health issues facing sub-Saharan African. The Center was established in 1995 as a Population Policy Research Fellowship program of the Population Council, with funding from the Rockefeller Foundation. In 2001, it became an autonomous institution with headquarters in Nairobi, Kenya. In partnership with the International Development Research Centre (IDRC) and the Ford Foundation, the APHRC introduced the African Doctoral Dissertations Research Fellowship (ADDRF) Program in 2008 to support doctoral students in African Universities. The program awards dissertation fellowships to doctoral students enrolled in sub-Saharan Africa universities who are conducting health-systems or sexuality related research.

The Invitation
There have been two cohorts accepted into the ADDRF Program. In 2008 there were 20 fellowships awarded to doctoral students from eight countries. In 2009 the number grew to 25 including 5 fellows from Francophone speaking countries. There were two international faculty members and the remainder of the faculty were doctoral assisted Asian faculty. International faculty reflections focus on cultural/anthropological aspects of being “the other” and how to converse or teach with the notion of cultural humility.

The Content: The curriculum was revised from Year 1 to Year 2 and aspects of the curriculum will be discussed including content and time-frame. An overview of the ADDRFF program and course work includes topics used in the curriculum and how the content has the potential to build capacity.

The Outcomes
Program outcomes will focus on the shared knowledge that is generated, issues related to research in Sub-Saharan Africa. Cultural differences are explored such as, understanding and sharing different cultures. The international faculty learn to listen to African-focused research topics, their appliability to respective populations, proposed policy change, and scope of the research.

Conclusion
This presentation concludes with an altruistic and alternative worldview. My world has been enlarged by the experience of being faculty in this program by sharing, individual and group learning, and networking. Upon returning to the U.S., my research and my teaching is informed by having had the experience with these African scholars. An exemplar will be used to close this session. Currently I have a Research Assistant in Francophone speaking doctoral student from Benin. The challenge to the audience is that expertise can be found in many areas of the world and as we become a global cancer community we must be open to the possibilities.

P-122
THE STUDY OF RELATIONSHIP AMONG HEAD NURSE'S TRUSTWORTHINESS AND NURSING STAFF JOB INVOLVEMENT.
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Abstract
In the nowadays interpersonal relationship becomes estranged in the society, the enterprise organizes the key point which manages besides in the system management, most consequence is cooperation and share between the internal supervisor and subordinates. The organization's foundation is trust and job involvement also is important attribute in the organization. In this perspective it facilitates the cooperation, share, and the essential factor of relative quality between the supervisor and subordinates.

In the past the interpersonal relationship in the organization was by management viewpoint mostly, however this research by subordinate's viewpoint, discussed between the head nurse's trustworthiness and nursing staff the job involvement.
There were 559 nurses’ participants in this study. The data were analyzed by SPSS 12.0. The study findings were as follows: (1) Among head nurses’ trustworthiness, their management competence, the specific characteristic, approval is highest; by the head nurses’ consistency the special characteristic, approval is lowest. (2) The head nurses’ trustworthiness has related nursing staffs’ job involvement in positive correlation and influence, the more perception of head nurses’ trustworthiness and the more job involvement of nurses. (3) The age, working experience, the ordinary unit of work and married of the nurses’ did influence their perception and level of trust. (4) Nursing staffs’ age, working experience and married of the nurses’ did influence their perception and level of job involvement. (5) There was a significant difference in clinical ladder nurses’, education level, having children factors and nurses’ perception of head nurse trustworthiness. The conclusion suggest that head nurses’ trustworthiness should be considered when nurses’ will establish believable management system and educate nursing manager.

P-124 WOMEN WITH BREAST CANCER: BARRIERS AND ENABLERS WHEN ACCESSING THE SPANISH HEALTH CARE SYSTEM

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According to previous studies, the lack of equity for access to health care services is linked to variables such as income, education level, cultural origin and living area. These variables correspond to structural schemes, which could facilitate or reduce the time of access to these services. The main objective of this study is to identify the possible socioeconomic and cultural inequities in women with breast cancer, diagnosed and treated, in an urban population area in Barcelona (Catalonia, Spain), in relation to their use of the health care services; and to comprehend the complexity of women pathways to their diagnosis and treatment. In Spain there is a lack of studies in this field.

This is an observational study, with a retrospective and prospective component. The studied population is 577 women diagnosed with breast cancer of the urban area of Barcelona (in Catalonia, Spain). The exploring variables evaluated are the following: sociodemographic data, income, education level, cultural origin, living area, clinical data and access to the health care system. Of the 577 eligible women, 67 were excluded according to the inclusion/exclusion criteria, and the final population of study were 510 women diagnosed. According to the literature review, previously done, we designed a phone-questionnaire and a data base. Three experienced interviewers were specifically trained for collect this data. A pilot test was made with 25 women with breast cancer, after this pilot test the phone-questionnaire was modified to solve the comprehension difficulties that aroused. All the data from the phone-questionnaire and the clinical data from the medical records were rigorously introduced in the database, and all the data were validated.

For the analysis descriptive and inferential statistics were used. Findings will show the inequities in accessing health care services for women with breast cancer when accessing the health system in Barcelona according to the way of diagnosis, and will illustrate the main social or family supports which contribute to health care services. Moreover, the relation between education level, income, cultural origin and the screening program (coverage degree, participation and reasons for non-participation) will be shown. These results will allow a further qualitative study to explore the social relations acting in the time of diagnosis and treatment for women with breast cancer in Spain. This study has been funded by the Spanish Ministry of Health, ISCIII; PI08/00888.

P-124 HARDWIRING THE 5 RIGHTS-COMPUTERIZED MEDICATION MANAGEMENT

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The deployment of information systems has been advocated by the Institute of Medicine as a strategy to improve patient care and decrease medication errors. Yet only 3.6% of U.S. hospitals have implemented closed loop medication management process according to HIMSS Analytics. Successful integration of information technology into the medication process is a major challenge for healthcare institutions and even more so for the complex regime of the oncology patient. This presentation will describe the journey undertaken by a four hospital, 10 service-oncology system to incorporate information technology into their workflow to increase patient safety in the medication management process. Information technologies implemented include Computerized Provider Order Entry (CPOE), a Pharmacy System module, electronic Medication Administration Record(eMAR) and Barcode Medication Administration (BCMA). Implementation strategy, challenges and lessons learned will be shared. Specific outcomes related to workflow, turnaround times and medication errors will be presented to address compliance with the Joint Commission Medication Management Standards.

P-125 IMPROVING DOCUMENTATION, ACCOUNTABILITY AND SAFETY IN THE CHEMOTHERAPY DAY UNIT THROUGH THE IMPLEMENTATION OF AN ONCOLOGY PATIENT INFORMATION MANAGEMENT SYSTEM.

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The introduction of CHARM has markedly improved the documentation of all chemotherapy medications administered within the Chemotherapy Day Unit. No longer do we struggle to read illegible handwritten orders. All adjustments are now traceable down to who has adjusted the orders and treatment dates with the ability to document the reasons underpinning and changes made. This facilitates the communication process among all relevant health professionals involved in the patient care. All treatments are now ordered by applying a pathway to the patient’s treatment profile which has significantly decreased the risk for error and miscommunication. All pathways have been set out according to the hospital policy and care guidelines, and approved by the various tumour stream clinicians. There is, therefore, a greater consistency in how and in what order chemotherapy medications are prescribed and administered. All standard premedication is recommended and discharge medications are also provided on the medication chart; clinicians are then able to adjust those as individually indicated. All pathways are able to be adjusted by the medical clinician so as to tailor the treatment personally for patients as required. When a patient is entered on a pathway this creates a proposed order for Pharmacy, once Pharmacy initiates the production of treatment, clinicians are no longer able to adjust that specific order without notifying the relevant department. This has the potential to reduce the volume of chemotherapy waste (and associated monetary costs) as well decrease the length of waiting time before chemotherapy commences.

By implementing this system the Chemotherapy Day Unit has successfully improved the accuracy of its documentation and increased individual practitioner accountability. By streamlining the prescribing, dispensing and administration process of chemotherapy medications, this has ultimately ensured optimal delivery of patient care and promoted greater patient safety.

P-126 THE ADVANCEMENT OF THE SAFETY OF THE CHEMICALS RECEIVED AND DELIVERED BY THE UNIT ASSISTANTS

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This project aims at advancing the safety of the chemicals received and delivered by the unit assistants. The duties of the assistants in the units of the Department of Oncology include receiving and delivering chemicals required by the units. Due to the chemical cytotoxicity, the improper treatment of the chemicals may impact the health of the personnel in charge of delivery. Through the Assistant Receiving and Delivering Chemicals Behavioral Cognitive Table, the cognitive accuracy totals 75%; through the Assistant Receiving and Delivering Chemicals Behavioral Observing Table, the behavioral accuracy totals 66.25%. Through the causal factor analysis, the units have excluded the assistants in the related in–service training so that the unit assistants lack the accurate knowledge relating to chemical toppling, splash or breaking treatment flow and promotion and have failed to set the exclusive safe appliances for receiving chemicals. According to the preceding findings, the improvement measures are made. The in–service education and training courses for assistants are opened and held yearly. Moreover, the posters of Chemical Toppling, Splash or Breaking Treatment Flow were put up in the preparatory rooms. Meanwhile, the related aided appliances exclusively for receiving and delivering chemicals, 2–level trolleys and chemical delivery boxes, are set. Furthermore, the personnel of the quality monitoring team monitor periodically the actual practices of unit assistants receiving and delivering chemicals. Through the improvement measures, the cognitive accuracy of unit assistants receiving and delivering chemicals is advanced from 75% to 100%; the behavioral accuracy rate is advanced from 66.25% to 95%, indicating that the project has achieved its goal and has promoted the safety of assistants receiving and delivering chemicals and promoted the circumstantial safety in hospitals.
**P-127**

**IMPROVING PORT-A CATHETER CARE BY A QUALITY CONTROL CIRCLE AT A UNIT**

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Chang Gang Memorial Hospital, Taipei, Taiwan.

Improving Port-a catheter Care by Quality Control Circle at a unit  
Liu Di Yun

Port-A is a permanent iv access for patients receiving chemotherapy. It provides stable way for intravenous drug administration long-term nutrition support. Although it can greatly reduce discomfort accompanying repeated venupuncture, improper care may result in various untoward complication such as infection, obstruction, pain, dislocation, eventual need for surgical removal.

The results disrupt of treatment and length status of hospitalization, may increase medical costs and threaten patients life. This study was to investigate the cause of improper Port-A care by chart review and direct observation. We found that cause of improper Port-A care included that (1) only 2 members received full subspeciality training. (2) Only 9.1% of nursing staffs read Port-A standard. (3) Only 71.5% of Port-A was conducted properly by nursing staffs and (4) lack of continual quality monitor Port-A care. Based on the previous, we decided to implement, the projects included that(1)We reviewed and revised standard procedure. 2. Established a series of curriculum to instruct nurse staff and Objective Structured Clinical Examination (OSCE). 3. Designed a pithy formulae make nurse easier to remember the Port-a catheter care procedure. 4. Included a quality monitoring to assure the care quality and used a checklist to check the nurses’ Port-a catheter care technique. 5. Computerized the standard procedure to make nurses to get the information quickly.

After the aforementioned activities, significant improvement was observed, included (1)manual ready rate improved from 71.5% to 98.9%. (2)The abnormal incidence reduced to 0.

**P-128**

**RESPONDING TO BENCHMARK DATA: TAKING AIM AT REDUCING PATIENT FALLS**

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**Purpose**

The goal of this project was to decrease the incidence of patient falls in the medical and surgical units of a small community hospital. The rate of patient falls in the units had remained significantly above national averages in spite of previous implementation of extensive safety initiatives.  

**Significance**

Falls are the leading cause of injury death for people age 65 and older, and the cost of treating fall injuries is expected to reach $32.2 billion annually by 2020. Hospitalized people may have increased risk of falling related to the effects of illness and therapy.

**Strategies and Implementation**

As part of a major initiative to reduce falls, detailed nursing standards for assessment of risk and prevention of falls were developed, bed alarms were used, and lifting equipment was purchased. These strategies alone did not have the desired effect on the incidence of falls. When measures of quality outcomes were discussed in staff meetings, bedside nurses provided insight into the limitations of standard approaches for preventing falls. They suggested using bright red gowns to identify patients at high risk, implementing a routine of hourly patient checks by nursing technicians, and including walking rounds as part of the shift report. The implementation of these strategies required staff education throughout the shifts.  

**Evaluation**

After a year, the incidence of falls per 1000 patient days was reduced from 5.39 to 1.74 in the surgical unit, and from 5.94 to 2.75 in the medical unit. This is also anecdotal evidence of how the changes have worked to keep patients safe. The use of red gowns has enabled staff throughout the hospital to identify patients who have a high risk for a fall.

**Implications**

National benchmark comparisons stimulated this project and provided a basis for monitoring progress. The input of bedside nurses was critical in identifying successful strategies. The result has been an improvement in patient outcomes. The use of red gowns, hourly rounds, and walking rounds at shift change are effective strategies for reducing the incidence of falls in medical and surgical hospital units.

**P-129**

**A STUDY TO ASSESS STAFF NURSES’ KNOWLEDGE AND PRACTICES OF BED SORE PREVENTION IN ORDER TO PREPARE SELF INSTRUCTIONAL MODULE (SIM) FOR THEM IN A SELECTED HOSPITAL, LUDHIANA, PUNJAB, INDIA.**

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**Abstract**

The majority of pressure ulcers are preventable. Nurses are able to constantly observe their client’s skin for breaks or impairment in skin integrity. Pressure ulcers not only cause suffering to the patients but also increases the workload on nurses.

**Aims and objectives**

To identify the deficits in knowledge and practices of bed sore prevention among staff nurses’ working in special units and general wards and to prepare a Self Instructional Module for improving the quality of nursing practices.

**Methodology**

An exploratory approach and participating observation approach was adopted. This study was conducted in Christian Medical College & Hospital, Ludhiana, and Punjab, India among 60 staff nurse working in general ward and special unit. Purposive sampling method was used for data collection with self prepared questionnaire with multi-choice options for study the knowledge level and an audit form with checklist for assessment of practice. The data was analyzed using in terms of descriptive and inferential statistics.

**Results**

Staff nurses working in special units have significantly better knowledge (72.92%) than general wards (62.50) and significantly better practice (60.29%) than (46.68%) in general wards. Overall knowledge of staff nurses was higher (67.71%) as compared to their practice (53.49%),

**Conclusion**

It is assumed that Pressure ulcers are preventable. But high prevalence of pressure ulcers among indoor patients have various contributory factors. So that self instructional module (SIM) was prepared on the basis of Deficits in the knowledge and practice of bed sore prevention and it can be used for improve quality of nursing care and reduce cost of prolong hospital stay of pt.

**Keywords**

Knowledge, Practices, Staff Nurses, Prevention, Bedsore, SIM.

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**P-130**

**IN SEARCH OF A CLOSED IV AND DRUG-TRANSFER SYSTEM FOR HAZARDOUS DRUGS IN OUR CANCER CENTER.**

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Occupational exposure to hazardous drugs has long been a concern for nurses and pharmacy staff. Several types of closed IV and drug-transfer system have been marketed and available for purchase in recent years. The challenge lies in which closed IV and drug-transfer system to choose? How do you select the best-closed IV and drug-transfer product that will meet the usability and safety needs of nursing and pharmacy with the least impact on workload? Our team will share the team’s experience in selecting and evaluating a number of closed IV and drug-transfer systems in an attempt to find the right fit for our centre taking into consideration staff requirements, our current IV infusion pump system, drug delivery process and safety standards. Part of the team evaluating the products included our human factors colleagues (biomedical and human factors engineers and cognitive psychologists). Incorporating human factors principles into the evaluation process was done to ensure the selected product was safe, usable and provided effective technology. The oral or poster presentation will highlight the initial product selection criteria, product trials, and evaluation process.
THE SAFE BEHAVIORS OF THE ADVANCED EXECUTED CHEMICAL THERAPIES
Kuo Chiu Ya, RN1; Hou Mei Jau, RN2; Lu Pei Chien, RN2.
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The primary objective of the patients’ safety is the medication safety. According to the statistics of Units Duties Records 2007 of the Department of Oncology in some local hospital, the average man times of monthly hos- pitalized chemotherapeutic patients are 98. Therefore, the chemotherapies are highly executed techniques; moreover, any error in any link of chemotherapies may result in damages to patients. Given that, this project realizes the status of the nurses involving in chemotherapies and finds that the entire recognition sums up 81% via the Chemicals Leakage and Splash Treatment Flow Recognition Survey and the technical integrity sums up 75% via the Chemical Injection Technical Assessment Table. The project proposes the strategies as to advance the chemotherapeutic safe behaviors of the nurses in the Department of Oncology and facilitate the medication safety of cancer patients:
1. to make the training plan of advanced recognition with periodical instructions and re-instructions to enhance the nurses’ recogni- tion of chemical leakage and splash treatment flow, 2. to make posters of Chemical Leakage and Splash Treatment Flow and Chemical Toppling, Splash or Breaking Treatment Flow and post them on chemical cabinets and in the preparatory rooms at nurse stations as the references to the nurses prior to executing chemotherapies to increase the recognition, and 3. to exercise the monthly monitoring of technical integrity of chemical injection under the Chemical Injection Technical Assessment Table. Through the improvement measures, nurses’ recognition of the Chemical Leakage and Splash Treatment Flow is advanced to 99% and the technical integrity of chemical injec- tion sums up 95%. The intervention of the project is expected to constantly advance the chemotherapeutic safety executed by nurses, prevent the med- ication negligence and facilitate the medication safety of chemotherapeutic patients.

P-132
THE EFFECTIVENESS OF PSYCHOLOGICAL SUPPORT FOR PATIENTS WITH CANCER
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Difficult and emotive psychological distress issues are common in cancer care and supportive patient–center care is a fundamental part of nursing practice. The aim of this study was to evaluate the effectiveness of providing psychological support for cancer patients. This study was a quasi–experi- mental design. Data were collected from before and after receiving psycho- logical intervention for cancers patients in a medical center in Northern Taipei City. Participants were 52 in the experimental group and 40 in the control group. Patients in experimental group received 40 minutes individual psychological support by psychiatric nurse during staying days. Participants in control group received routine care as usual. The research measurements were using Hospital Anxiety and Depression Scale (HADS), symptom distress scale. Statistical methods were using paired t-test and Wilcoxon signed ranks test. The results found significantly in depression scale of HADS with exper- imental group. There was no difference in depression scale with control group. But both of two groups were found significantly in anxiety scale of HADS. This study showed providing psychological support could reduce de- pressive mood status of patients with cancer. The results suggest that cancer patients who need psychological support can be referred to participate in a psychosocial intervention by psychiatric nurses.

FROM CASE MANAGER TO “CARE” MANAGER
Denise Geuder, Gina Mihelich and Fran Reichel.
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This presentation will discuss the concept of Nursing “Care” Management at Cancer Treatment Centers of America, an organization with four geograph- ically diverse oncology programs. The role is a hybrid of traditional case management and the nurse navigator. The recent installation of an electronic health record will be discussed as a tool to enhance the function of this role and the subsequent increase in patient satisfaction as a result. Sustainable metrics will be shared to include productivity, call turnaround times and em- ployee satisfaction as well.

P-134
PRIMARY NURSING IN AN OUTPATIENT SETTING - IS THIS OPTIMUM CARE?
Moira Gillespie, BSN, Moira Gillespie, BSN, PG Dip Health Science.
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Patients receiving chemotherapy need an experienced, knowledgeable and skilled nurse who is able to educate, deliver safe care, monitor, advise and support the patient on their cancer journey. Primary nursing is recognised as being one nurse primarily responsible for coordinating, delivering and evalu- ating care to the patient. This is in contrast to the team approach where two or more nurses may deliver care to an individual patient. Often touted as the optimum way to deliver care, the primary nurse forms strong therapeutic re- lationships with the patient, however, there can also be problems with this approach with primary nurses reluctant to share information or see other members of the team as “interfering”. This presentation will look at both sides of the argument and pose the question – Does Primary Nursing work in an Outpatient Oncology setting and is this the best care for the patient?

P-135
EVALUATION OF EDUCATION-BASED INTERVENTION ON AN OUTPATIENT BASIS TO HELP TOTAL GASTRECTOMY PATIENTS REBUILD THEIR LIVES
Masataro Horikoshi, MHSc, Tamei Futawatari, Ph.D. Gunma University, Muebashi, Japan.

Objective
To help rebuild the lives of total gastrectomy patients following discharge, this study was designed to clarify patients’ anxieties and difficulties, and evaluate the effects of educational intervention.

[Methods] Subjects: The subjects were two men in their 50s and 60s who had undergone total gastrectomy due to stomach cancer (stage I a/b). Period: January to May, 2009.

Methods
They were instructed to record daily weight changes, primary complaints, and the frequency of eating using an independently developed self-record form, starting immediately after discharge. Then, semi-structured interviews were held on the basis of their records at discharge, and on the first and second visits after discharge to allow them to freely describe their anxieties and symptoms. The interviews were recorded verbatim, and analyzed in a qualitative and inductive manner. Educational intervention was conducted at each visit.

Ethical consideration: This study was approved by the ethics committee of the institution to which the researcher belonged, and permitted by the director of the hospital where the study was conducted. Written informed consent was obtained from both subjects.

Results
Interviews with the subjects identified “uncertainty over life”, “anxieties over the prognosis”, “worries about eating”, and “anxieties over returning to work” at discharge, “uneasiness about symptoms (regurgitation, epigastric dis- tress)” and “concerns about weight loss” on the first post-discharge visit, and “concerns about decreased strength”, “relief due to the stabilization of symptoms”, “self-confidence through the successful management of symp- toms”, and “relief due to the restoration of strength” on the second visit. The educational intervention included: 1) reconfirmation of how to take meals and their contents, 2) instructions on how to manage symptoms, and 3) guidance on daily activities and rest. After each intervention, the subjects expressed their will to actively confront their conditions.

Conclusion
Patients who undergo total gastrectomy receive guidance on their post- discharge life during hospitalization. However, they desire more practical information as their anxieties and concerns become more concrete on gain- ing experiences of the various difficulties after discharge. The period up to 1 month after discharge is the most important for them to adapt to their new life. This study suggested the importance of fully covering their primary complaints on each occasion, and conducting feasible educational interven- tion depending on their ability to rebuild their lives.
This study comprises 2 stages.

First stage: We created a nursing model that encompasses the difficulties experienced by cancer patients undergoing outpatient treatment and the nursing care for providing support with difficulties. We conducted a metaethnography using 3 doctoral theses and 9 original theses describing the experiences of cancer patients undergoing outpatient treatment or nursing care for cancer patients undergoing outpatient treatment. And we created a theoretical “nursing model for promoting the empowerment of cancer patients undergoing outpatient treatment”.

Second stage: We verified the theoretical nursing model created in the first stage. Based on the sub-items contained in the categories of the nursing model, we created a questionnaire. The questionnaire comprised items regarding nursing care (24 items), items regarding stress (24 items), items regarding anxiety (24 items), items regarding changes (22 items), items regarding difficulties (6 items), and items regarding demographic variables. We distributed the questionnaires to 229 cancer patients undergoing outpatient treatment and collected the results by mail. In the data analysis, we first conducted an exploratory factor analysis of struggles, nursing care, and changes by using the factors obtained from the factor analysis as variables.

Conclusion
As a result of this study, nursing care model for promoting the empowerment of cancer patients undergoing outpatient treatment was thus established. We believe that the utilization of this care model allows for the easy assessment of struggles with difficulties experienced by cancer patients and the provision of deliberate nursing care.

P-138
CANCER LINK NURSES: IMPROVING COMMUNICATIONS AND ACCESS TO CARE IN RURAL COMMUNITIES
Maggie Stowers, Melinda Williams, Barwon South Western Regional Integrated Cancer Service, Geelong, Victoria, Australia.

Introduction
People living with cancer in rural communities face many challenges including access to specialist nursing care. In order to improve the experiences of those affected by cancer within a region in rural Australia a Cancer Coordination (CC) project was introduced.

Method
The CC project involved mapping of complex cancer journeys that provided data on patient needs, referral pathways and gaps in the delivery of cancer care and support. Patient information was collected and entered onto the CC web based database. A gap was recorded if a cancer service was not accessible to a cancer patient.

The data analysed in this initial phase was over a twenty-month period and included 215 patients. The data indicated that the service most requested by patients was psychological/emotional support. The second highest service requested was information provision and included both clinical and general cancer information. The highest gap in cancer service identified was access to specialist nurses. A gap was recorded if inability to access a specialist nurse had impacted on the cancer patient’s pathway or outcomes.

This evidence has informed the development of a sustainable phase of the CC project, the introduction of Cancer Link Nurses into rural health services.

Aims
Enhance continuity of care for cancer patients
Improve communication links between clinicians
Increase availability of cancer nurses
Create sustainable regional links in cancer care

The Cancer Link Nurse undertakes specialist cancer education and attends a mentor program at the main cancer treatment centre. Video conferencing into multidisciplinary care meetings and education forums assists in overcoming some of these challenges.

Access to the web based secure database allows Link Nurses across the region to communicate online in a paperless manner and share updated patient and multidisciplinary meeting information in real time.

Conclusion
Cancer Link Nurses can become the cornerstones for sustainable regional cancer coordination, enhancing communication links for treatment teams and providing up to date information, education and support at a local level, thus improving patient journeys.

P-139
PRODUCTIVE WARD RELEASING TIME TO CARE
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It was found through studies documented in the Nursing Times that nurses and practitioners felt that they spent little time on patient care and according to the NHS Institute for Innovation and Improvement, ward nurses spend an average of just 40 per cent of their time on direct patient care. As a result the NHSS developed the productive ward modules releasing time to care.

Productive ward releasing time to care was rolled out a busy radiotherapy inpatient ward in a regional cancer center as a showcase ward at it consists of 13 self directed modules to improve patient care and safety and reduce length of stay.

As a busy 33 bedded in patient radiotherapy ward processes needed to be streamlined to ensure smooth running.

Initially a hierarchy of management shadowed staff to monitor areas for improvement in saving time, areas were then discussed with staff and suggestions for improvements made and implemented.

Staff were released to attend productive ward study days to support implementation and guide changes, below are some areas identified and changes made.

Nursing team – three teams system with named nurses, teams identical layout with nurses station and paperwork. Three case trolleys for three teams with daily sho/Registrar/consultant ward rounds pharmacy and other disciplinary invited.
P-140 MAMMOGRAPHY ADHERENCE EDUCATION FOR NONADHERENT AAW: TWO ALTERNATE MODELS
Eva D. Smith, PhD, Diana Wilkie, Ph.D, Barbara Dancy, PhD, Debra Boyd-Seale, PhD, Southland CBPR Coalition, University of Illinois at Chicago, Chicago, IL, USA.

Aim
The population with whom our team works consists of socioeconomically marginalized African American women (AAW) who encounter a number of access challenges in pursuit of health care, including health education. To promote greater accessibility, we developed and tested two alternate mammography adherence intervention models, 4-hours and 6-hours, derived from our 8-hours (four 2-hours sessions) intervention.

Methods
We conducted content analysis of the 8-hours intervention and identified the core content that was essential for all models of the mammography adherence intervention. We then adapted the core content to the time allotted for each model. A purposeful sampling plan was used to recruit two groups of AAW. Women who were 40 years of age and never had a mammogram (n=14) or were relapsed from regular mammography screening (n=38). We used the Transtheoretical Model (TTM) of behavioral Change (Adoption) as our conceptual framework. According to the TTM, the acquisition and maintenance of health behaviors is a complex process that includes moving through several stages of screening adoption, examining pros and cons (decisional balance) of changing behavior, and having confidence (self-efficacy) to carry out the behavior. All educational sessions were held in community settings. We used a pre-post test design to determine the impact of the intervention on knowledge, beliefs, decisional balance, self efficacy, and stage of mammography adoption.

Findings: No significance was found in knowledge pre to post assessment group means. However, significance differences were found in knowledge questions related to early detection strategies, support for mammography maintenance, mammography frequency guidelines, risk factors for breast cancer (p<.001), and age to begin mammography screening (p=.05). Stages of adoption were significant with both forward and backward movements at post assessment: 3.8% (n=2) moved one stage backward, 42.3% (n=22) moved one stage forward, and 46.2% (n=24) remained in the same stage of mammography adoption. Post intervention stages of adoption were 6.3% (n=3) in precontemplation stage (no desire to change behavior) and 93.7% (n=45) in the contemplation stage (intent to have a mammogram). No significant changes were found in beliefs, decisional balance, and self efficacy between pre and post assessments.

Conclusion
The two alternate intervention models were successful in increasing some areas of knowledge and intention to have a mammogram demonstrated by mammography stage of adoption forward movement. We will have to conduct further research to determine if one session intervention models provide sufficient time for impacting long held beliefs between pre and post assessments.

P-141 PLANNING FOR THE SUSTAINMENT OF A 24/7 ONCOLOGY CLINIC: AN ACTION RESEARCH PROJECT USING LEAN A3 MANAGEMENT
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Background
Usually in oncology settings patients experience multiple cycles of inpatient and outpatient care throughout their care continuum. Problematic in this cycle is the lack of options for acute symptom management especially when a patient is being seen as an outpatient. The optimum care would be a single cycle is the lack of options for acute symptom management especially when a patient is being seen as an outpatient. The optimum care would be a single

Objective
This paper describes the new service that provides supportive care to oncology patients 24 hours a day, 7 days a week. The presentation describes the process used to develop evaluation metrics including the clinic’s functions, utilization and operations.

Method
This project used an action research methodology with Lean methodology utilizing the A3 management principles. This combined approach allowed for the evolutionary drive of action research with the A3 format giving appropriate rigor for the documentation and findings of the research. Stakeholders within the hospital participated in the development of the quality indicators measured by the hospital. Interviews were conducted with oncology patients to identify patient needs, opinions and ideas for a 24/7 Cancer Care Clinic. The goal of evaluating these two groups was to meet both internal and external stakeholders’ needs and plan for sustainability and growth of the clinic.

Findings
The patient interviews revealed two main themes that define their needs. Fear and anxiety are the forces behind many of the patient needs and desires. Inclusion of the voice of the patient in addition to the hospital employed stakeholders in the sustainment plan of this clinic will help provide better care and patient satisfaction. Many of the metrics identified are measured by current hospital operations and should be added to the quality indicators measured by the hospital. Patient specific metrics reflect ability to accept patient and provide services as needed. These metrics will be monitored for quality and sustainment efforts to provide for accurate assessments for purposeful changes and growth.

Implications to Practice
This paper serves as a foundation to identify 24 hour oncology care on demand as an option and to provide the beginning for further research into patient needs for this type of service as well as benchmark measures for quality improvement.

P-142 ROBOTIC SURGERY FOR ENDOMETRIAL CANCER DEMONSTRATING COMPARABLE OPERATIVE TIME TO LAPAROTOMY: A CASE SERIES IN A PRIVATE GYNECOLOGY PRACTICE
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Objective
The objective of the study was to report on our experience in a large private Gyn Onc practice utilizing Robotic surgery in patients with early stage endometrial cancer.

Study Methods
From Jan. 12, 2007 to June 27, 2008 56 patients underwent Robotic TAH/BSO and staging for endometrial cancer and during that same period 50 patients underwent traditional laparotomy/staging. The surgeons were the same for the Robotic and Open cases. Patients in the open group refused robotic surgery either because it was not covered by their insurance or they viewed robotic surgery as a new technology that they did not want to participate in.

Patient charts were reviewed retrospectively and demographic data was collected. Cancer stages, mean operative times, blood loss (EBL), lymph node yield, complications, length of stay (LOS), uterine weights, conversion to laparotomy, incidence/percentage with prior abdominal surgery were all reported as well.

Results
Of all the patients undergoing robotic staging or laparotomy staging all were eligible for review with all available data. The mean age in the robotic (Group A) was 58.8 and 61.5 yrs old in the laparotomy (Group B) group. The majority of both groups were Caucasian with a mean BMI of 32 in both groups. Most patients had Stage I disease in both groups with Group A = 76.3% and Group B = 75.6% of patients in Group A and 22.5% in Group B had Stage 2 disease.

Mean EBC = 102cc compared with 256cc. LOS in hospital = 1.4 days versus 5.8 days and complications (5.3% versus 36%) were reduced for Group A. Mean operative time in Group A was 134 min compared to 91 min in Group B. Weight of uterus was 136 Gms. in Group A compared to 235 Gms in Group B. Patients with prior abdominal surgery accounted for 58.9% in Group A compared to 70% in Group B. In the robotic group only 1 patient had to be converted to laparotomy. In group A 54 patients (96.4%) underwent lymph node dissection with the mean LN retrieved = 7.7. In Group B 49 patients (78%) underwent lymph node dissection with the mean number retrieved = 9.8. There were no on–op or post–op deaths in either group. All patients were seen post–operatively after hospital discharge to discuss pathology and further treatment plans.

Conclusion
It is our collective experience that robotic hysterectomy/staging is a feasible.
solution in patients undergoing surgery for early stage endometrial cancer with operative time and EBL comparable to patients undergoing laparotomy. There was a significant subset of patients with BMI >30 and in our final estimation the advantages of robotic surgery in these patients; specifically less hospital stay and lower complication rates should make this approach the standard of care when evaluating these patients for surgery for early stage endometrial cancer.

P-145
CONCEPTUAL ANALYSIS OF HARM: DELIVERY WOMAN
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This paper according Meleis’(2007)three concept strategies: concept exploration, concept clarification, and concept analysis. Based on literature reviews, concept exploration explored the definition of harm: somebody did X something faults, impolite words, no respect, ignorance of committing errors, offense, insult, or illegal protection) to another person, and thus led this person to physical or mental hurt or injury, and loss of face or reputation. In terms of concept clarification: we invited seven people to conduct interviews and asked their opinions about the definition of harm. We detected that the scope of harm, based on their viewpoints, was beyond literature review of harm; therefore, we added a new part—spiritual injury(no value, no loving). In terms of concept analysis, we analyzed 5 Taiwanese woman’s lawsuits and also interviewed 5 postnatal women to discuss their painful experience during the delivery. Among these ten cases, we found that medical both staff’s callousness and ignorance and doctors’ delay to offer medical treatment led to serious harm to patients and their family. For example, two newborn babies died, two patients suffered from permanent disability, and even a mother passed away in the process of delivery. In conclusions, medical health professionals should avoid the harm of lying—in women to make sure their safety, helps newborn baby stay healthy, and ensures that the process of delivery is comfortable and safe. If nurses play their roles properly, lying—in women will get nice experience of delivery, health, happiness, comfort, and no harm.

P-146
EVALUATION OF INTRODUCTION OF A NURSES PRECHEMOTHERAPY ASSESSMENT CLINIC
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What and how patients are told about chemotherapy may influence what they expect to happen, and their actual experience of side-effects. Side effects reported by patients are likely influenced by what and how the patient is told about chemotherapy side effects. This makes communication about cancer treatment a challenge for both the patient and the professional.

Research findings show that the provision of information accompanied with emotional and social support help to reduce the anxiety and stress of patients commencing chemotherapy, and may subsequently improve their confidence, compliance and coping capabilities. Moreover, adequate patient education has been shown to decrease the burden of invasive treatment procedures by early recognition of adverse treatment effects and insight on how to handle these.

Oncology nurses play a central role in the care and guidance of a cancer patient because they are principally involved in different aspects of chemotherapeutic care, i.e. in patient education, counselling and preparation, in administration and in the monitoring of the side effects. Apart from providing relevant factual information patients therefore also expect that nurses show understanding, empathy and support. In addition, patients believe that nurses as their primary communication link to the medical system and the oncologist.

This poster will present the patient evaluations after the introduction of a one on one session to discuss the planned chemotherapy prior to commencement of treatment. It looks at the patient’s level of satisfaction with the quality and quantity of information the received prior to commencement of treatment and evaluates nurses level of comfort with providing education to patients.


P-147
WHAT IS INFORMED CONSENT? WHY IS INFORMED CONSENT IMPORTANT IN RESEARCH WITH HUMAN SUBJECTS?
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Ethical Principle and application

The Belmont Report tells us that, “Respect for persons requires that subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them.” Informed consent is not just a form or a signature, but a process of information exchange that includes subject recruitment materials, verbal instructions, written materials, question/answer sessions and agreement documented by signatures.

The Belmont Report states that “the consent process can be analyzed as containing three components: information, comprehension, and voluntariness.” Informed consent is a process of information exchange that takes place between the prospective subject and the investigator, before, during and sometimes after the study. The subjects could give enough information to make the decision with autonomy and they would be protected in research during this process. So, informed consent is very important in research with human subjects. The Belmont Report says, “first, that individuals should be treated as autonomous agents; and second, that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy. But we can apply additional protections to maximize possible benefits and minimize pos-
sible harms for those subjects with diminished autonomy, it is ethical ac-
ceptable to waive the requirement of informed consent for the subjects with
diminished autonomy, those who need to protect them with carefully and still
respect for their autonomy."

The challenge of informed consent process in Taiwan:
The medical and research environment in Taiwan are changing and promot-
ing. More and more clinical researches involves human subjects develop in
Taiwan. The traditional culture of clinical decision-making process still re-
layed on physicians, especially out of the big cities. The relationships of
physician-patients and investigator-subjects need to be clarified. The regu-
lations for clinical research and social–behavioral research on human
subjects need more comprehensive developing. The Institutional Review
Boards and principal investigator need to play an important role in human
researches for subjects protecting especially in this changing period. IRBs are
made to think more detail how to protect the subjects. With education in research ethics, policy-making, guidelines setting up, well training investigators, well designed research, and well IRB system will help
subjects or the society maximize the benefit from the research with respect-
ning for human welfare and rights as well as minimize the harm or risks
during the research process.

P-148 FINDING NEW PATHS: THE NEED FOR CLINICAL TRIALS FOR CANCER SURVIVORS
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As far back as the 1700’s doctors and scientists conducted what would now
be known as clinical trials. Today, according to the “Declaration of Helsinki”,
the primary purpose of medical research involving human beings is “to im-
prove prophylactic, diagnostic and therapeutic procedures and the under-
standing of etiology and pathogenesis of disease”. Even the best proven
methods “must be continuously challenged for their effectiveness, efficiency,
accessibility and quality”. Clinical trials are necessary for developing new
therapies for serious diseases such as cancer. But in spite of the fact that
trials have been part of Oncology care for a long time; with their published
outcomes helping to define what is safe and effective, less than 5% of pa-
tients with cancer will take part directly in a clinical trial. (American Cancer
Society)

It is safe to say that the number of cancer survivors in the world is steadily
and critically increasing. The challenges related to these increasing numbers
of people with this devastating disease can be underestimated. Issues
related to new, often complex treatment options; long-term follow-up; qual-
ity of life and chronicity are just a few. Can access to enhanced knowledge
and surveillance through the screening and diagnosis stage; then into treat-
ment and follow-up with evidence-based care help support cancer patients
through this difficult cancer journey?

In this paper, the important role of clinical trials will be explored; from pur-
pose, process and description; to the facts and myths. The dilemmas facing
patients will be addressed. The role of the clinical trial team, and in particular,
the important role of nurses as advocates and educators will be described.

It is believed that the more patients and their informal caregivers learn about
education, close surveillance and published outcomes of a clinical trial.
Assisting many more cancer patients to acquire the necessary knowledge to
explore these new paths needs to remain an ultimate goal in promoting
quality care.

P-149 SATISFACTION OF CANCER PATIENTS WITH THE INFORMATION ABOUT THE DISEASE
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Introduction
Every patient has the right to be informed about his health situation (WHO, 1994). Several studies show that the patients’ wish to be informed (Degner et al. 1997; Doyal 2001; Martins 2003; Martins, 2004). But persists in the minds of some professionals, some fear that the information can be harmful, especially on a situation of a serious disease. Many factors contribute to this situation, mostly the paternalist attitude of health professionals and patients’ relations, and, sometimes, true facts of silence are build.

The objectives of the study are to evaluate the level of satisfaction of the Portuguese cancer patients with information about the disease and its possible outcomes, compared with some clinical and sociodemographical variables.

Material and methods
We have applied the Patient Satisfaction with the Information Questionnaire to 254 hospitalized patients, after surgery, in a public Portuguese Oncology Centre, to know how the patient was going. The gathering of the data was preceded by the respective administrative assistance to the host institution which included the approval of the local Ethical Commission.

Results and discussion
The Portuguese cancer patients present low satisfaction with the informa-
tion. The dissatisfaction is negatively related with the number of hospital-
ization days (p<0,001) and with the degree of instruction (p<0,001). Also
found statistically significant differences according to the job/occupation
(p<0,001). In this way, it seems that the most vulnerable patients are the
ones who present themselves less satisfied with the information, which
compromises even more their exercise of autonomy.

Conclusion
This study demonstrates that there is dissatisfaction on the cancer patients
with the information about the disease. We emphasize the need for nurses
to devote special attention to the most vulnerable patients, assuming a pos-
ture of bigger initiative in the information process.

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P-150 ETHICS EDUCATION ON CANCER NURSING IN JAPAN
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Introduction
The patients’ rights, especially the current situation of Informed Consent (IC)
have been emphasized for medical staffs since 1990s in Japan.

However, there are some differences and diversities about ethical issues of
IC between Japan and Western countries, because of cultural differences.
For example, in Japan medical doctors (MD) often tell family members first about
the truth, not patients.

If family members don’t hope to tell the severe truth to a patient in order to
avoid causing him/her mental anguish, MD will follow their decision.

Consequently, there are a lot of nurses facing dilemmas and conflicts when
they take care of cancer patients who do not know about the truth of their
disease, condition, remaining life span expected etc.

We have tried to improve these situations for Japanese nurses. In fact, we
gave some lectures on the ethical issues on cancer nursing.

Methods and results
1. The case of ethics education for nursing students

We taught nursing students basic ethical knowledge and methods of ap-
proaching ethical problems, using case study based on clinical settings. The
lectures helped the students understand a meaning of ethics in cancer nurs-
ing, and raise their interest in human rights. They recognized that patients
have different value, hope, belief, lifestyle and priority in obtaining IC. They
also learned that the ethical problems are closely related to various back-
grounds of patient’s life.

They could acquire the skills necessary to analyze and solve the ethical
problems through the lectures.

2. The case of ethics education for nurses

We taught nurses including advanced nurses ethics education, using com-
plicated model cases. This program is based on group discussion, so the
participants can find ways to solve the ethical problems in cancer nursing by
sharing them with their colleagues. They can also make sure what nurses
can do, and what nurses should do to solve the ethical issues for cancer
patients.

After the lectures, they could realize that nurses take important roles as
coordinators and advocates for patients in team medical management.

Conclusion
Ethics education using case study can give nurses not only knowledge, but
also opportunities to know other nurses’ ideas, as well as their own
thoughts.

Through this ethics education, we found it important to develop sensitivity
for ethics and discuss ethical issues as much as possible. In addition, we
realized that we should pay more attention to Japanese culture when we
try to solve the ethical problems in Japan.

Considering the circumstances mentioned above, we should start ethics
education on cancer nursing at an early stage so that nurses can acquire the
skills to solve ethical problems, which help them provide better nursing
service to patients and protect the patients’ human rights.

Keywords
Cancer nursing, nursing education, ethical problem, informed consent
P-151 VOICES OF DIFFERENCE: CONSENT CONVERSATIONS FROM OBJECTION TO POST COLONIALISM
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Clinical research is expected to be performed with informed consent. The regulation of consent traces its earliest foundations back to the Nuremberg trials where an international tribunal ruled Nazi practices of pursuing research were done without express permission and without any reasonable hope of benefit for participants. One of the current day issues in international research is that clinical trials rely upon positivist theoretical framework in consent process for trial participation. Little thought is given to how research is perceived or understood by the individuals being consented. An understanding of postcolonial influences needs to be taken into account as researchers enroll people in countries other than their own, as well as when enrolling individuals of marginalized populations within their own country boundaries. Postcolonialism invites consideration of descriptive terminology and classification of individuals related to historical construction, and examines the impact as it relates to participation in clinical trials. We need to question what aspects of social construction regarding race and culture are stigmatizing, creating negativity, vulnerability, and dehumanizing conditions thus detracting from optimal care to those involved in research. Postcolonialism articulates race as a historically constructed and culturally bound set of practices. These practices include conventional ways of thinking, doing, talking about differences that make differences seem common or natural, and make the marking of difference seem like a neutral value.

It is important for researchers to attend to the issues of informed consent in clinical research participation and just how that consent is garnered. The language and conversations that surround attaining consent are deeply embedded with issues of power and personal agency. Social conscience of difference is very different in objectivist perspective than a postcolonialist perspective. This presentation will challenge current paradigms of practice and provide examples of how to reconstruct the consent process recognizing individual’s personal power and influence. Ethical considerations of how to protect human subjects while advancing clinical science need to be comprehensively examined for how the system has regulated the consent process dehumanizing what should be the very process that protects and acknowledges individuals.

P-152 A CANCER NURSING EDUCATION PROGRAM BASED ON THE PHILOSOPHY OF LIFE AND DEATH IN CANCER SURVIVORSHIP
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Background: At the 15th ICCN, we presented our findings regarding the views on life and death of nursing students, nurses and nursing instructors involved in cancer survivorship, and supporting value formation and transformation. For patients, living with cancer signifies living side by side with death, and focusing on views on life and death from a cancer survivorship perspective is important in cancer nursing education that fosters solid ethical values and is useful in nursing practice to increase the QOL of cancer patients and their families.

Purpose: To develop a cancer nursing education program that confers life-oriented views on life and death from a cancer survivorship perspective.

Methods: We designed an education program based on Bloom’s learning theory, ways of thinking about cancer survivorship and the findings of our previous research.

Results: We developed the LESPACF program, which focuses on attaching value to views on life and death. The educational goal is to foster nurses who commit to life, and who have life-oriented views on life and death and help cancer patients increase life fulfillment. Learning content includes understanding cancer survivorship, skills to support life fulfillment and an open attitude toward cancer survivors. Training comprises the following 6 steps. 1) L, life and death: understanding cancer survivorship through the words of patients and their families, lectures and videos; 2) S, sensitivity: increased sensitivity and cultivating the skills to talk to patients through role play and listening to patients; 3) E, end of life: deepening knowledge increasing sensitivity and cultivating the skills to talk to patients through role play and grief care; 4) C, commitment: cultivating an attitude of commitment to care that confers a sense of life fulfillment through cases; Training comprises the following 6 steps. 1) L, life and death: understanding cancer survivorship through the words of patients and their families, lectures and videos; 2) S, sensitivity: increased sensitivity and cultivating the skills to talk to patients through role play and listening to patients; 3) E, end of life: deepening knowledge increasing sensitivity and cultivating the skills to talk to patients through role play and grief care; 4) C, commitment: cultivating an attitude of commitment to care that confers a sense of life fulfillment through cases; 5) P, partnership: deepening caring skills to conferring a sense of life fulfillment in cooperation with the patient, family and team members through role play and grief care; 6) R, research: conducting research on the impact of the program on the patient, family and team members.

Conclusion: In the LESPACF program developed in this research, the core content (knowledge domain and content L,E) is clearly presented; therefore, it can be easily and flexibly expanded to suit the instructor. Educational ability is also clearly required by these teaching methods. Education based on the philosophy of life and death from the perspective of cancer survivorship is based on the relationship between education and nursing practice rooted in deep insight into cancer nursing phenomena.

P-154 ACHIEVING CONTINUITY OF CARE AND CLINICAL TRIALS SUCCESS WITH CABIG CLINICAL TRIALS SUITE
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Clinical trials are essential to advancing healthcare. However, they present a challenge to continuity of care because patient healthcare information is segmented. The result of this segmentation hinders delivery of care and patients often become lost in the process of enrolling in a clinical trial. The Center for Biomedical Informatics and Information Technology at the National Cancer Institute has developed a comprehensive set of modular, interoperable and standards-based tools — the caBIG® Clinical Trials Suite, for managing clinical data; and the Life Sciences Distribution Bundle for tracking and managing biospecimen data and analyzing and integrating genetic microarray data. These tools bring technological solutions to solve this problem. The caBIG® Clinical Trials Suite facilitates data access and collaboration. Using the interoperable clinical trials framework, health care information collected prior to diagnosis can be retrieved seamlessly by the clinical trial site at the time of enrollment. Once the patient is enrolled into a clinical trial, the Suite is used for registering, trial logistics, patient scheduling, recording, and reporting adverse events and integrating lab information to maximize treatment and trial success. Following the patient’s completion of the clinical trial, their electronic medical record is current and available to future care providers, thus ensuring continuity of care. Within the clinical trial framework, the ability to integrate data from the patient’s profile, pathology, treatment, and outcomes allows clinical researchers to develop and refine strategies that are tailored to the individual’s unique care needs. This poster will describe a patient’s health record following the patient from the Veteran’s Administration health system, into the caBIG® Clinical Trials Suite, then to another primary care physician at Kaiser-Permanente using the caBIG® data framework and the Nationwide Health Information Network.

P-155 TRENDS AND TOPICS IN RESEARCH ON BREAST CANCER PATIENTS RECEIVING BREAST-CONSERVING SURGERY
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Objective: Research trends and topics were analyzed based on publications dealing with breast cancer patients who underwent breast-conserving surgery published between 1999 and 2008 in Japan.

Methods: The study involved 52 original publications identified by a search of Japana Centra Revuo Medicina with the key words “breast cancer,” “nursing,” “breast-conserving surgery” and “breast-conserving therapy (BCT).” Referring to previous similar studies, the present study collected data using the analytical format composed of type/design of research, data collection/analysis method, research subjects, disease stage, cancer type, research topics, and so on. The analysis was conducted through calculation of descriptive statistics as to the number of research publications, methods, etc. and through classification, naming and categorization of research topic codes according to similarities in meanings and contents, referring to the method reported by Berelson et al.

Results: Quantitative research accounted for more than half (51.9%) of all publications, with the most frequent type being descriptive research (55.8%). In analysis of the timing of research, 90% of all studies were carried out at the early stage of treatment or at the early and subsequent stages of treatment. Research topics were divisible into 6 categories: psychological changes and stress coping in breast cancer patients (15 codes: 28.8%), influence of treatment on QOL (11 codes, 21%), patient’s aware-
ness of lymphedema and effects of drainage (10 codes, 19.2%), factors affecting surgery and continued treatment and the needs of patients (8 codes, 15.4%), nursing support for self-concept changes (4 codes, 7.7%) and development and evaluation of nursing intervention programs and systems (4 codes, 7.7%).

Discussion
These results indicate two trends in research in this field, i.e., evaluation of the mental and physical influences of breast-conserving surgery and continued treatment from the viewpoint of QOL, and interventional research with nursing intervention programs targeted at management of lymphedema and psychological problems experienced by breast cancer patients. It is desirable that more interventional studies be carried out henceforth in order to develop valid interventional programs based on evaluation of the data collected through such studies.
Background
Home intravenous (IV) chemotherapy is a type of chemotherapy that allows patients to live at home by using a disposable continuous infusion pump for administration of anticancer drugs in Japan. Because the self-care performed in daily life by patients undergoing treatment for recurrent or advanced colorectal cancer is broad, it is necessary to elucidate specific types of self-care when investigating more patient-oriented methods of nursing support.

Objective
To elucidate the self-care performed by patients receiving home IV chemotherapy for recurrent or advanced colorectal cancer. Self-care is defined as health-related actions performed by patients.

Methods:
1. Study design: Exploratory factor analysis using a qualitative and inductive method.
2. Participants: Patients receiving outpatient chemotherapy for metastatic, recurrent, or unresectable colorectal cancer.
3. Data collection: Data were collected from semi-structured interviews and medical records.
4. Analysis method: Interview contents were transcribed verbatim and encoded and categorized for each patient from the perspective of the self-care performed by the patient. In addition, core categories were identified by comparing the categories of all participants and combining similar categories.

Discussion
The self-care performed by patients was thought to involve the patients’ use of their own ability as well as the human resources around them in responding to changes caused by home IV chemotherapy. In particular, self-care for reconstructing self-image, awareness of one’s unwavering beliefs and values helped patients accept the loss of physical function or health. Furthermore, reconstruction of self-image was thought to influence other self-care by enabling patients to set targets in daily life based on their physical condition and to find ways to live with cancer and chemotherapy.

P-162
IMPACT OF BIOTECHNOLOGY IN CANCER. THE ROLL OF NURSE. NATIONAL ONCOLOGY AND RADIObIOLOGY INSTITUTE. CUBA. 2009

Armando Moret Montano, Master Anabel Garcia Escalona, National Oncology and Radiobiology Institute, Havana, Cuba.

In multiple cases the onc specific treatment is not able to control the progression of the disease so that grand efforts in the search of new products come true that they contribute to decreasing the incidence and mortality. This disease constitutes an almost impossible pathology of combating in only one way, let alone even achieving cure in so phases advanced, hence, with objective to offer new therapeutic alternatives.
Cuba has accomplished an intense process of development and of formation of human resources that permits to have a complex and integrated fact finding system and production in the area of applied biotechnology in the society’s different area. In this sense we had institutions dedicated to the quest of new products for the diagnosis and treatment of cancer, thus I eat of diseases of the immune system. The National Oncology and Radiobiology Institute, in coordination with another cubans institutions and foreigners an important arsenal of products has achieved wide-ranging biotechnologies so that we expose some results as well as the nursing role within all this fact-finding process and development.

Stomatitis, an inflammation and ulceration of the mouth, is a common and devastating complication of cancer therapy. Incidence levels range from 10% to 90%. Therapy factors include the chemotherapy regimen, treatment schedule, drug dose, and the use of radiation therapy. Stomatitis can cause treatment delays and dose reduction, severe pain, weight loss, difficulty talking, infections, emotional distress, and altered mobility and mortality (Sonis et al., 2004). Management of OM requires thorough assessment. Currently, the WHO scale is considered to be the “gold standard” for assessment and staging of stomatitis in general cancer care. However, there is no evidence related to the validity or reliability for this tool. The use of a simple tool that yields valid and reliable scores would be easier to incorporate into a routine nursing assessment. The Western Consortium for Cancer Nursing Research (WCCNR) developed of a tool, the WCCNR Stomatitis Staging System. The French version of the WCCNR tool was created by Francophone living in Quebec, using the translation–back translation approach. This 3–item instrument was found to be a reliable and valid both in the French and English versions. While findings indicated that the instrument was a valid and reasonably reliable tool for staging stomatitis due to cancer therapy, three concerns were identified. First, the kappas were not as high as anticipated and the percentage of cases correctly classified using discriminant function analysis was lower than expected. The study team for that project identified the primary problem to be the training of the data collectors. Second, application of the scoring system developed suggested that moisture might be a better predictor of stomatitis severity than bleeding. The purpose of new pilot study is to address the validity and reliability of the translated 4–item French version of this tool to be used with a French population. In preparation for the study, we have developed an improved training program for our data collectors. The English version will be evaluated based on these results.

Factor analysis will be used to assess the validity of the 4 factors. Item total correlation evaluation will be used to establish the internal consistency of the instrument. Weighted Kappa or intraclass correlation coefficients (or generalizability theory) will be used to test the instrument ‘s inter-rater reliability to take into account chance agreement. The concurrent validity of the instrument will be tested by correlating the scores of the WCCNR with the WHO scales.

P-164
PROFILE OF WOMEN WHO DON’T SUBMIT TO CERVICAL PAPSMEAR: A LITERATURE REVIEW
Isabelle P. Gomes, Sra, Master1, Raphaelle Iennaco Campos Pereira, Specialist2, Paula Elaine Diniz Reis, doctor3, Jean Fabricio Lima Pereira, Specialist4, Marisa de Fatima O. Santos, Master2.

The cervical cancer causes physical as well as emotional consequences in women lives. However, it is a disease of high probability of secondary pre- vention. With the objective of reviewing the literature for the profile of the women who do not carry out the preventive examination for cervical cancer – Papanicolaou –, this revision of literature were taken from the data-bases of BIREME, LILACS, Scielo, BDENF and MEDLINE, between the period from 2003 to 2008. The study has found out the following facts associated with women who did not performed the Pap smears test: black or mixed-race, lower school grade, lower social layer women, who had not been to a medical appointment in the past three months, not to have companion, advanced age, predominantly house–working, who had been attended at Basic Health Units, behavior/feeling reasons (shame, fear, lack of interest, empathy with the professional), ethnicity other than the country of residence, living in rural areas, not informed about pap smear importance, no gynecological symptoms and smoking. The result points out the necessity of developing strategies to search for women with these characteristics in the areas of coverage of health programs for families with lower adherence to preventive examination of cancer of the cervix of uterus, in order to work directly with high–risk individuals and to increase the change of early diagnosis and treatment.

P-165
HOW DO 30-YEAR OLD WOMEN REASON ABOUT VACCINATIONS AGAINST HUMAN PAPILLOMA VIRUS? A FOCUS GROUP STUDY FROM SWEDEN
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Focusing on preventive health care, vaccination against human papilloma virus (HPV) is recommended by health authorities. In Sweden the demand has been high and the coverage seems good. However, there are women who do not accept the HPV vaccination. This study aimed to explore how 30-year-old women reason about HPV vaccination. The study was guided by a broad perspective of comprehension and included women aged 30 years in Stockholm, Sweden. Five focus groups were conducted on 4 occasions at 2-3 weeks interval. Ten participants were recruited through snowball technique. Data were analyzed through “Matrices analysis” which was a modified version of “framework analysis”.

Locally cervical cancer has the second highest mortality rate for cancers among women. Most cases of cervical cancer are caused by two types of
human papilloma virus (HPV). HPV is a sexually transmitted infection, which is usually asymptomatic. Since 2006, vaccines have been available that target two high-risk oncogenic HPV types. If vaccination programs are interest-ingly implemented, it is important to understand how women reason about them. The aim of this study was therefore to explore how 30-year-old women, residing in the capital area of Sweden, reason about HPV vaccines. A randomized stratified selection strategy was used to recruit 30-year-old women through the registry for the regional population–based cervical cancer screening program. Women were assigned to internet-focus group discus-sions (FGDs) based on commonalities in their cervical cancer screening histories. The FGDs took place in real time via a chat platform developed for this purpose, and were inductively analyzed. This analysis is part of an under-graduate thesis project. We found that most participants were positive to vaccine, although some anxiety and fear about side effects was expressed. It was notable that the relationships between the HPV and its transmission, the vaccine and cervical cancer were unclear to nearly all women. A common view was that women had too little knowledge about the vaccine to be able to have an opinion about its benefits and disadvantages. Most women said they would consider vaccinating their children/future children, but would need more specific information prior to making a decision. In this sample, many women stated that protection against sexually transmitted diseases was a responsibility to be shared between partners, and therefore discussed vaccinating boys in positive terms. Women described receiving most information about HPV and HPV vaccinations through mass media, including advertising. This study indicates that while most of the participants were positive about HPV vaccinations, they lacked impartial information about their benefits and risks. Even though this is in line with findings from previous Swedish studies, no such information is yet available in Sweden. The nursing profession can play a more active and important role in improving information and educa-tion about preventing HPV infections and cervical cancer, to support women in efforts at promoting and maintaining health as well as preventing disease.

P-166
STRUGGLING WITHOUT RELIEF FROM INCONCLUSIVE BRCA1/2 RESULTS: PSYCHOLOGICAL IMPACT OF INDIVIDUALS AT RISK FOR HEREDITARY CANCER
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Title
Struggling without relief from inconclusive BRCA1/2 results: psychological impact of individuals at risk for hereditary cancer

Background: Results on the impact of genetic testing for BRCA1/2 shows that non-carriers derive significant psychological benefits while affected carriers generally experience no change in psychological distress or can also experience a reduction in well-being. 1 To date, little knowledge exists on the psychological impact of receiving inconclusive results to BRCA1/2 among women affected with cancer. This study aimed to address this gap by de-scribing emotional reactions to the receipt of inconclusive BRCA1/2 results as experienced by 21 women affected with breast cancer.

Methods
A retrospective descriptive interpretive design was used. Analysis consisted of identifying common themes among the 21 open interviews conducted with women at risk of hereditary breast and ovarian cancer who received inconclusive BRCA1/2 genetic test results. All women were recruited from one hereditary cancer program in Canada.

Results
Lack of receipt from the receipt of inconclusive BRCA1/2 results was expressed by 17 of the women. Lack of relief came from not knowing the etiology of their own cancer diagnosis; why there were so many cancers in their family; not knowing if their family was truly at risk of hereditary cancers, and from not knowing if they had passed down an inherited cancer mutation to their children.

Conclusion
Contrary to what clinicians might assume that those who receive inconclusive genetic test results experience relief similar to those who test true-negative, the findings from this study revealed that, even among those who felt relief, the relief was only temporary.

P-167
MAMMOGRAPHY SCREENING BEHAVIORS IN A SAMPLE OF HOMEBOUND WOMEN WITH MULTIPLE SCLEROSIS
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Introduction
Multiple Sclerosis (MS) is a disease characterized by chronically progressive dysfunction caused by inflammatory changes in the central nervous system. Women are affected more, at the ages of 20–40 years when they are most active. An estimated 182,460 women were expected to be diagnosed with breast cancer in 2008, and recent data revealed 60% of women ages 40 or older have not had a mammogram in the last 12 months. Underutilization of mammography screening is associated with the disease of MS even more, as evidenced by markedly disparate annual rates. According to the National Multiple Sclerosis Society (NMSS), in 1999 only 1.5% of homebound women received mammograms.

Purpose
The purpose was to determine the relationship between variables of the Expanded Health Belief Model (EHBM) including: perceived suscepti-bility and severity, perceived benefits and barriers, cues to action, self-effi-cacy, and modifying factors; and adherence to mammography screening.

Method
A total of 612 subjects were recruited by purposive sampling. All subjects were confirmed cases of breast cancer patients from breast surgery at two medical centers in central Taiwan. Face-to-face interviews were conducted by trained interviewers to collect data on disease treatment and diagnosis. Statistical methods performed included descriptive analysis, t-test, ANOVA and multiple regression analyses using SPSS 12.0 software.
Results
Results from ANOVA indicated significant association between diagnostic delay and hospital ranking (p<0.001), and number of hospitals consulted prior to diagnosis (p<0.001). Subjects who received magnetic resonance imaging (MRI) were also significantly associated with diagnostic delay (p<0.001). Multiple regression analyses further indicated significant difference when number of hospitals for medical consultation before diagnosis was three (p<0.0001) and four or above (p=0.004).

Conclusion
Findings of this study showed that the higher the hospital ranking or the less hospitals visited before diagnosis, the shorter the diagnostic delay. These results can be implicated in health care service policy-making for reduction in diagnostic delay for breast cancer patients, allowing for both earlier treatment and increased survival rate.

P-170
BREAST CANCER SCREENING IN BULGARIA
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Breast cancer is the first leading cause of death from cancer in Bulgarian women. The aim of breast cancer screening is to reduce mortality from breast cancer by detecting and treating it early, before it has had the chance to spread.

Commonly used screening tests in Bulgaria for breast cancer are: breast self-exam, clinical breast exam, a mammogram, nuclear magnetic resonance, tissue sampling. Image guided biopsy of impalpable lesions using ultrasound or x ray stereotaxis for abnormalities not visible on ultrasound, is highly accurate.

Screening tests have risks. Screening may not help you if you have fast-growing breast cancer or if it has already spread to other places in the body. Also, some breast cancers found on a screening mammogram may never cause symptoms. False-negative test results can occur. One in 5 cancers may be missed by mammography. False-positive results may occur as well.

Current data indicate that the reduction in mortality is greatest in women aged 50-65 (25%). A smaller reduction in mortality of 21% is achievable in younger women (40-50), but screening is less cost effective, because of the lower incidence of breast cancer in these women.

In Bulgaria mammography remains the main screening tool while the effectiveness of clinical breast examination and self-examination are less. New screening modalities are unlikely to replace mammography in the near future for screening the general population.

P-171
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Daniela H. Simova, Nurse.
Regional Oncology Hospital, Sofia, Bulgaria.

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P-172
WHAT’S THE FUSS ABOUT BARRETT’S ESOPHAGUS?
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Barrett esophagus (BE) is a condition in which the normal stratified squamous esophageal mucosa is replaced by a columnar-lined epithelium (Heitmiller, 1996). The prevalence of Barrett esophagus can go unrecognized for many patients. However, this condition typically occurs in association with gastroesophageal reflux disease (GERD) that has been allowed to progress over time. Patients that have this condition are 30 to 40 more times at risk of developing adenocarcinoma than patients who have not had Barrett esophagus. Therefore, once Barrett esophagus has been diagnosed, it is imperative that these patients are followed closely by their gastroenterologist for progression of their condition.

A prerequisite for learning this material is an inquisitive mind for assessing complex gastrointestinal symptoms.

By the end of the session, the attendees will have a better understanding of Barrett esophagus, how it occurs, diagnostic and treatment modalities, and the “buzz” surrounding Barrett esophagus.

P-173
PREVENT AND EARLY DETECT & #304; ON OF CANCER
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Ege University Faculty of Medicine, Izmir, Turkey.

PREVENT AND EARLY DETECT & #304; ON OF CANCER
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According to the World Health Organization (WHO) an estimated 7.6 million people died of cancer in 2005, accounting for 13% of all deaths worldwide. The estimates that there are 24.6 million people living with cancer world wide, with approximately 10.9 million new cases being diagnosed every year. Cancer is the second leading cause of death in the United States after heart disease. More than 1.4 million new cases of cancer are expected to be diagnosed in 2007, according to the American Cancer Society. Cancer can be divided broadly into two groups solid tumor cancers which are characterized by the growth of malignant tumors within the body in areas such as the brain, lung, liver, breast or prostate and hematological, or blood borne, cancers such as leukemia. Cancer prevention and control is burgeoning field because of advances in understanding the biology of carcinogenesis. The field has expanded beyond the identification and avoidance of carcinogens to include studies of specific interventions to lower cancer risk, as well as screening for early detection of cancer. Central to cancer prevention and control is the concept that carcinogenesis is not an event but a process, a series of discrete cellular changes that result in progressively more autonomous cellular processes.

Cancer screening: screening is a means of detecting disease early in asymptomatic individuals, with the goal of decreasing morbidity and mortality. While screening can potentially save lives and has clearly been shown to do so in the case of cervical, colon, and probably breast cancer, it is also subject to a number of biases, which can suggest a benefit that doesn’t actually exist there is none. More information on screening from National Cancer Prevention programmes.

Policy and Managerial guidelines
• General cancer screening
• Cervical cancer screening
• Colorectal cancer screening
• Oral cancer screening
• Prostate cancer screening

References
• WHO (World Health Organization)
• http://www.WHO.int/cancer/detection/en
• http://www.aafp.org/afp/20010201/513.html

P-174
SURVEY ON PATIENTS’ SELF-CARE AGENCY TO MANAGE CANCER PAIN
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Purpose
In Japan at present, 50 to 60% of patients are known to be relieved of pain.
Because of the recent trend toward shorter hospital stays, patients must be in and out of the hospital several times and are required to manage pain on their own. Accordingly, we conducted a survey to reveal the possible relation between self-care agency to manage pain and related factors in patients being treated for cancer pain.

Methods
1) Study period: October 2007 to March 2008
2) Subjects: Patients with cancer pain treated with medication
3) Methods: Survey contents, demographic data, information on treatment of pain, and pain intensity on the visual analogue scale (VAS), and a scale for measuring self-care agency were used. This scale was a 4-point Likert scale consisting of 45 items. Questionnaires were returned by regular postal mail.
4) SPSS 14.0 software was used for data analysis.
5) The survey was conducted after obtaining approval from the ethics committees of the participating institutions and those to which the researchers belonged.

Results
1) The questionnaire was distributed to 20 hospitals, and 257 questionnaire sheets were returned (collection rate: 57.4%), of which 251 were valid.
2) Respondents: 133 males (53%) and 118 females (47%), with 149 patients (59.4%) being treated on an inpatient basis, while 102 patients (40.6%) were being treated on an outpatient basis. The patients were 59.5 ± 11.3 years old (mean ± SD). The period after diagnosis was 25.7 ± 33.3 months (mean ± SD), while the duration of pain treatment was 6.8 ± 8.3 months (mean ± SD). All patients were receiving medication for pain relief, and 158 (63%) of them were also being treated with opioids. The pain intensity was 4.0 ± 2.7 (mean ± SD).
3) Self-care agency: The score was 133.8 ± 18.0 points (mean ± SD), ranging from 80 to 174 points (Cronbach’s α 0.93).
4) Relation between survey items and self-care agency: Evaluation of the possible relation between self-care ability and the gender, age, place of treatment, disease, pain, duration of treatment, or status of opioid use in the study subjects revealed that the score of self-care agency was higher in women than in men (t-value, 2.65; significance probability, 0.009 [P < 0.05]). The more severe the patients’ pain and the older the patients, the lower the score tended to be, but no significant differences were noted. The score was lowest in patients who were within 1 month of treatment, and tended to increase as the duration of treatment increased.

Implication
The status of self-care agency revealed by the survey suggests that nurses should spend sufficient time providing care for men, elderly patients and patients who have received pain treatment for a short period.

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P-178 PALLIATIVE CARE IN THE END OF LIFE
Isabelle P. Comes, Master; Alan T. O. Souza, Master; Joael R. F. S. Franca, Master; Maria de Fátima O. Santos, Master; Solange F. G. Costa, Doctor; UFFPB, João Pessoa, Brazil.

With the technology evolution and automation for sustenance of life, the care of the patient in the end of life became a difficult and burdensome process. In this moment of fragility, the palliative care promote better dignity of life, assist patients with integrity in their needs. The purpose of this study is to relate the palliative care in the end of life, according with the literature review. This is a bibliographic study, developed based in articles found between 2002 and 2009, using databases LILACS, SciELO, WHOLIS and PAHO. The key word used was “palliative care”. The data was analysed by suggested approaches in a literature review.

We analyzed 27 articles. Based in methodological approaches found by the authors, some themes emerged, like ethics and bioethics, emotional care, psychological, and spiritual technical care. The articles emphasized the quality of life with priority in palliative care. Although, questions have appeared whether medical technology have advanced to promote automation of life, with undoubled longer survival, but without improvement of quality of life. The articles featured bioethics principles – autonomy, justice, beneficence, non-maleficence. However, the autonomy principle was emphasized, because the terminal patients should have the right to decide about important, sometimes crucial procedures in proposed treatment, participating in decisions regarding proper care, basing in their own beliefs, and their own comprehension about the disease. In psychosocial aspects, several issues were raised, highlighting the merit for verbal and nonverbal communication and psychological and spiritual pain, which requires psychospiritual monitoring, including reception, protection and humanization. Technical care gave emphasis to the management of pain. There is a lack of understanding of the magnitude of the philosophy of palliative care, a lack of investment, distribution and, especially, a lack of interest in developing projects that enable the deployment of this type of care, since many of the chronic patients generate expenses. Thus, it is understood that it is necessary to install health policies geared to this, including professionals, families and patients who need palliative care, so that everyone is really co-participants in care.

P-179 A WAY OF CARE: A PALLIATIVE CARE ONCOLOGY PATIENTS
Isabelle P. Comes, Master; Maria de Fátima O. Santos, Master; Valeria G. O. Barbosa, I.; Joael R. F. S. Franca, Master; Alan T. O. Souza, Master; João P. F. Sal, 1, Jean E.L. Pereira, Specialist; Paula E. D. Reis, Doctor.

Palliative care is an approach that improves the quality of life of patients and families facing problems associated with the life threatening diseases, including cancer. The purpose of this study was to identify palliative care as a different approach in caring for cancer patients. This is a documentary study with exploratory approach, which has the empirical material of scientific articles on palliative care nursing to patients with cancer, contained in the online journals in the period 2002 to 2008. The Universe of the study was composed of 184 articles, and the keywords used for the search “palliative care” and “cancer.” The articles were in journals: Acta Paulista, Anna Nery, Electronic Nursing, Latin American Nursing, Text and Context, USP Nursing and Brazilian Nursing, all of national impact, the sample was represented by 54 articles. The articles show that different from the curative model, which emphasizes the pathophysiological understanding of disease more than the disease itself and the patient, subjecting them to aggressive approaches to curative treatment, even when it becomes impossible for instance of a patient with incurable cancer, the model is focused on palliative patient and family in itself, with the essence not only attention to physical needs, but also psychological and spiritual needs of patients. This approach to care by the press prevention and relief not only attention to physical needs, but also psychological and spiritual technical care. The articles emphasized the quality of life with priority in palliative care. Although, questions have appeared whether medical technology have advanced to promote automation of life, with undoubled longer survival, but without improvement of quality of life. The articles featured bioethics principles – autonomy, justice, beneficence, non-maleficence. However, the autonomy principle was emphasized, because the terminal patients should have the right to decide about important, sometimes crucial procedures in proposed treatment, participating in decisions regarding proper care, basing in their own beliefs, and their own comprehension about the disease. In psychosocial aspects, several issues were raised, highlighting the merit for verbal and nonverbal communication and psychological and spiritual pain, which requires psychospiritual monitoring, including reception, protection and humanization. Technical care gave emphasis to the management of pain. There is a lack of understanding of the magnitude of the philosophy of palliative care, a lack of investment, distribution and, especially, a lack of interest in developing projects that enable the deployment of this type of care, since many of the chronic patients generate expenses. Thus, it is understood that it is necessary to install health policies geared to this, including professionals, families and patients who need palliative care, so that everyone is really co-participants in care.

P-180 NURSES’ KNOWLEDGE, ATTITUDE AND BEHAVIOR INTENTION IN Caring THE CANCER PATIENTS WITH DYSPNEA IN THE TERMINAL STAGE
SHENG-YUNG HOU1, Ru-Ping Lee2, Hui-Ji Chiu3, Ying-Wei Wang4.

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The main purpose of this dissertation is to study the current status and the correlation of the important factors including knowledge, attitudes and behavior intentions of the dyspnea patients under nursing care in the terminal cancer stage. This study is conducted by a crossing-sectional research method under random sampling surveying 128 nurses working in an eastern regional educational hospital by questionnaires consisting of diverse factors affected by three functions – knowledge, attitudes and behavior intentions. Those research data are analyzed by statistics, such as mean, standard deviation, one-way ANOVA, t-test, Pearson correlation, and Chi-Square etc., using SPSS 12.0 software. The conclusions of this study are as follows: First, the most important factor affecting the knowledge is “nursing measurement” and other two least important factors are “assessment” and “treatment”. Second, positive attitudes are the result of the survey. Third, the most significant factor related to the behavior intentions is “nursing measurement”, and the least important one is “the interaction and operation of medical teams”. Fourth, the knowledge factor is highly influenced by the “nurse’s background” parameters including professional ability, capacity, area of responsibility, experiences, and associated meanings. However, the fifth result shows that the attitudes are not significantly affected by the “nurse’s background” factor. Sixthly, the behavior intentions is affected by the “nurse’s background” factor, including the experiences of caring for personal relatives and friends in the terminal cancer stage and the related courses taken in her professional training. Finally, the correlation between the attitudes and behavior intentions is “positive”. This result also indicates that most nurses working in hospice wards have insufficient knowledge about how to care for a dyspnea patient in the terminal cancer stage. Some of them are not well educated and trained.

Therefore, we recommended that training courses and practices related to the palliative care should be incorporated into the nursing education. To enhance nurses’ knowledge and ability in caring dyspnea patients in the terminal cancer stage, it is also necessary to set up guidelines, including the on the job training and cross training program for the palliative care and associate palliative care in hospice for caring dyspnea patients in the terminal cancer stage.

P-181 PARENTAL TREATMENT DECISION MAKING IN TERMINAL STAGE OF CHILDREN WITH CANCER
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Background & Purpose
Background
Few focus on the treatment decision making of children with cancer and their families regarding their parents have decision making in the child’s clinic treatment process in the terminal stage.

Purpose: This pilot study purpose to explore the family’s parental treatment decision making of having a child diagnosed with cancer in the terminal stage.

Methods: The institutional review board at the hospital approved all study procedures. Research design use the ethnography in the medical fieldwork, Semi structured interview questions. The participant was parent of a child diagnosed with cancer in the terminal stage. Using a participant observation study approach for data collection and themes were uncovered from each interview data set and rigorous methods to data analysis. Record the data with the process recording in interview and participant observation. Data analysis by authors and parent.

Results
A 9 years old hepatic cell cancer children, his parent in the children was diagnosed from August to March,2009.there are four themes(1) Look for information of treatment intention (2) Keep in treatment process (3) Try do the best decision making for children(4) keep the hope in the mind (5) The final decision in the end of life(6)Understand the culture belief,fate . Discussion:The parental treatment process decision making there are many influance to childen treatment ,parent accept the culture belief,fate . Disscussion:The parental treatment process decision making there are many influance to childen treatment ,parent accept the culture belief,fate .

Keywords
Decision making, children with cancer, terminal stage.
P-182
CHARACTERISTIC OF NURSING PRACTICE FOR THE ADVANCED CANCER PATIENTS WITH EATING DISTRESS IN JAPAN
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Background
Changes in eating behavior, as observed in anorexia and dysphagia, are the main symptoms of advanced cancer. In addition to the patient, advanced cancer is a big problem for the family of the patient. Furthermore, eating distress because of the change is a big problem. Most research on eating problems in advanced cancer patients in Japan has been conducted from a nutrition management aspect, and sufficient research on the psychosocial effects of changing eating patterns has not been done. The purpose of this study was to identify the characteristics of nursing practice for advanced cancer patients with eating distress in Japan. Data were collected by using a semistructured interview. The average duration of the in-depth interview was 60 min. The interview was recorded and transcribed word for word. Information regarding nursing practice for advanced cancer patients with eating distress was obtained from the transcripts. Analysis: This study referred to the methods of Walker & Avant’s concept analysis. The content of nursing practice and those meaning put in data have been found, and also the concept that the patient could not lack them as nursing practice for advanced cancer patients with eating distress were found and they clarified. The ethics of the cooperative hospital were examined. The purpose and confidentiality of this study were explained to the subjects and their consents obtained.

Findings
The following attributes have been found: 1. Importance of the patient eating a normal meal. 2. To be able to determine the possibility of eating extensively while ascertaining the risk of eating. 3. Patience to wait for the patients to gradually come to terms with not being able to eat. The meaning of eating for the patient, family, and nurses existed as the antecedent. Eating symbolizes living; therefore, the importance of eating, derived from each life history, influenced the nursing of patients with eating disorders. As the consequences, the pleasure and satisfaction of eating has deepened with relationship, and the hope of living has developed.

Conclusion
The main characteristic of nursing practice for advanced cancer patients with eating distress was to support the patient to live. Understanding various eating behaviors of patients and being supportive and caring to the patients are some of the requirements of the nursing practice.

P-183
THE EFFECTS OF HOSPICE SHARED CARE IN FAMILY CAREGIVER OF ADVANCED CANCER PATIENTS IN ACUTE WARD SETTING
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5RN, BSN, Supervisor, Department of Nursing, Mackay Memorial Hospital, Taiwan.

Goal
Family caregivers have reported high levels of psychological distress with advanced stage cancer. Support for family caregiver is an integral element of hospice care. Bureau of Health Promotion implemented hospice share care project in Taiwan. This care model combined with hospice care team and original medical team to provide cancer patients and family related service. The purpose of this study is to assess the effectiveness of a hospice share care service for family caregiver’s psychological health.

Patients and Methods: Quasi-experimental design was used in this study. One being the control group and the other being the experimental group. A total of 30 family caregivers of terminal cancer patients were enrolled. The experimental group received at least 3 times of hospice shared care will be enrolled, control group as usual care. They are supposed to admit at medical, surgical wards of medical center in Taipei city. Data were collected by using Hospital Anxiety and Depression Scale (HADS). The data were analyzed by t-test.

Results: Results indicated that (1) there were significantly statistical de creasing the anxiety level of family caregiver receiving hospice share care comparing to receiving usual care. (2) there was no significantly statistical change about the depression level.

Conclusions
Finding form this study support that the hospice share care was effective for decreasing the family caregiver’s anxiety level, and improve psychological distress.

P-184
NURSING TO SUPPORT THE PSYCHOLOGICAL COURSE OF MIDDLE-AGED WIDOWERS AFTER TERMINAL CANCER-ANALYSIS OF TWO MIDDLE-AGED WIDOWERS
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1 Gunma Prefectural College of Health Sciences, Maebashi Gunma, Japan, 2 Gunma University, Maebashi, Gunma, Japan.

The aim of the present study was to investigate psychological support for middle aged widowers who had conducted terminal care for wives with cancer. Subjects comprised two middle aged widowers who had been the principle caregivers for their wives who had died in hospital suffering from cancer. Their psychological course and occurrences during the period from the beginning of cancer treatment has been approximately 3 years after the wife’s death. Data were examined. Data were collected through semi-structured interviews using a phenomenological method. For both widowers, “Conflict due to transfer of domestic roles” was strongly felt at the start of medical treatment and, as husbands, “seeking understanding of their wife’s life up to that point”, “seeking understanding of their wife’s wishes regarding medical treatment”, “conflict due to the difficulty of finding someone to provide advice”, and “stress due to having to suppress feelings because of being a man” were strongly felt during the process of accepting their wife’s lifestyle while under medical treatment. Furthermore, both widowers had children who were at a sensitive age during the treatment period, causing problems with “parent-child conflict due to the difficulty for the child in accepting their mother’s illness”. One year after each wife’s death, “sense of loss of due to wife’s death”, “regret at not understanding their wife’s life sufficiently” and “regret at not fully understanding their wife’s wishes regarding medical treatment”, were strongly felt. Conversely, it was clarified that at the same time, “adapting to real life through the transfer of domestic roles”, they were trying to heal themselves of the sorrow through adapting to real life. After approximately 3 years had passed, the children’s psychological problems due to the death of their mother were not resolved in either case and the lost of “conflict regarding playing the role of mother”. It was clarified that from the period of medical treatment, widowers had various problems regarding role transfer, and that obtaining advice regarding this caused difficulties. Additionally, it was elucidated that the effects of psychological problems from their wife’s treatment period were still prevalent even after becoming a widower. Based on this psychological process, these findings suggest the need for nurses to be actively involved from the start of medical treatment of cancer patients.

P-185
PALLIATIVE CARE TRAINING FOR THE MANY TYPES OF MEDICAL STUFF RESULT AND A FUTURE PROBLEM
Ruka Seyama, MHSc, Masataka Horkoshi, MHSc, Akemi Takei, MHSc, Tamae Fatuawati, Professor Kiyoko Kanda, Professor Gunma University, Maebashi, Japan.

Introduction
Cancer is a disease of the first place death rate of Japan, but there are few experts who can make treat or care transversely and multidisciplinary. Therefore, it is urgent business to train them. So the government judged the action at the graduate school level for carrying out the education organically to be necessary. Receive it we take the choice / the furtherance of “the cancer professional training plan” from Ministry of Education, Culture, Sports, Science and Technology in Japan to bring up a high quality medical stuff and push forward education about the cancer care.

Purpose
The purpose of this study was to compile the intermediate result of the intensive training of the palliative care in the general ward for the many type of medical stuff, and get a suggestion about a future problem.

Method
The date of object was 586 participants in the training. We carried out ques tionnaire about the training of / the utilization of training contents / the impression about the training and hope and analyzed it. In addition the participation form of the program was a team and an individual, but the date of object assumed it only the latter.

Result
It was a nurse that there were most of the type by job of the particip ant(75.0%). The participant of a doctor and the pharmacist was 10% each. Personal participation accomplishment degree added “All Ready” and “Receive it we take the choice / the furtherance” of the cancer professional training plan was 96.0%. For the impression, there were many opinions that view of not only the knowledge but also ethic was developed. There was an opinion about the weekday holding of the training and the enforcement of case study.

Conclusion
It is desirable for the palliative care to be offered by a team, and it is essential for a member to wrestle with a patient or family with common complex. So it was suggested that continuing holding the training was necessary. On the occasion of enforcement, it is important to put a lecture and practice to
include contents aimed for the acquisition of the basic knowledge, improvement of the ability for assessment, rearing such as the outlook on ethic. Moreover, it is necessary to perform the enlightment activity promoting interest in palliative care at the same time.

P-186 THE FACTORS INFLUENCED ON THE LAST STAGE CANCER PATIENTS’ CHOICE OF DEATH PLACE IN TAIPEI CITY. Kuang-Chi Huang, Chi-Hao Lee, Jin-Ying Tang, Kung-Fuh Lin. Taipei City Hospital, Taipei, Taiwan.

Purpose The study purpose of investigating what factors influenced the capital citizen to choose among death place.

Design This research was a retrospective study design. It complemented by south the patients’ medical services use records and tracked back questionnaire investigation of the telephone. The study had investigated 55 primary caregivers of patients who had received hospital nursing home care service. The questionnaire was initially designed based on clinical observation and literatures review. Night experts had evaluated, and the content validity index was 0.89. Human rights were protected by obtaining informed consent from each of the participants.

Results There were 40 (72.7%) patients died at medical care institutions, and 15 (27.3%) patients died at home. The influence factors were the patient’s education degree, patients’ will, caregiver’s arrangement, the relationship between patient and caregiver, receiving home care for dying at home, and who to do the finally decision (P<0.05). The family’s structure has already changed now, in addition, it is different situation between city life and rural life. The major reasons of caregivers though that patients died at medical care institution were convenience to deal with all the things, and their home environment was inconvenient. The major reasons of caregivers though that patients died at home were patient’s will, custom, and too late to send patient to the hospital. The patient who died at hospital, the decision was made by family, or family caregiver. The patient who died at home, the decision was made by patient self.

Conclusion & Suggestion In the modern city the people face to decision where is the appropriate death place, we can not just to discuss base on the custom and not to consider the city life situation. We have to already, the substitute is that the patient handles going to after growing with the convenience of the environment of the house. Except custom, we must consider the convenience of the environment for patients’ family to dealing with patients’ all the things from dying to death, and than after.

Keywords Death place, custom, cancer.

P-187 THE SYMPTOM EXPERIENCE OF LOW INCOME AFRICAN AMERICANS WITH ADVANCED CANCER Katherine Yeager, RN, MS, Tammie Quest, MD, Susan Bauer-Wu, RN, PhD. Emory University, Atlanta, GA, USA.

Background The most recent cancer statistics show that the 5-year survival rate for African American adults is less than that for White adults within each stage of disease for nearly every type of cancer. Moreover, African American men and women are more likely to be first diagnosed at a more advanced stage of cancer compared with non-Hispanic Whites. These alarming disparities in the cancer experience of African Americans extend to include the symptom experience. Often the cancer experience for African Americans is complicated by a lack of resources since African Americans are disproportionately represented in the low socioeconomic group. Little information is available to describe this group of underserved cancer patients in the United States.

Methods The purpose of this cross-sectional study is to explore the symptom experience of low-income African American adults with Stage IV cancer. Specifically, using descriptive, correlational analysis this study examines the effects of personal factors (age, gender) and disease-related factors (cancer type, co-morbidities) on symptoms and overall symptom distress among low-income African American adults. A sample of 185 cancer patients was recruited at a teaching hospital in Atlanta, Georgia. The Edmonton Symptom Assessment Scale, a self-report measure of symptom severity, was used to assess symptom burden. The study included patients who were 18 years or older, had a cancer diagnosis, and were receiving care at an outpatient palliative care clinic in an urban hospital in Atlanta. The study was approved by the institutional review board.

Results The mean symptom scores at the first visit to the clinic are 5.43 (fatigue), 2.78 (anxiety), 3.57 (dyspnea), 3.17 (constipation), 2.80 (depression), 2.73 (drowsiness), and 2.08 (nausea). Additional analyses are in progress and will explore the relationships between age, gender, cancer type, or co-morbidity status and with overall symptom distress and specific cancer-related symptoms.

Conclusions The findings demonstrate significant distress caused by multiple symptoms in this sample of cancer patients. This investigation is one of the first to describe the comprehensive symptom experience in low-income African Americans with advanced cancer. This work serves as a foundation for continued work to further understand the unique issues of and to guide care for an understudied and underserved population who experience a disproportionate amount of advanced cancer.

P-188 PHARMACOLOGY KNOWLEDGE RETENTION IN ONCOLOGY / PALLIATIVE CARE NURSES Regina Kendall. Ballarat Health Services, Ballarat, Australia.

The Grampians Regional Palliative Care team developed a series of pharmacology study days to assist nurses in developing their knowledge of common medications used in the palliative care setting. The study days attracted two hundred and sixty three nurses, and addressed the fundamental pharmacological principles of medication management in Palliative Care.

In order to gain an insight into knowledge retention of nurses, a questionnaire comprising 20 multiple choice questions was developed to reflect the content of the lectures, and was completed by participants at commencement of the study day, at the conclusion of the day and six weeks post study day. Test results indicate that nurses had limited knowledge of pharmacological principles prior to the study day with a pass rate of only 21%. Post audit study demonstrated an increase in knowledge of medications by the nurses who attended. Overall nurses who returned the test at six weeks demonstrated a high retention rate of pharmacological knowledge.

P-189 BASIC SYMPTOMS IN THE PALLIATIVE FACE OF CHILDREN WITH CANCER: TMH EXPERIENCE Shalaka S. Chandorkar, Si, Tata Memorial Hospital, Mumbai, India.

All over world children are living with and dying from life- threatening illnesses in a wide variety of social, economic, and health environment. Pediatric palliative care with its broad approach to symptom management, psychosocial, spiritual, and practical care has the potential to help in the care and relief of suffering of these children and their families. The components of pediatric palliative care at our center are outreach nursing care, liaison, expert advice, direct hands-on care, telephone on call, bereavement follow up.

TMH has a specialised pediatric palliative care program wherein a multidisciplinary team cares to the needs of children and families with advanced cancer. The study aims to make a comprehensive inventory of physical and psychosocial symptoms of recipients of PCC at our centre and to examine the extent to which health professional address them.

P-190 EXPLORING SEXUALITY WITH PEOPLE WHO HAVE CANCER: PERCEPTIONS OF THE SPECIALIST PALLIATIVE CARE TEAM. Debra L. Clark, MSc,BSc(hons). NHS, Gloucestershire, United Kingdom.

Aim The aim of this study was to explore if professionals working in specialist palliative care perceived whether they were identifying and addressing issues regarding sexuality with cancer patients.

Background Specialist palliative care claims to offer patient care within a holistic framework. This framework should encompass the sexual wellbeing of patients. In spite of the importance of sexuality to patient welfare; it is often excluded from specialist palliative care team practice.

Method Focus groups were used. Members from a specialist palliative care team in an acute hospital trust were invited to attend. Participants included, doctors and hospital and community nurses.
Results
This study suggests that many obstacles exist which are preventing the specialist palliative care team from identifying and addressing issues of sexuality with their patients. Values, beliefs and inhibitions appear to be the major barriers which may ultimately influence professional practice. The findings also demonstrate that the participants believe in the fundamental principle of holistic, patient centered palliative care. They recognise that deficits exist in their knowledge base and that these need to be addressed in order for standards to be improved in this care area.

Conclusion
Education is the crucial key in ensuring that patient’s sexuality is identified and addressed by specialist palliative care professionals. It can only truly be said that holistic care is being delivered when it is addressed with every palliative patient.

P-191
THE PREFERRED PLACE OF CARE FOR PALLIATIVE CARE PATIENTS
Sandra E. Morris, MSc.
Countess Mountbatten House, Southampton, United Kingdom.

An important goal of palliative care has always been to achieve a ‘good death’ for the terminally ill patient. The importance of having choice and control over where death occurs is widely acknowledged.

Analysis of secondary data, relating to a recent audit, was undertaken to examine whether terminally ill cancer patients are able to die in their preferred place of care, identifying factors which may have facilitated or inhibited this process.

A documented ‘preferred place of care’ was noted in 34 patient records, out of the sample of 70 patients. 29 patients [85.2%] were able to die in their preferred location. Over 83% of patients who had stated a home as a preference were able to die there. Only one of these patients died in an acute hospital setting.

This was compared to eight patients dying in an acute hospital, when their preferred place of care had not been previously documented. Numerous factors may have facilitated or inhibited this process.

These include: Family / Friend Support; Primary Health Care Team Support; Specialist Palliative Care Team Support; Communication / Liaison / Advance Care Planning; Hospice Bed Availability; Acute Events.

Findings support other studies, which have identified that patients are more likely to die at home, if this had been previously documented as a preference. The length of time that a patient had been under the care of the Specialist Community Palliative Care Team was also identified as a possible factor in determining whether the preferred place of care had been documented.

This research study demonstrates the importance of documenting the preferred place of care for terminally ill cancer patients, and thereby supports the introduction of the national ‘Preferred Priorities For Care’ document.

P-192
FACTORS RELATED TO SPIRITUAL NEEDS AMONG TERMINAL CANCER PATIENTS
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DIV> THIWARIN WATTHANAWATTHU ASSOC.PROUREEPORN THANASIL D.N.S.

The purpose of this descriptive research was to examine factors that related to the spiritual needs of terminal cancer patients. A conceptual framework used in this study was the Spiritual Needs of Taylor Model (2006). A simple random sampling was applied to receive 120 terminal cancer patients, aged 20–59 years. They were treated in Chulalongkorn Hospital, the Great Center of Mahavatchilalogkorn Tayburi, Pathumthani province and Arokayasarn Wat Kumpramong, Sakon Nakhon Province. Four questionnaires were used to collect data; Family Relationships, Intuitive Ability to Perform Routine, Spiritual Needs of Taylor Model, and Perception of the Symptoms Management of Symptoms, assist for maintenance of ordinary own life and management of environment. In existing, this included 2 strategies which were to know the patients, and to join with the place and time of them as individual. Acceleration to clarify the aim of alive, management of symptoms, assist for maintenance of ordinary own life and management of environment. In this study, we also were asked about patient’s hope and using strategy to enhance it in the impressive experience of EOL for cancer patients. Recordings of the interview were transcribed verbatim, and transcripts were reviewed by researchers.

P-193
THE PREFERRED PLACE OF CARE FOR PALLIATIVE CARE PATIENTS
Sandra E. Morris, MSc.
Countess Mountbatten House, Southampton, United Kingdom.

Conclusion
Education is the crucial key in ensuring that patient’s sexuality is identified and addressed by specialist palliative care professionals. It can only truly be said that holistic care is being delivered when it is addressed with every palliative patient.
a good nurse–patient relationship to care this case. We provide health education and interventions to alleviate pain and improve post-operative wounds and instill the self-confidence and independence of cases and their families at home to take care of the colostomy. We enhanced the self care skills of the patient with intestinal stoma and to live together with the stoma. Also, by the continuous, individual, and holistic nurse by nurse, we enhance the quality of life of the patient.

Conclusion

This is a nursing experience of caring a rectal cancer patient with permanent intestinal stoma. The patient suffered from the problems of pain, body massiveness, dryness, swelling, anxiety, and bodily image problems. After our interventions, the patient overcame the difficulties. It is worth to share this experience with the nursing staffs.

P-195

THE SEVERITY OF SYMPTOMS AND CORRELATING FACTORS IN HEPATOCELLULAR CARCINOMA PATIENTS RECEIVING PERCUTANEOUS ACETIC ACID INJECTION THERAPY

Lee-Shia Hu, master, Ming-Huan Wen, master, Ching-Yen Wang, Taipei Veterans General Hospital, Taipei, Taiwan.

Hepatocellular carcinoma (HCC) is one of the most common cancers in Taiwan, and percutaneous acetic acid injection therapy (PAIT) is among the major treatments. Cancer patients are most likely to experience fatigue due to their anxiety on the disease’s symptoms. This study is focused on the relationship between the severity of symptoms and fatigue severity, sleep condition, anxiety, and depression in HCC patients receiving PAIT treatment. The study adopted the longitudinal method and the subjects were 28 HCC patients from a medical center in Taipei, who compiled with the criteria of the study. A total of 8 rounds of data collection on the severity of symptoms, fatigue and sleep condition were conducted daily, from the day before treatment to one week afterward. The data were analyzed by statistic tools such as mean, standard deviation, t-test, Pearson correlation, repeated measure analysis of variance and stepwise regression. The results showed that: (1) The most severe symptoms experienced by the subjects after PAIT, listed in the order of severity, are; fatigue, pain, dry mouth, weakness, back pain, insomnia, lost of appetite, drowsiness and nausea. The severities of these symptoms exhibited significant differences during the course of data collection. (2) The severity of symptoms correlated positively with anxiety and depression before PAIT, and correlated positively with fatigue and anxiety during PAIT. On the 7th day of the second treatment, the severity of symptoms correlated positively with fatigue, anxiety and sleep condition. (3) The factor to predict the severity of symptoms is the anxiety prior to PAIT, which changes to fatigue and anxiety during PAIT. The result of the study may be used as reference in clinical care to enhance medical care quality and improve patients’ quality of life.

P-196

NURSING EXPERIENCE OF A PATIENT WITHRECTAL CANCER WITH COLOSTOMY

Chia-Chun LIN, RN, Ai-Ling CHANG, RN, Changhua Christian Hospital, Changhua, Taiwan.

Purpose of the study

The aim of this article is to explore the nursing experience of a patient with rectal cancer in a medical center of central Taiwan. This patient was a 77-year-old female patient with recurrent rectal cancer. The patient was treated with operation of subtotal colonectomy, and colostomy.

Methodology

Nursing period was from February 8, 2007 to February 20, 2007. The author applied Roy’s theory to carry on this patient, and utilized integrity nursing, encouraged the case to express its inner feelings. In the nursing process, we did the comprehensive assessment and defined the health problems, and made the care plans according the care plans.

Results

The major health problems were discovered (1) Nutrition condition change (2) skin integrity damage (3) sleep status disorder (4) bodily image disorder (5) exchange of gases barrier. We found the suffering of the disease and the “new” colostomy. The author utilized integrity nursing, we provided the individual interventions and continuous care, and helped the patient to improve the problems and prevented further complications.

Conclusion

For this case, we found the importance for the medical teamwork. And, the case should participate in the care plan making process. This nursing experience would be helpful for other nursing staffs in the clinical practice in the future.

P-197

SOCIAL SUPPORT, PSYCHOLOGICAL AND PHYSICAL STATES AMONG JAPANESE ELDERLY WOMEN WITH BREAST CANCER

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Purpose

It has been reported that social support has effects on health outcomes among Japanese women with breast cancer. However, little is known about social support, and psychological and physical states among Japanese elderly women with breast cancer. The purpose of this study was to investigate the relationships of social support and psychological and physical states among Japanese elderly women with breast cancer.

Methods

A descriptive, comparative and correlational study was part of a larger cross-sectional study that examined the effects of social support on the psychological and physical states among Japanese elderly women with breast cancer. A convenience sample of Japanese elderly women with breast cancer participated in the study. Two instruments with established reliability and validity were used: the Social Support Scale for Japanese Elderly and the General Health Questionnaire. They also reported their personal and illness-related data. Data analysis included descriptive statistics, t-tests, and Pearson’s correlations.

Results

Descriptive statistics showed that the size of social support network ranged from two to 34 (M=9.14; SD=6.60), and the members of social support network were their spouses, daughters, sisters, sons, friends, and the others. Psychological states significantly correlated with the size of social support network and emotional support. Physical states correlated significantly with emotional and instrumental support. In addition, the negative side of social support was significantly correlated with psychological and physical states.

Conclusion

The results reveal that there are some significant relationships of social support, and psychological and physical states among Japanese elderly women with breast cancer. This study provides an understanding of social support, and positive and negative aspects of social support, psychological and physical states among Japanese elderly women with breast cancer.

Research Implications

Findings from this study point to a need for additional research to investigate the relationships of social support, and psychological and physical states among Japanese elderly women with breast cancer as a process of breast cancer experiences.

Clinical Implications

Healthcare professionals should provide information of social support as an important factor to help Japanese elderly women with breast cancer.

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P-198

THE EXPERIENCE OF ELDERLY CANCER PATIENTS UNDERGOING OUTPATIENT CHEMOTHERAPY IN REGIONAL CITIES IN JAPAN

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Purpose

Since the Cancer Control Act was implemented in April 2007, the cancer medical services in Japan have changed dramatically. In addition, more cancer patients are presenting at an advanced age. The purpose of this study was to explore the experience of elderly Japanese cancer patients undergoing outpatient chemotherapy in regional cities with limited information and human recourses, for outpatient nursing care.

Methods

An inductive, qualitative research design was utilized, involving interviews with cancer patients ≥ 65-year-old who were continuing outpatient chemotherapy at hospitals in a regional city for three or more cycles. All of the patients provided their informed consent to participate in this study. The patients were recruited from two core hospitals in a regional area in Japan. The present study was approved by the ethics committee of both the participating university and hospital.

Results

There were 16 subjects (7 male and 9 female ), with a mean age, of 73.2 years. The treatment period of the outpatient chemotherapy ranged from three months to eight years. The participants identified fourteen difficul-
ties such as; Numbness and pain in the limbs as a treatment side effect; Re-
greg the weight loss caused by the therapy; Physical strength tended to de-
crease after each treatment; They are unsure whether they would show any improvement after chemotherapy; They worried about their own judgment when they are in poor condition; Living alone in the future is difficult; I be-
come sick and it troubles my family, etc. The results regarding 14 categories of difficulty were classified into six groups; 3) Treatment related side effects associated with various types of pain; 2) A decrease in physical strength which was not expected to recover easily; 3) Shock of cancer diagnosis and relapse; 4) Uneasiness concerning the deterioration of their condition and uncertainty about the treatment; 5) Uneasiness concerning their ability to cope with problems; 6) Inability to visit the hospital regularly to continue therapy.

Conclusion
This research clarified the difficulties of elderly cancer patients who continued chemotherapy on an outpatient basis in regional cities. The patients were affected by symptoms which included the side effects of the chemotherapy. In addition, they felt insecurity with regard to their social isolation, slow restoration of strength, and the problems of living alone. Improvements in the outpatient nursing support for such patients are there-
fore required.

P-199
NUTRITIONAL STATUS OF ELDERLY PATIENTS IN AMBULATORY CHEMOTHERAPY
Yoshiko ISHIDA, Master of Health Education1; Kikae KODAMA2;
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The number of cancer patients who receive chemotherapy in the ambulatory setting has been growing rapidly over the last ten years in Japan because of the consideration of quality of life of patients and the consideration of the system of financial remuneration. The ambulatory patients need to put a va-
riety of efforts and side effects of chemotherapy into practice by them-

The maintenance of quality and quantity of food intake to maintain nutritional status is one of the most important and sometimes difficult as-
pects of care to do. To make matters worse, undernourishment is also caused by many factors related to aging, so elderly patients are at high risk of falling into malnutrition. However, there have so far been few studies in Japan which focus on the nutritional status of elderly patients receiving chemotherapy. Generally speaking, the ability to cope with a new problem emerged is failing with age. Moreover the Japanese population is aging faster than any other in the world, the study for the aged is a pressing need.

The aim of this study is to obtain the nutritional profile of elderly patients receiving chemotherapy in ambulatory setting as contrasted with younger patients. This study is a part of a large investigation concerning nutrition impact symptoms of elderly patients in ambulatory chemotherapy. Patients aged over 20 attending ambulatory chemotherapy settings at any stage of the treatment pathway will be recruited at a general hospital in Japan. They will complete SF-36(MOS 36-item Short-Form Health Survey) and the researchers will collect demographic and disease–related informa-
tion, nutritional assessment data such as serum albumin and anthropometric measurements. This presentation will describe the nutritional status of the elderly patients as contrasted with the younger and discuss their needs of nursing care.

P-200
THE INFLUENCE OF ENVIRONMENT IN PEDIATRIC CHEMOTHERAPY UNIT: EXPERIENCE REPORT
Isabelle P. Gomes, Master1; Neusa Collet, Doctor2; Paula E. D. Reis, Doctor3; Jean F. L. Pereira, Specialist4;
1UFFPB, João Pessoa, Brazil, 2UNIEURO, Brasilia, Brazil, 3Napoleão Laureano Hospital, João Pessoa, Brazil, 4BRAZIL.

Currently, the search for excellence on the assistance of care generates more concern regarding the influence that the building physical appearance has on patients, staff and cancer care. The purpose of this study was to identify the expe-
rience in a chemotherapy unit that was transformed into a playful room to accommodate children with cancer. Data were collected during performance time as oncology nurse, responsible for the pediatric chemotherapy unit. The chemotherapy unit was environmentally transformed based in Finding Nemo (Pixar® – Production). There were available toys, books, dis-

The chemotherapy unit were celebrated as the staff and the children became enchanted with a magical ambience, visiting the new room called Aquário Carioca. In the daily routine, we noticed that the staff was feeling more valued and glad to work in a different hospital envi-
r
oment. The care was facilitated with the utilization of distraction technology present in the unit, improving the quality of care. Sometimes the minimiza-
tion of symptoms related to medical procedures and chemotherapy side effects were rapidly noticed, such as: decreased disturbance during venous puncture and catheter manipulation, decreased nausea and vomiting during chemotherapy infusion, discomfort for delayed infusion was forgotten and the wish to stay in the room was common. Effects of this environment on treatment and care were remarkably positive. These occurrences are consis-
tent with the expectations that the playfulness would offer to the children, whatever age they were. Refreshing and funny activities enable distraction, tranquility, safety and more treatment adhesion.

P-201
EXPERIENCE AND TRAINING OF NURSES CARING FOR CHILDREN WITH CANCER
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1UFFPB, João Pessoa, Brazil, 2UNIEURO, Brasilia, Brazil, 3Napoleão Laureano Hospital, João Pessoa, Brazil.

The pediatric cancer represents 0.5% of all tumors in most populations. Therefore, modern treatments and change in care have created new chal-
len ges and prompted nurses to monitor this development, providing more effective intervention and accountability. However, there are shortcomings from academic and professional’s own interest to acknowledge this princi-
ple. This work had the objective to search among nurses who work with pediatric oncology at Napoleão Laureano Hospital (regional reference for the treatment of cancer in the state of Paraíba – Brazil) how adequate training in this area determines daily care and describe the relation between practice and content. We used a qualitative approach to research, with technique of semi-structured interviews applied to 6 nurses. Results were submeted to content analysis technique and themes converged to following categories: elements that influenced production of care and transformations that nurses have been searching towards improvement and integrality of oncopediatric assistance. Results reveal that those factors, like nursing skills, practice, institution’s stimulation and psychological prepara-
tion influenced in daily nursing practice and that nurses have been searching improvement in this area with the purpose of providing better assistance. We concluded that the activities in this area leads to the nurses in search of knowledge to assist the child with cancer that can deal with the medical team the different approaches in caring for this patient.

P-202
THE DEVELOPMENT OF THE PAEDIATRIC ONCOLOGY NURSING SERVICE - IN ONE CANCER INSTITUTE IN A LOW-RESOURCE COUNTRY
Virginia A. Cunyel, Shaukat Khanum Memorial Cancer, Lahore, Pakistan.

This presentation will outline the development of the Paediatric Oncology Nursing Service. Shaukat Khanum Memorial Cancer Hospital & Research Centre is a fully functioning state–of–the–art cancer institute with a developed Paediatric Oncology Program.

A Paediatric Oncologist has always led the Service – but the gap was in the Paediatric Oncology Nursing Service.

Firstly there is no provision in Pakistan to educate and develop Paediatric Nurses and there was no provision to educate Paediatric Oncology Nurses. In 2005 a number of initiatives were taken to develop the paediatric oncology nurses and to provide in–house education and training. Advice was sought for a world renowned Children’s Hospital in the UK and we accessed Special-

This module can be taken independently as a stand-alone module or as part of the Diploma in Oncology Nursing. A staff nurse with potential who had completed the Diploma in Oncology Nursing was identified and sent to the UK for a month’s “Clinical Observer-
ship” to observe Hospital and Hospice Care for Children.

This was very beneficial and on her return she was appointed Specialist Pae-
diatric Oncology and Palliative Care Nurse – the first in the country.

Currently she has been appointed as Clinical Nurse Manager to lead and develop the Paediatric Oncology Nursing Service.

This development has had a positive effect on patient care and Play Room fa-
cilities have been added with the addition of a Play Therapist and a School Teacher in the Inpatients, Outpatients, Chemotherapy Day Suite and Radia-
tion Department.

This is a local solution to the problem as nurses have to be developed into specialist roles to meet the challenges of the patient population.

Reference
TREATMENT ORIENTATION BOOKLET FOR PATIENTS AND FAMILIES

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Purpose
This article is to discuss the nursing experience of caring a dying school-age child with neuroblastoma, and to discuss how the child to adapt physical, psychological, social, spiritual needs in the disease process.

Methodology
We collected data from January 18, 2009 to January 28, 2009, and we applied systematic nursing assessment including physical, psychological, social and spiritual aspects. We collected data through interview, observation, direct care process. This study collected subjective and objective data and we found nursing problems are: (1) pain (2) ineffective breathing pattern (3) anxiety (4) the expected nature of grief. By understanding this case of pain, fear and distress, we set up a medical team through palliative care such that the patient relative comfortable, psychological support, companionship, affirmative and respect to patient and patient family faith.

Results
After our interventions, the patient’s pain could be properly control, and this patient and his family could overcome their anxiety, fear and other feelings. By the medical team interventions of individuality and appropriateness, the patient and family could be peaceful to face the dying process.

Conclusion
During this process, the corporation of the medical team was very important and individual nursing could help the dying patient and family, especially in this child of terminal stage.

NURSING EXPERIENCE OF A PATIENT WITH ACUTE MYELOID LEUKEMIA AND SPINAL CORD COMPRESSION

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Purpose of the study
This case report was to discuss the nursing experience of a patient who had acute myeloid leukemia with acute spinal cord compression and the physical and psychological impact to the family who facing the diagnosis, treatment and rehabilitation of the disease.

Methodology
According to holistic nursing, assessment through personal care, observation interview companionship, we use Gordon 11 functional health patterns survey between February 23, 2009 until March 21, 2009.

Results
To establish the patient with following health problems: 1. Change of urinary pattern. 2. Physical dysfunction. 3. Change of body image. 4. Anxiety in care giver of the patient. To maintain empathy, participation of program, supportive manner with patient and the families during nursing care period. We establish good nurse-patient relationship, through individual and comprehensive care measure, and improving physiological function and psychological adjustment.

Conclusion
The nursing experience would be helpful for other nursing staffs in the clinical practice for caring acute myeloid leukemia patients with acute spinal cord compression.

VALIDATION OF THE IMPLEMENTATION OF A CHEMOTHERAPY TREATMENT ORIENTATION BOOKLET FOR PATIENTS AND FAMILIES

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This study was developed in an outpatient pediatric hematology and oncology clinic in the city of Jundiai that functions as a day hospital. The objectives were to revise the written communication tool “Chemotherapy Treatment Orientation Booklet for Patients and Families” and to validate this tool with its target public.

The booklet evaluation questionnaire was handled to the main caregiver, that is, the one that escorted the child to the clinic. Illiterates were excluded from the research.

We highlight some findings of our study. Although it was not the main objective, we found in our study a mother who requests the inclusion of additional information for them. This because forwarding the patient for admission in non-specialized hospitals brings serious consequences.

Another point to be highlighted is the relation to the education level of the interview subjects. Against the initial expectation, that high educational level equals greater critical sense, the interview subjects with incomplete first grade had a more active participation, providing suggestions that definitively improved the content of the booklet.

In relation to the evaluation of the information regarding the side effects, considered as bad/good, I perceived that some of the interview subjects did not understand that they would have to evaluate the information contained in the booklet and not the side effects presented by the patients. Whenever I noticed the lack of understanding of a subject on what they would have to validate, I reinforced the orientation and, from there on, they evaluated only the booklet.

The orientation booklet will be implemented in the clinic in the next months, thus facilitating the educational role of the nurse that needs to insert the family in this new context, at a moment when they are still shaken by the diagnosis. The de-hospitalization made possible by the outpatient treatment in day hospitals, puts the family at home in a position where it has to know how to deal with the treatment side effects. It is necessary to educate for the self-care so that it can guarantee the continuity of the home assistance, as well as the quality of the treatment. We also intend to release this work in the scientific community.

THE LONG-TERM PSYCHOLOGICAL INFLUENCE OF THE SISTER WHO BECAME A BONE MARROW DONOR AT HER CHILDHOOD AND THAT OF HER MOTHER

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Purpose
To elucidate the long-term psychological influence of the sister who became a bone marrow donor at her childhood and that of her mother, with the aim of obtaining some suggestion on nursing care for the sibling donor.

Method: The subjects were a 21-year old woman (Ms. A) who donated her bone marrow at the age of 8 to her sister at the age of 6 and her mother. Their desire concerning the marrow donation just now was analyzed in the content of each interviews.

Results: Ms. A: When I was informed of the concordance in HLA, I was put in a dilemma between the two thoughts: “I don’t want to become the donor because of the pains” and “I have to do it, because there is nobody else to be able to save my sister.” Although my parents gave me the right of choice, I was repeatedly told about the eventual situation which might be caused by my refusal, and the fact that Ms. A was the only person to save my sister, and I was implored for giving my consent. The reason why I was determined for the donation was due to my prevailing thought that “I really want to save my sister. Except me, nobody can save her.” However, just recently I have come to know that, even after the transplant, the disease may relapse, making me scared. In my sister’s body, the same blood is running, causing me to feel that she is my other self. I feel proud that I have brought a complete remission to my sister’s disease. Mother: As our parents’ HLA was found to be not concordant, I implored A to save the A’s sister. I was glad about her concordant HLA. However, I was afraid that A, too, might be dead. I solicited A to donate her bone marrow. The mere thought that the transplantation was decided not by the will of A, but by us, parents, gives us a mixture of complicated thoughts, but I would like to believe that our eventual decision for the transfusion was not wrong. I feel deeply grateful for A in having saved her sister. I wish that A could continue to take a good care of her sister, while the sister should always keep in mind the fact that she was saved thanks to A.Discussion: The author confirmed that Ms. A was highly proud of saving her sister by becoming the donor of her own will. However her mother was considerably seized with remorse in having induced Ms. A to donate the bone marrow not at her own will. It was considered that the fear of Ms. A caused by the information on the uncertainty of the transplantation was influenced by the sense of togetherness with her sister. It was suggested that, after the bone marrow transfusion, it would be necessary to provide the information taking into consideration the developmental stage of the donor as well as the conditions of the recipient, and to extend the psychological supports towards the parents as well.

THE THERAPY-RELATED SYMPTOM CHECKLIST-CHILDREN (TRSC-C) IN ONCOLOGY INPATIENTS

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Improved pediatric treatment efficacy concomitantly raises concern about treatment symptom manifestations. The purpose of the study was to describe symptoms experienced during therapy and reported by pediatric oncology patients and their parents/caregivers. The study questions were:
Using the Therapy-Related Symptoms Checklist-Children (TRSC-C): (a) What symptoms are reported most frequently and severely by children treated for diagnosis of Leukemia, Leukemia-like & Other groups? (b) How does prosthesis use differ among these? (c) Are there any differences in severity between groups of the TRSC-C symptoms? 

Data were collected from 45 pediatric oncology patients undergoing treatment as inpatients; about half of patients had leukemia. The Therapy-Related Symptom Checklist-Children (TRSC-C) was used: higher scores indicated greater symptom frequency/severity. TRSC-C, self-report or parent-report; severity ratings of 34 symptoms, 5-point scale: "0" [None], "1" [A little bit], "2" [Quite a bit], "3" [A lot], and "4" [A whole lot]; Cronbach's α = 0.89 [Williams et al, 2006]. Secondary data analysis was used. Fisher's exact tests on each symptom were used to compare the two diagnoses groupings, Leukemia vs. Other (Question 2); and frequencies and percentages (Question 1). 

Results showed that 22 of 34 symptoms were reported by 50%- of respondents. Most frequent: Loss of appetite (88%); nausea (88%); hair loss (86%); feeling sluggish (86%); taste change (76%); Irritable (74%); shortness of breath (73%); vomiting (72%); afraid (62%); skin changes (61%). Severity/concern Means on items near "quite a bit": hair loss, feeling sluggish, loss of appetite, nausea, vomiting, irritability. Items on subscales Fatigue, Eating, and Nausea (and their component symptoms) were most frequently reported and most severe among patients. The subscale Fatigue includes the items feeling sluggish, depression, difficulty concentrating, difficulty sleeping. The subscale Eating includes the items taste change, loss of appetite, weight loss, difficulty swallowing. The subscale Nausea includes the items nausea, vomiting, irritability. 

Results showed also that significant differences in severity by diagnosis group were reported on 2 symptoms. "Agitation" was reported by children in the Leukemia group significantly more than those in the Non-leukemia group (p<.03). "Nausea" was reported by Non-leukemia group more than Leukemia group (p<.07, a "trend"). In conclusion, the TRSC-C may be a comprehensive list of symptoms of concern to oncology patients. Symptoms assessment improves clinician-patient communication, prioritizes symptoms needing intervention, and evaluates outcomes [evidence-based practice].

P-208
UNCERTAINTY COPING BEHAVIOR AND QUALITY OF LIFE IN PARENTS OF CHILDREN WITH NEWLY DIAGNOSED AS CANCER: GENDER DIFFERENT
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The purpose of this study was to explore the gender difference and uncertainty and coping behavior and quality of life of newly diagnosed of cancer children’s parents. Both parents(N=45)from 45 newly diagnosis of cancer children recruited through the medical center, in northern Taiwan. Data were collected longitudinal standardized measured, including Parental Perception of Uncertainty Scale:Chinese version, Short Form (PPUS_C_SF), Parental Stress Index (PSI_SF), Parental Coping Strategy Inventory (PCSI) and Short-Form 36 (SF 36)were use to evaluate gender different and uncertainty and coping behavior and quality of life of newly diagnosis of cancer children’s parents. Descriptive statistical analysis was used to describe subjects, demographic characteristic and independent t test and Levene examination.

The results showed that the parental perception of uncertainty was not different with the newly diagnosis cancer children’s parents. And this finding was not reached statistically. In parental stress index, the mothers had higher parenting stress than father, especially in dysfunctional interaction was had reached statistically. In parental coping strategy inventory item that results showed parents did not have different, but fathers also reported more frequent use of emotion coping strategies than mother. The father reported statistically higher quality of life than mother, especially in physiology functional, mental health and social health. This result had reached statistically significant. When parents were had impact in first diagnosis level, nurse need to provide relationship information and resource give mental support just in time. We hope parent was had good coping strategies to face to the first diagnosis level and keep good quality of life.

P-209
PROFILE OF HOSPITALIZED PATIENTS IN PEDIATRIC ONCOLOGIC NURSERY
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Introduction
The pediatric client has care specificities and needs that require an appropriate demand of technology and specialized human resources. Into this context we have the pediatric oncology defined as being of high complexity, by bringing in its core the pain experience, of the mutilations and of the healing perspectives and ending experienced by the children and the family. The pediatric cancer incidence is of 0.5 to 3% of all the tumors in the most of the populations as informs the Cancer National Register. In this work, we demonstrate the profile found in the interments in a Pediatric Oncology nursery at the Rio de Janeiro city. After data analysis we found a monthly morbidity occupation rate of 63.4%; between 66% of the interments had clinical motives. The 32.8% of these interments were caused by any infectious process and 3% by patients out of present healing possibilities (FPJA). The interments by surgical motive had permanence media time of 4.5 days. The pediatric cancer patients had permanence media time of 4.3 days. The 19% of the interments were of children in the schooling age 31.7% and adolescents 32.7% totaling 64.4% of all of the interments. The rate of patients transferred to the pediatric UTI was of 12% and the monthly media death rate was of 2.7%. Objectives: The objective of this work is measure the process indicators of an oncologic pediatric nursery in order to allow knowing the profile of the attended clientele. Material and methods: Study based on process indicators/result, where was used an Excel information formulary for data register of daily interment. After register analysis of 6 months of interments were measured: occupation rate; interment motive (clinical and surgical); permanence media time (clinical and surgical); clinical interment motive; percentage of interments by surgical clinic; sex; age pathology; death rate; FPJA patients rate and rate of transferred patients to the UTI. It was used the methodology of quality for indicators elaboration. Conclusions: The high rate of occupation is justified due is the unique reference center in the attendance of all the solid neoplasias of the childhood in this State. The male sex was the most prevalent due the childhood neoplasias attack more frequently the boys. Despite the Service does not have a specific local for attendance to FPJA children yet, the low rate of transfer patients for those in need of support the philosophy of the Service on trying to remain them the more time possible in its residence. These data can contribute to the construction of an adequate space directed to the care of children carriers of neoplasias, attending theirs special needs and providing improvement of the process involved in the care.
P-211

FAMILY GROUP: A STRATEGY FOR PROBLEMS RESOLUTION IN A PEDIATRICS SERVICE IN ONCOLOGY

Ana Paula K. A. Tomaz, Specialist in Oncology SBE0, Fabiana V. Simões, MD, Maria da Penha S. Lessa, Social assistant of the INCA.
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This study presents a new vision about the groups’ educative practice in oncology, bringing a strategy vision for problems resolution observed and rose in an educative group with possibility of posterior intervention. Realized with companions (familiars/significant persons) of children included in the pediatrics service in onco-hematology of a reference Hospital in cancer, the National Cancer Institute (INCA), the family group aims at: becoming aware the companion of its role during the hospitalization; amplifying the companion’s conscience about the child’s pathology and treatment; diminishing anxieties through the doubts clarifying and providing interaction with the health team and among the own companions. The family group’s activities are realized on Wednesday in the morning, in an altered form, with the companions from the pediatrics and the pediatric hematology settings. The same are invited in the nurseries to participate of the group while an entertainer group and an educator realize playful activities with the children hospitalized during the participation of theirs companions in the group. The group dynamics is established in a following way, the coordinators present the group’s objectives and realize a dynamics of the participants’ presentation. After this initial stage, the group stays open in order to the participants can express through the doubts, claims, suggestions or other forms of expression as “relief”. For support, information providing (like hospital routines) and doubts clarifying, participate beyond the nurse and social assistant, nutritionist, the speech therapists, the psychologist and the clinician the professionals. During the group’s evaluation it was observed problems brought by the companions that were not brought to the professionals from the internment setting, where the health team involved in the group work makes possible the utilization of that it has available in a health Institution, relating to the physical and human resources. In this study the strategy relation with the group work was the one of problems resolution that rose in the development of this practice bringing one more look to enrich the group possibilities.

P-212

FAMILY GROUP: A STRATEGY FOR PROBLEMS RESOLUTION IN A PEDIATRICS SERVICE IN ONCOLOGY

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P-213

EDUCATIVE PROMPTUARY “PLAYING TO KNOW”- A LUDIC PURPOSE OF NURSING FOR THE EDUCATION AND ADHESION IMPROVEMENT TO THE TREATMENT OF CHILDREN BEARERS OF NEOPLASTIC DISEASE

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Introduction

The infantile cancer despite of the low incidence when compared with other diseases that also children is presently an important cause of infantile death. With the advancement of the treatment forms and of new technologies, the possibility of cure can reach 70%, but consequently are generated new care needs. In order to approach the care we must understand that the child with neoplastic is treated rather in this entire environment full of treatments and procedures that are not part of its life routine that can have consequences in its development. It is necessary utilization of educative strategies to improve the adhesion to the treatment and diminish the impact that the hospitalization can cause, once the child needs to know the therapeutics which is being submitted and for that, the education must occur in ludic form. Objective: To create ludic promptuary, personalized to improve the adhesion and information with respect to the treatment and procedures to which children with neoplasia are submitted. Methodology: The theoretical reference utilized was relating to the Education that becomes aware of (1993). The work will be developed by nurses of the pediatric ambulatory and internment unit of an Oncology Public Institution of the Rio de Janeiro City. The target public are children in the school and pre-scholar phase that will receive, in the enrollment time, an illustrated promptuary denominated “Playing to Know” contain general information related to the consults, exams types, care of hygiene and healthy alimentation importance. After the neoplasia diagnosis confirmation, there will be added in accordance with the individual need of each child, educative-ludical cards about the neoplasia, clinical complications, chemotherapy, surgery, radiotherapy, catheters, tubes, ostomies, etc. Final Considerations: The knowledge originated in the practice associated with the theoretical support signals the need of using a model of inclusive education utilizing tools with language accessible to the child’s cognitive age. In this context, the nurse should establish dialogue with the patients, surpassing the habitual theoretical formalism that contributes with the acceptance, adhesion and success of the treatment.

P-214

EFFECTIVENESS OF NURSE PARTICIPATION TO REDUCE THE REQUIREMENTS OF SEDATION IN CHILDREN RECEIVING RADIATION THERAPY.

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In Panama, malignant tumors is the fourth cause of mortality in children. Neoplasia in children is considered a treatable and curable disease (if treatment is properly treated). Frequently, due to anxiety, inherent fear, and other limitations, during the transition and adaptation to teletherapy treatments in linear accelerators, the small children require sedation. However, because of their high potential to generate unwanted secondary effects, the use of sedative drugs is undesirable. The nurse as a functional axis and for union during the treatment and procedures to which children with neoplasia are submitted, is undesirable. The nurse as a functional axis and for union during the treatment and procedures to which children with neoplasia are submitted.

In order to evaluate the significance of nurse interventions in reducing the requirement of sedation in children under five years old to be subjected to radiotherapy, the nursing diagnostic results, the care plan and the result “sedation requirement” of the nursing classification results, were evaluated. A group of patients, under five years old (15-both genders) suffering of malignant neoplasia and in teletherapy treatment in linear accelerators of the Instituto Oncológico Nacional de Panamá, was selected. Education and psychology strategies (Empathy, parent-child interaction) were applied. For support, information providing (like hospital routines) and doubts clarifying, participate beyond the nurse and social assistant, nutritionist, the speech therapists, the psychologist and the clinician the professionals. During the group’s evaluation it was observed problems brought by the companions that were not brought to the professionals from the internment setting, where the health team involved in the group got with solutions in a short, medium and long term. The group work makes possible the utilization of that it has available in the Health Institution, relating to the physical and human resources. In this study the strategy relation with the group work was the one of problems resolution that rose in the development of this practice bringing one more look to enrich the group possibilities.
P-215 ANXIETY AND DEPRESSION LEVEL IN CANCER INPATIENTS AT A MEDICAL CENTER
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The purpose of this research was to investigate the moods status (anxiety and depression) among six types of cancer inpatient (oral cavity/ head & neck cancer, breast cancer, cervical cancer, colorectal cancer, lung cancer, and stomach cancer) at a medical center. This study adopted a purposive sampling method to select 120 cancer inpatients with surgery. The demographic data form and Yang’s (1996) “moods status scale” in Chinese version were used to collect data by case managers from Sep, 2006 to July, 2008. The demographic variables included age, gender, cancer stage, job status, history of diseases, and religious beliefs. The scores of moods status for anxiety and depression range from 0 to 18 and 0 to 24 respectively with higher score representing a higher level of anxiety and depression. SPSS version 15.0 was used to analyze the data. The results showed that the average score of in-patient’s moods status with anxiety and depression were 4.86(SD=4.21) and 4.04(SD=5.23) respectively. We found that anxiety level for different gender and cancer stage was significantly different (p < .05). Nurses should provide more physical and psychosocial support and pay more attentions to cancer inpatients.

Keywords
Anxiety, depression, cancer inpatient

P-216 PROMOTING THE PERFORMANCE AND THE DISCOMFORT DEGREE OF THE MOUTH CARE IN ORAL CANCER PATIENTS
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Purpose of the study
The aim of this study was to improve the performance and the discomfort degree of the mouth care in oral cancer patients in one medical center of the central Taiwan.

Methodology
We developed a nursing standard for mouth care with evidence base. We developed a training program of nursing staff, and the program including of knowledge and skill training for mouth care. We developed a checklist for the mouth care nursing skills in real practice. We developed and questionnaire for the satisfaction of oral cancer patients and compare on day 3 after operation and on discharging day. Participants were 20 nurses and 23 oral cancer patients in one medical center of central Taiwan.

Results
1. The accuracy of the mouth care nursing skill is improving from 60% to 95% after the training program for nursing staff. 2. Five items for the discomfort degree of patients were significant changing on day 3 after operation and on discharging day. The five items are including of discomfort for the blood clot and secretion, discomfort for the flavor in the mouth cavity, discomfort for the wound feeling, anxiety for the healing of the wound and anxiety for the infection of the wound. (p < .05).

Conclusion
The nursing standard for mouth care is very important for oral cancer nursing practice. The training program including of knowledge and skill is useful for the accuracy nursing practice. Good quality nursing practice for mouth care can improve the discomfort feeling of oral cancer patients. However, 30.4% of patients still worry for the infection of the wound on discharging day. It is worth for further continuing improving.

P-217 FROM RESEARCH INTO PRACTICE: PREVENTION AND MANAGEMENT OF AXILLARY WEB SYNDROME OF BREAST CANCER PATIENTS
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Background
Post-surgical shoulder exercises can reduce occurrence of shoulder morbidity, and oncology nurses are the major resources for patients in learning arm exercises. Some patients experienced axillary web syndrome (AWS) which characterized by postoperative pain and limited range of motion, mainly on shoulder abduction. AWS is frequently overlooked and confused with shoulder limitations caused by simple articular restriction or post-operative muscular shortening. We should clarify the incidence, causes, clinical symptoms, and treatments for early education to prevent AWS induced shoulder dysfunction after breast cancer surgery.

Methods
Searches were conducted using PubMed(1966 to July 2009) and Google-Scholar with keyword “axillary web syndrome” and “cord” to identify eligible studies. Searches were undertaken to identify any additional articles in the bibliographies of studies found through electronic databases. Non-English language studies were excluded.

Results
AWS is a self-limited process that developed in 6% to 72% of the patients after breast cancer surgery with axillary clearance, either by axillary lymph-node dissection (ALND) or by sentinel lymph-node dissection(SLND). The term AWS was first coined by Moskovitz et al. and the proposed pathogenesis is lymphovenous injury, stasis and hypercoagulability from either of above procedures. The AWS is characterized by axillary pain that runs down the medial arm reaching the elbow; limited range of motion of the shoulder, mainly for abduction; and cords of tissue (like guitar strings) extending from axilla into medial arm, made visible or palpable by shoulder abduction. AWS developed mainly during the 2 week period after surgery, but also appeared or recur after adjuvant therapy (chemotherapy or radiotherapy). Both of Leidenius et al. and Lacomba et al. reported patients with AWS were slimmer than those without AWS. In the literature review, the syndrome may resolve without any specific treatment within 1 month of onset. In clinical practice, patients suffered visible fibrous cords underneath the axillary skin, hardened and painful upon performance of shoulder abduction, so they received skin traction technique to gently stretch the cords and manual lymph–drainage technique offered by trained oncology nurses. After a few treatment sessions, dramatic pain relief and shoulder mobility obtained.

Conclusion
Oncology nurses can be proactive by including AWS in preoperative and postoperative teaching along with arm mobility exercises and lymphedema precautions. Patients need to know the possible complications to their mobility so they can seek treatment early and prevent further functional loss.

P-218 THE STRESS PERCEPTION OF NEWLY DIAGNOSED BREAST CANCER WOMAN--A QUALITATIVE STUDY
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Background
In 2005, the incidence rate of breast cancer is 59/100, 000 around Taiwan, which is 2.63-fold of 1992, 22.4/100, 000. The growing rate is alarming. The mean age of breast cancer was changed more and more young. In the 1980s, susceptible age of breast cancer incidence ranged about 50–54 years old in Taiwan, whereas ranged 40–49 years old after 1995. It is already impact the woman’s health and family. Few studies explored the experience in newly diagnosed breast cancer woman.

Aim
This study is a qualitative research to explore with new diagnosed breast cancer patients of their stress experience.

Methodology
A medical center in Taipei breast surgical ward was studied. With the pre-operative patients of breast cancer as the research subjects. In-depth interview were administered under semi-structured questionnaires. 20 women were interviewed and data analysis by content analysis.

Results
The experience feeling of newly diagnosed breast cancer women from feeling knowing diagnosis, suffering from cancer for life carrying on adjustment to facing challenge include unbelieving the facts of cancer diagnosis, to no acceptance their own stage of cancer, afraid feeling of cancer, sadness weeping, confused self–treatment, poor appetite, anxiety, fear, worrying about disease future development, insomnia, well sleeping, collecting breast–related information, to fear of breast losing impact on the attractiveness of husband, breast loss impact on social communication, life changes, worrying about families, worrying about work utilize the methods to face illness with courage. Choosing good hospital and physician to build up confidence, worrying about arm problems, worrying about the side effects of chemotherapy, and feeling a along–load of anti–cancer.

Conclusion
Results were recommended that in newly diagnosed breast cancer woman, professional s should provide adequate interventions depending on the finding of woman’s stress perception.

P-219 CAN ESSENTIAL OIL MASSAGE REDUCE THE PAIN OF CANCER PATIENTS?
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Background
Many cancer patients have suffered from pain. For clinical nursing staff, the essential oil massage is a non-invasive treatment, and is an independent and unique intervention of clinical care. Can essential oil massage reduce the pain of cancer patients? It is worth to be explored.
Methods
We apply the evidence-based nursing steps to find the answers. First step, we form the PICO question. And then, we find the best evidence form Chinese Journal of Title index system and PubMed database. And we put the keywords respectively with (Essential Oil or aromatherapy oils or aromatherapy), (complementary or alternative medicine), (massage), (cancer or oncology or leukemia), and (pain). We choose the randomized controlled trials, and limit the literatures in English.

Results
The results showed that after 30-minute massage, there were significant differences in effect until 24 hours after the massage. The essential oil massage can not only decrease the pain scores, but also effect on 12, 16, 20, 22 hours. Continuing use of essential oils massage can achieve pain control effectively (Li, Lu, Huang, 2008). The literature of Kuther shows the results that the essential oils massage can reduce the emotional pain of cancer patients and there is a better effect immediately after the massage. The literature of Soden and Louis shows that essential oil massage for cancer patients can improve pain, but only a few improvements.

Conclusion
Essential oil massage can reduce the pain of cancer patients, but it need be used in evidence-based. We need more evidence to know the frequency and the composition of essential oil. We need to do the training for nursing staffs to apply the accuracy knowledge and skill in cancer care practice, and then reduce the pain of cancer patients effectively.

P-220
A PILOT STUDY OF SYMPTOM’S DISTRESS AMONG HEAD AND NECK CANCER PATIENTS IN TAIWAN
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Background and aims
Cancer has been the primary cause of death for Taiwanese since 1981. In the case of head and neck cancer, which is ranked the sixth leading types of cancer-related death, always is diagnosed among the young-adults. Therefore, it really has a great impact on national society as well as the families. The aim of this study was to inquire post-operative symptoms distress among head and neck cancer patients in a medical center in northern Taiwan.

Method
A structured questionnaire regarding post-operative symptoms distress was composed, and 21 patients with head and neck cancer were recruited from Jan. 2008 to May 2008. Result: The common symptoms distress in participants were found as follows: dry mouth (95.2%), neck stiffness (85.7%), dysphagia (81%), fatigue (71.4%), and trismus (71.4%). In view of the degree of symptoms distress by rating from 1 to 10, with higher scores representing high levels of symptom distress, including poor appetite (7.8), fatigue (6.2), and trismus (6.2) were the top three leading items. Conclusion: The findings from this pilot study can be references for future research as well as in constructing more efficient care services for head and neck cancer patients.

Keywords
Head and neck cancer, symptoms distress

P-221
NURSING EXPERIENCE OF A PATIENT WITH TONGUE CANCER WITH ROY’S ADAPTATION THEORY
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Purpose of the study
The aim of this article is to explore the nursing experience of a patient with tongue cancer in a medical center of central Taiwan. This patient is a 47-year-old male patient with tongue cancer stage 3. The patient was treated with operation of wide excision of tumor, radical neck dissection, split thickness skin graft, resection of mandible, and tracheotomy.

Methodology
Data were collected during the period from August 1, 2007 to August 17, 2007 by observation, participation and deep interview during nursing process. It was then evaluated and analyzed according to Roy’s theory that includes physiological function, self-concept, role function, and interdependence.

Results
The major health problems were discovered (1) infection (2) acute pain (3) body image changing (4) communication impairment (5) spiritual distress. The author adopted the unique nursing function and to maintain this patient’s basic needs and physical comfort in order to set a new balance between physical and spiritual life and redefine value of life. Finally, the health problems were getting better and still keeping the life quality.

Conclusion
This nursing experience would be helpful for other nursing staffs in the clinical practice.

P-222
BODY IMAGE AND QUALITY OF LIFE IN WOMEN WITH BREAST CANCER
Kaori Matsuda, master, Hisami Sasagawa, master. Kyoto Prefectural University of Medicine, Kyoto, Japan.

Background and literature
Breast cancer surgery is an emotive topic and rather than just simple cosmetic issues, the final appearance of the operated breast has been shown to have a significant impact on psychologic well-being and overall quality of life.

The aim of this study was to describe the relationship between changes in body image and quality of life (QOL).

Methods
The women after breast cancer surgery were recruited from 2 hospitals in 2 big cities in Japan, and mailing and receipt of survey. The participants completed 2 established questionnaires, the Body Image Scale and the Functional Assessment of Cancer Therapy-Breast (FACT-B). The FACT-B consists of the following subscales: physical well-being (PWB), functional well-being (F WB), emotional well-being (EWB), social/family well-being (SWB), and breast cancer-specific concerns (BCS). The study was approved by the ethics committee on the university.
Result: A highly significant statistical positive correlation was observed between the total body image score and FACT-B total score (r = 0.827, p<0.001). Higher total body image score was correlated with a higher QOL score for physical well-being (PWB) and functional well-being (FWB) and emotional well-being (EBW), and breast cancer-specific concerns (BCS) (r = 0.560~0.658, p<0.001). FACT-B total score was correlated with all subscales of the body image, especially disturbed body cathexis, low body-control and low body-esteem were the moderate degree correlated (p<0.001).

Discussion and Conclusions
Physical, functional, emotional and breast cancer–specific QOL were related to the body image. That is, the person who has poorer QOL is influenced to speech and behavior because a mental image to the body is large, the sense that can control the state of the body for myself loses, and the confidences and the satisfaction to the body have decreased.

P-223
COMPARISON OF BODY-IMAGE AND QUALITY OF LIFE IN WOMEN WITH BREAST CANCER AND WITH GYNECOLOGY CANCER
Hisami Sasagawa, master, Kaoi Matsuda, Master, Masako Nakagawa, Master. Kyoto Prefectural University of Medicine, Kyoto, Japan.

Objective
The diagnosis of cancer threatens the psychological and bodily integrity. Based on this assumption, women with breast or gynecologic cancer felt a loss of femininity, and uncertain what bodily changes. It influences on their body image and overall quality of life (QOL). We aimed to describe the differences and similarities of body image and quality life between breast and gynecologic cancer patients.

Method
A convenience sample of 43 women after breast cancer surgery were recruited from two hospitals in 2 big cities in Japan, and 26 women after gynecologic cancer surgery were recruited from a university hospital in Japan. The instrument used for data collection was a self administered paper questionnaire with a covering letter that explained the outline of this study aims, benefits and guaranteed confidentiality. The participants completed 2 established questionnaires, the Body Image Assessment Tool (BIAT) and the Functional Assessment of Cancer Therapy-General (FACT-G). The BIAT (Fujisaki, 1996a1997), a 4-points questionnaire comprised 27 items, it assumed that following five sub-concepts had adequate representations of human’s disturbed body-image: “disturbed body-cathexis”, “disturbed body-boundary”, “body-depersonalization”, “low body-control”, and “low body-esteem”. The FACT-G also consists of total 27 items (using the form of four –point Likert scale) the following subscales: physical well-being (PWB), social/family well-being (SWB), emotional well-being (EBW), and breast cancer-specific concerns (BCS). For comparisons between breast cancer patients and gynecologic cancer patients, inde- pendent t-tests were used. The study was approved by the ethics commit- tee on the university.

Result: There were no differences in the Body Image Assessment Tool (BIAT) between breast cancer patients and gynecologic cancer patients. On the other hand, the data pertaining to FACT-G showed significant dif-
ferences: Breast cancer patients had a lower score in comparison to gynecologic cancer patients for “physical well-being” (p<0.005), “functional well-being” (p<0.005), and “FACT-C total score” (p<0.05).

Discussion and Conclusion: The results of this study indicate that physical and functional QOL were differences between breast cancer patients and gynecologic cancer patients, although their perceptions of body image were similar. That is, lymphatic edema may affect to physical functioning and health perception in breast cancer patients rather than gynecologic cancer patients.

P-224
THE PALLIATIVE NURSING EXPERIENCE OF CARING A LIVER CANCER PATIENT WITH TERMINAL STAGE
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Purpose
The aim of this article is to explore the nursing experience of a patient with liver cancer patient with terminal stage in a surgical ward and in a medical center of central Taiwan. The patient was suffering from the discomforts in physical, mental, spiritual, and social field.

Method
Nursing period was from January 20, 2008 to January 20, 2008. The author applied Gorden 11 functional health assessment as a tool, and collected objective and subjective data from listening, interviews, observation, and practical care process. In the nursing period, we did the comprehensive assessment and defined the health problems, and made the care plans according the care plans. We provided the care with palliative care model.

Results
The major health problems were discovered (1) comfortable condition changing (2) anxiety (3) grieving. We found the patient suffering from terminal disease. We provided the individual interventions and continuous care, and helped the patient to maintain the life quality and rebuild the hope even at terminal stage. Also, we found the families accompany were meaningful for the patient especially for the end of life. And, we provided the care including families could help the life rearrangement.

Conclusion
It was not easy to provide the whole palliative care in the surgical ward. But it was still important to have palliative care concepts during the care, and the hospice consulting grouped could help a lot. We hope that nursing experience could share with the nurses, and provide the reference for the future of clinical care.

P-225
THE LIFE OF YOUNGER CANCER SURVIVORS - HEALTHY OR ILL ?
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Purpose
The following questions are being asked:
•Which problems do younger adults, who have received curative treatment, experience after the completion of treatment?
•Has anything changed: physical or psychological changes, relationship to spouse, children, work, education or social activities?
•Does the group of younger adults, that they are “healthy” or is there still a feeling of being a cancer patient?

Methods
A systematic literature survey was carried out using Medline ( National Library of Medicine ), PsykINFO and CINAHL Search terms “ Neoplasms as a metastern” for cancer is combined with “Nursing”, “Rehabilitation” and “Survivors”, and is limited to ages 19 – 44 years old, published within the last 5 years. Only articles published in English are included in the search. All in all 15 articles were indentified as meeting the selection criteria. Nine articles use a questionnaire study, two articles use interviews and four carried out reviews.

Results and conclusions
Literature survey results show the need for a more focused effort to deal with physical and psychological changes such as fatigue and fear. Fear was about relapse and consequently the future. Also the attitude towards becoming a parent needs attention. Many survivors are unrealistically ( or unnecessarily ) worried about pregnancy and the health of the child. No study has shown a larger proportion of birth defects in children born to parents treated for cancer. More focus is needed by professional health care workers on this subject, a focus which should start at the time of diagnosis and continue during the course of treatment, to prevent misunderstandings and so that a decision on parenthood can be made. Groups can be established for couples, who have experienced having children after the illness. Studies of the experiences of parenthood by survivors are recommended.

A professional handling of rehabilitation initiative for younger cancer patients, so as to minimize the distance between “being ill” and “being healthy”, is called for.

P-226
THE EXPLORATION OF THE ASSOCIATION BETWEEN PSYCHOLOGICAL FACTORS AND BREAST CANCER DEVELOPMENT
Lee Tso Ying.
Cheng Hsin Rehabilitation Medical Center, Taipei, Taiwan.

Background
In 2005, the incidence rate of breast cancer is 59/100, 000 around Taiwan, which is 2.63-fold of 1992, 22.4/100, 000. Many risk factors are involved with breast cancer, whereas psychological impact of cancer is still a controversial factor to breast cancer.

Aim
To explore the relationship between breast cancer and pressure development

Methodology
A limited prospective study with cross-sectional design. Subjects were the cases received mammography screening. Questionnaires were got according to stress, anxiety and depression scale. Data analysis was tested with student-t, Pearson correlation, multiple logistic regressions, odds ratio to explore the association of breast cancer development with psychological factors.

Results
There is a significant difference of ducation level between breast cancer and non breast cancer group. The higher level of breast cancer risk with a higher level of education or lower education level than the average level of education. 2. Through education factor adjusted, psychological factors (anxiety ,stress) are the significant factors. Psychological factors are associated with breast cancer development.

Conclusion
Results were recommended that psychological health of women should be strengthened.

Keywords
Breast cancer; breast cancer risk factors; psychological factors; stress...
P-228 COMPLEMENTARY AND ALTERNATIVE THERAPIES USE AMONG JORDANIAN PATIENTS WITH CANCER
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Background
Jordan has been overwhelmed by the dramatic increase of cancer diagnoses. Cancer disease promotes patients, family and community to seek any kind of health treatment and cure. Though there is worldwide use of the complementary/alternative (CA) therapies among patients with cancer and its use is well documented. However, there is unclear picture about CA therapies use among Jordanian patients with cancer, one of the Eastern countries, giving the fact that most of the studies were conducted in the Western countries, whereby people have different beliefs and tradition.

Purpose
To assess the complementary/alternative (CA) therapies use among Jordanian patients with cancer. Specifically, to describe CA therapies use among Jordanian patients with cancer and to describe the relationships between the CA therapies use and patients’ characteristics.

Setting: In-patient or out-patient cancer settings (Al-Bashir, Jordan University, King Abdullah hospitals, and King Hussein cancer hospitals, and clinics)
Population
Adults (more than 18 years) patients, male and female with different types of cancer at different disease stages, who are able and willing to participate.

Design
Descriptive correlational design using convenience sample was utilized. The questionnaire consists of 2 parts. The first part includes the demographic characteristics, while the second part includes questions related to A/C therapies, which includes the purposes of using, type of the therapy, and the sources of the information.

Statistical analysis: The data will be analyzed using the Statistical Package for Social Science (SPSS) version 15.0 for Windows. The results of the study will be highlighted at the conference.

Implications
The study would contribute to better understanding of patients’ behavior and would provide more insight about Jordanian patients with cancer use of A/C therapies that would provide the health care providers with knowledge about patients’ practices. The results would also help in formulating educational materials for patients and their families regarding C/A therapies used and allay any misconception related to C/A therapies use among the community.

Results
One month after the surgery, patients are invited to join the patient group, and share the advantages and difficulties while executing rehabilitation exercise. The effectiveness of this nursing education will be evaluated according to the frequency of executing rehabilitation exercise, the joint range of movement of the patient, and the occurrence of other complications during home care visits.

Conclusion
This project reestablishes the instruction materials and the rehabilitation exercise film. Procedures related to medical care, community, volunteers and rehabilitation are integrated to ensure that each patient receives the nursing instruction. The use of DVD increases the execution rate to prevent and reduce complications after surgery. Therefore, this model is worth promoting. Yet, this evaluation is conducted based on patients’ subjective responses. It is expected that a more objective measuring tool can be used.

P-230 NURSING EXPERIENCE OF A YOUNG FEMALE PATIENT WITH ACUTE LYMPHATIC LEUKEMIA
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Purpose of the study
The aim of this article is to explore the nursing experience of a young female patient with acute lymphatic leukemia in a medical center of central Taiwan. This patient is a 24-year-old female patient with initial disease acute lymphatic leukemia. We share this nursing experience for the hematology nursing staff for further clinical application.

Methodology
Data were collected during the period from November 10, 2008 to November 21, 2008 by observation, participation and deep interview during nursing process. It was then evaluated and analyzed according to Gordon 11 functionality healthy state appraisal that includes health awareness and health handling, nutrition metabolism, excretion, activities – sports, sleep – rest, cognitive – feelings, Role – the relationship between, sexual – reproduction, Response – stress tolerance, and Values – belief pattern.

Results
The major health problems were discovered (1) Anxiety (2) Hyperthermia (3) Risk of bleeding. The author adopted the continuous care and active care to establish a good nurse–patient relationship, so that cases can be the expression of inner feelings and reduce anxiety on the psychological and physical impact. Finally, the case was confident of the successful completion of the first course of treatment. In addition, the nursing staff did the implementation of aseptic technique when caring, and gave individual care and guidance of the chemical treatment of self-care attention. We prevented the cases from chemical treatment of the complications during nadir stage.

Conclusion
This nursing experience would be helpful for other nursing staffs in the clinical practice. And it is worth to do the further research and application.

P-229 AN EVALUATION OF THE EFFECTS OF COMPREHENSIVE NURSING EDUCATION ON POST MODIFIED RADICAL MASTECTOMY PATIENTS IN CENTRAL TAIWAN
Shu-Ling YU, RN1, Shu-Nu SU, RN1, Jui-Chun KAO, RN1, Shu-Nuan CHEN, RN1; Su-Fen LIAO, MD2, Mei-Wen WU, RN3.
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Background
Patients with breast cancers were found to have many complications after modified radical mastectomy (MRM). And after these patients discharged from hospital, the rate of executing rehabilitation exercise is not high. Therefore, the purpose of this paper is to establish a nursing education program to promote the effect of nursing instruction, and prevents or reduces complications.

Method
This project was implemented at a medical center in central Taiwan. We recruited cases for 2 months, from February 13 to April 13, 2008. The subjects were 37 breast cancer patients aged from 30 to 50 years old. The patients who were in need of related combined therapy and hospitalization over 7 days after surgery were excluded. The traditional education programs were mainly conducted by using information sheets and instruction of the home care nurses. In this new directive model, a case manager and rehabilitation DVD were included. The contents and tools of nursing education are established by surgeons, rehabilitation doctors, the case managers, home care nurses. The rehabilitation exercise DVD is 15 minutes. Before the MRM surgery patient watches the DVD for the first time, and on the 3rd day after surgery the case will execute the rehabilitation exercise lead by the case manager. Patients are required to watch the DVD and execute rehabilitation exercise right before discharging from the hospital. They are able to bring the DVD home, wake it on performance rehabilitation exercises at home according to individual status.
Results
The pre-GCRA period may be the most distressing time for these women. Perceived sense of lack of information and uncertainty about what to expect appeared to play a key role in distress. Most women initially had negative expectations (expecting the worse or bad outcome), but ultimately felt hopeful that they could learn more about the GCRA process and what it meant for them. Information was cited as the primary contributor to positive psychosocial outcomes, specifically increased locus of control and self-efficacy. The major cultural themes identified were destino, religious and spiritual coping, how cultural attitudes and beliefs influence lack of information, community awareness, and public health issues.

Conclusions: Preliminary data indicate that the pre-GCRA window may be most distressing for this population indicating that this may be the most appropriate time for psychological intervention.
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