incomplete and as contradicting the first-hand everyday experience of personal and social networks. Consequently, issues surrounding personal, social and contextual factors shape the way in which healthy lifestyle messages are received and show the situated nature of lay cancer beliefs and behavioural change. Ways in which healthcare professionals can take these factors into account when encouraging healthy lifestyles will also be discussed.

Conclusions: These findings have important implications for the clinical practice, future research and educational needs of health professionals who engage with those most affected by cancer: disadvantaged populations.

4174 ORAL

Information and support for Asian and African Caribbean women affected by breast cancer: role of voluntary organisations in meeting needs

E. Blows[1], J. Hatfield[1], K. Scanlon[1], A. Richardson[2], E. Ream[2]. [1]*Breast Cancer Care, Policy & Research, London, United Kingdom;* [2]*King's College London, Florence Nightingale School of Nursing and Midwifery, London, United Kingdom*

Background: Few studies in the UK have explored information and support needs, or interventions to satisfy these, for women with breast cancer from Black and Minority Ethnic (BME) groups. Voluntary organisations can potentially play an important role by providing services that are appropriate to the needs of these groups (Blows et al, 2009). This study explored the needs of South Asian and African Caribbean women with breast cancer in England, and the suitability and accessibility of services provided to them.

Materials and Methods: This was an exploratory qualitative study. Four focus groups were held (2 South Asian and 2 African Caribbean) (n = 20). Women were recruited via local community organisations. Groups were recorded, transcribed verbatim and analysed using Framework Analysis (Ritchie et al, 2003).

Results: Participants had unmet information and support needs, particularly relating to skin and hair care, and diet, both during and after treatment. Breast care nurses were considered an important source of information and support, but were inconsistent in signposting to services appropriate to the needs of women from these communities. Women were concerned that educational materials did not reflect their cultural needs and portrayed breast cancer as a 'White women's disease'. They reported difficulties obtaining coloured prostheses or lymphoedema sleeves, and accessing suitable hair loss services. 'Finding a connection' with women who had experienced cancer was important. Peer support was strongly desired, both for emotional support and practical 'tips'. Knowledge and use of cancer charities varied. Services provided by the statutory and voluntary sectors were often not seen as relevant to, or representative of, women from these communities. As a result, women were often dissatisfied with services used.

Conclusions: Both the statutory and voluntary sectors need to make services more inclusive, by raising awareness that breast cancer affects *all* ethnic groups and through greater representation of BME groups across staff and services. Facilitating peer support as well as providing, and signposting to, culturally appropriate services are important considerations. Ultimately, the statutory and voluntary sectors, and patients, must collaborate to improve the BME cancer experience.

4175 ORAL

Care needs of the elderly cancer patient and their informal care givers

P. Stolz Baskett[1], L. Imhof[1], E. Ream[2]. [1]*ZHAW, Gesundheit Institut Pflege, Winterthur, Switzerland;* [2]*Florence Nightingale School of Nursing & Midwifery, King's College, London, United Kingdom*

Background: The number of elderly cancer patients is increasing rapidly. At the same time we see an increase in cancer treatments given within the ambulatory care setting. There is some evidence, that social network characteristics play an important part in the management and coping of cancer patients. However, there is little knowledge available about the specific care needs of the elderly cancer patients and their informal carers in this setting.

Material & Methods: An integrative literature review has been carried out. The databases CINHAL & Medline were searched for research studies using terms: "Oncology", "cancer", "elderly", "older adult", "geriatrics", "gerontology", "family caregiver" and combinations thereof. All references that were published in English language were imported to Endnote, doubles cleared and abstracts reviewed. Studies addressing the focus theme of this review, namely the care needs of elderly cancer patients and their informal care givers were reviewed in their full text version with findings summarized in an integrative literature review.

Results: No study could be found that specifically addressed the care needs of elderly cancer patients treated in the ambulatory care setting and their informal care givers. Research evidence with regards to support needs and/or specific care delivery models for elderly cancer patients is marginal, and only few studies have included social networks characteristics of elderly cancer patients.

The reviewed studies are to disparate in main focus and aim, research methodology employed and conceptualisation or instrumentalisation of main variables to directly compare the results or attempt a meta-analysis or meta-synthesis.

Conclusions: This integrative literature review suggests that only little knowledge on the care needs of elderly cancer patients and their informal care givers that are treated in ambulatory care setting informs nursing care planning. To investigate the care needs of elderly receiving ambulatory cancer treatment and their main support persons in relation to their symptoms, side effects and functional status profile with regards to the impact on their quality of life further research is needed.

4176 ORAL

Working whilst receiving chemotherapy: patient's experiences

A. Shewbridge[1], A. Richardson[2], T. Wiseman[3]. [1]*Guys and St Thomas NHS Foundation Trust, Oncology and Haematology, London, United Kingdom;* [2]*Kings College London, Florence Nightingale School of Nursing and Midwifery, London, United Kingdom;* [3]*Kings College London/Guys and St Thomas NHS Foundation Trust, Florence Nightingale School of Nursing and Midwifery/Haematolgoy and Oncology, London, United Kingdom*

Background: The purpose of this study was to describe the number of patients who continued to work whilst undergoing ambulatory chemotherapy and to present personal or treatment related factors that influenced this. Advances in treatment and supportive therapies have meant that most chemotherapy is now given in an ambulatory setting. This paper will present the results of a study which estimated the prevalence of work whilst receiving chemotherapy and identified personal/treatment related factors that influenced this. Factors influencing decision making and the experience of those who continued to work are also presented.

Method: A cross sectional survey, using a self completion questionnaire was undertaken. Content validity was tested through scrutiny by an expert panel and cognitive interviews. 55 patients undergoing their final course of adjuvant chemotherapy for breast or colorectal cancer or first line chemotherapy for lymphoma took part.

Results: Sixty four percent (n = 35) of respondents were working when cancer was diagnosed. Fifty four percent (n = 19) of respondents were working when chemotherapy began but as treatment progressed only 29% (n = 10) continued to work in any capacity. Women undergoing treatment for breast cancer were more likely to stop work during treatment. Overall, respondents found their employers and colleagues supportive but there was some evidence they became less supportive as treatment progressed. Respondents described how the impact of cancer influenced ability to work and their experience.

Conclusion: Although the sample size was small, the survey clearly identified areas for improvement in clinical practice and future research. Health care professionals need to become more aware of the place of work in the lives of patients undergoing chemotherapy by including work issues as part of routine assessment. Approaches must be developed to allow those who wish to continue to work.

4177 ORAL

Agreement of French nurses with euthanasia for end-of-life cancer patients: focus on haematology and oncology hospital nurses

M.K. Bendiane[1], A.D. Bouhik[2], A. Galinier[3], R. Favre[4], D. Rey[1], J.P. Moatti[2], P. Peretti-Watel[2]. [1]*ORS PACA – INSERM UMR912, SE4S, Marseille, France;* [2]*INSERM UMR912, SE4S, Marseille, France;* [3]*AP-HM, Hôpital Sainte-Marguerite, Marseille, France;* [4]*AP-HM, Hôpital de la Timone, Marseille, France*

Background: Nurses are frequently the first caregivers to receive a patient's request for euthanasia. They can be involved in both the decision-making process to euthanasia and the performing of the request of euthanasia, even sometimes without consulting a physician. This report aims to study French haematology/oncology hospital nurses' propensity to consider euthanasia or PAS for end-of-life cancer pain, using data from a nationwide survey.

Method: In 2006 a telephone survey was carried out among a national random sample of French home and hospital nurses (including oncology/haematology nurses). The questionnaire included a module dealing with nurses' agreement with prescription of lethal injection to an end-of-life cancer patient using 4 clinical vignettes: patient with unremitting severe pain, patient with functional debility, patient burden on family and patient who views life as meaningless. Age and gender of the patient was randomly attributed. For each clinical vignette, nurses were asked if they agreed with the prescription of a lethal injection and if so, if nurses should do this injection.

Results: Response rate was 78% among district nurses (n = 602), and 60% among hospital nurses (n = 1502, including 550 nurses of haematology/oncology units).

49% of nurses agreed with the prescription of a lethal injection for a patient with unremitting pain (vignette with the higher level of agreement) versus 10% for a patient who views life as meaningless (vignette with the lower level of agreement). However, only 21% argued that nurses should do this lethal injection for a patient with unremitting pain (higher level) versus 5% for a patient who views life as meaningless (lower level). Agreement of haematology/oncology unit nurses was significantly lower for each clinical vignette.

After multiple adjustment using logistic models, individuals characteristics of nurses (age, gender, religious beliefs, training, attitudes toward end-of-life patients . . .), individuals characteristics of the patient (age and gender) and external factors such as professional context (intervention of association in the hospital unit) were associated with the level of agreement with lethal injection.

Conclusion: Findings indicate that attitudes of nurses toward euthanasia not only depend on individuals' factors but also depend on external factors. Indeed, interventions of associations specialized in end-of-life management should be promoted in order to help nurses to face stressing situations as euthanasia requests from patients or relatives.

Oral presentations (Tue, 22 Sep, 14:45−16:30)
Service delivery and care initiatives

4180 ORAL

Development of nurse-led, cancer follow-up clinics in community hospitals

L. Adams[1], E. Taylor[2], D. Lynch[3], K. Wardlaw[3], K. Smith[2], E. Chisholm[2], W. Johnston[2], B. West[1], G. Macdonald[3], L. Samuel[3]. [1]*NHS Grampian, Cancer Services, Aberdeen, United Kingdom;* [2]*NHS Grampian, Aberdeenshire Community Health Partnership, Aberdeenshire, United Kingdom;* [3]*Aberdeen Royal Infirmary, Cancer Services, Aberdeen, United Kingdom*

Background: A growing elderly population, earlier detection of cancer, a rise in the incidence of some cancers and declining mortality all challenge the traditional way of delivering cancer services. The development of a novel, nurse-led follow-up clinic for cancer patients in four community hospitals in North East Scotland is presented as an alternative model of high quality care. Patients with colon cancer on completion of their potentially curative treatment, including surgery +/− adjuvant chemotherapy, were the first group to be included. This development supports both local and national policy:

- strengthening health care in remote and rural areas
- developing practitioners with extended roles
- educating health care professionals for practice in local hospitals
- supporting self management in cancer survivors.

Prior to establishment of these clinics, patients were seen by medical staff at the regional cancer centre. Now patients are seen by generalist nursing staff in community settings.

Methods: Before establishing clinics the following was undertaken – activity analysis; service development analysis; budget identification for nurse staffing and education; development of clinical management plans, operational policies and protocols; patient inclusion and exclusion criteria; delivery of education programme and identification of competencies required; agreement of audit and evaluation requirements; and the development of a framework document to aid others who wish to develop such a service.

Results: Evaluation identified support from patients and staff for a service close to patients' homes, providing continuity of care, avoiding travel to the cancer centre, and reducing the carbon footprint of the service. The education programme met nurses' needs, particularly the clinical sessions at the cancer centre. Furthermore, this development optimised nurses' skills and provided opportunities for role development. The need for robust referral and communication systems between community and cancer centre was also identified.

Conclusion: A safe, acceptable, cost effective, 'green' and sustainable service has been developed. This has been a hugely successful project. In addition to the achievements described, it resulted in cancer centre and community working effectively together on common issues relating to cancer care and management. However, the main benefits achieved are undoubtedly the benefits to patients living in the North East of Scotland.

4181 ORAL

Nurse case managers in oncology

K. Dieperink[1], M.B. Poulsen[1], A.G. Andreasen[1], S. Larsen[1], P. Andersen[1], L.S. Hansen[1]. [1]*Odense University Hospital, Onkologisk Afd. R, Odense C, Denmark*

Background: Department of Oncology at Odense University Hospital receives annually 2700 new patients. As cancer patients they experience a variety of treatments including in some cases a change from curative to palliative treatment. This causes an increased level of anxiety and many questions. Since many patients reported difficulties in finding the correct staff person or unit to address these questions, the department appointed two nurse case managers (NCM) for a one-year project period. These case managers were expert cancer nurses with insight into symptoms related to either disease or treatment, and to the protocols applied. The NCM were on phone call weekdays from 8 to 15, and received calls from patients, relatives and collaborators. The study had two primary aims: 1) To answer the questions from the patients and reduce their anxiety. 2) To reduce the interruptions of the staff caused by incoming phone calls, hopefully reducing staff stress and improving patient safety. This study describes the first experiences with cancer NCM in Denmark from an organisational perspective.

Material and Methods: The study was conducted as a point-survey over 2 working days 3 months before the NCM initiative, repeated nine months after. The survey had 3 parts: 1) All incoming calls were registered. 2) All doctors, secretaries and nurses answered a questionnaire about interruptions and their influence. 3) A simultaneous questionnaire asked patients to which degree they felt safe and had the support they needed, and if they knew the person who had the comprehensive view of their treatment.

Results: We observed a significant reduction (218 calls) in questions to the staff during the study period despite increased activity in the department. The NCM had answered a significant part (127) of these. The staff response rate was 81%. The staff members reported the decline in phone interruptions to have a positive impact on quality of work. The patients' response rate was 85%. The patients reported a significant improvement in continuity of care.

Conclusion: The appointment of NCM relieved other staff members, who were less frequently interrupted by phone calls during work. Patients experienced improvements in continuity of care. Therefore, the department has continued and expanded the NCM initiative.

4182 ORAL

The use of a prefilled medication box results in improved care for patients receiving chemotherapy

J. Salome[1], E.M. Ponsioen[1]. [1]*Sint Franciscus Gasthuis, Oncology, Rotterdam, The Netherlands*

Background: Patients on chemotherapeutic treatment experience problems in the correct use of anti-emetic drugs. Medication schedules often appear to be to complex for patients, leading to inadequate dosage and timing of anti-emetic drugs. In addition, anti-emetic medication is not uniformly prescribed. Furthermore, side effects interfere with optimal anti-emetic treatment. Our goals were to enhance uniformity in prescribing anti-emetic drugs and to improve correct use of these drugs in order to alleviate symptoms of nausea, vomiting and constipation.

Material and Methods: A baseline questionnaire was carried out with patients to gain insight in the use of anti-emetic drugs and the prevalence of side effects of chemotherapy. We reviewed all available cytostatic drugs with respect to emetogenicity and divided them into classes ranging from 1 to 4 (1 being slightly emetogenic and 4 being highly emetogenic). We defined a policy regarding the use of anti-emetic drugs, related to emetogenic class of chemotherapy. We developed a medication box, in which medication could be prefilled. Drugs were separated by day and hour, and by class. The box contained anti-emetic drugs, a laxative and a sedative (the sedative only for class 3 and 4) with extra written information about these drugs. After four, sixteen months and 3 years we sent a questionnaire to patients, physicians, nurses and employees of the pharmacy department to evaluate the project.

Results: Patient satisfaction increased significantly with the uniform anti-emetic drug prescription combined with the prefilled medication box (7.4 baseline vs 8.4 last evaluation) After the first evaluation, only the anti-emetic schedule for 5Fu-Epirubicine-cyclofosfamide (FEC) chemotherapy needed to be reclassified into a higher class. In addition anti-emetogenic medication schedules were simplified into 3 classes in stead of 4. After 16 months patients (n = 59) had fewer complaints of nausea, vomiting and constipation (34±12% vs 54±19%, 14±9% vs 23±16% and 36±13% vs 72±17%, respectively) as compared with baseline results (n = 26). Additional prescription of drugs against nausea, vomiting or constipation