

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

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ORAL

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

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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.

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ORAL

Nurse case managers in oncology

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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.

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ORAL

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

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Background: Patients on chemotherapeutic treatment experience problems in the correct use of anti-emetic drugs. Medication schedules often appear to be too 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-Epirubicin-cyclofosamide (FEC) chemotherapy needed to be reclassified into a higher class. In addition anti-emetogenic medication schedules were simplified into 3 classes instead 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