1497 POSTER

GCP: sensible documentation or bureaucracy ?

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The Good Clinical Practice guideline was implemented in 1998 to protect the patients' rights and safety, and to guarantee the quality of the data collected in a trial. Since then the quantity of documentation related to clinical research has increased enormously. Nowadays we are confronted with all sorts of paperwork, which aims to protect the investigator, the institute and the sponsor, but has little to do with the protection of the patient or the quality of the trial. Rightly this is called bureaucracy.

The protection of the patient and the quality of the investigation are key issues of a Quality Assurance system in the Netherlands Cancer Institute/Antoni van Leeuwenhoek Hospital. To avoid bureaucracy, the documentation this system demands is described in relation to the basic principles of the Good Clinical Practice guideline. It also must have a direct and measurable effect on the quality improvement of the care and execution of the trial.

The Quality Assurance system includes two parts which are very closely connected: the description of the procedures and quality control.

The routing of the patient in a clinical trial is described in Standard Operating Procedures. The activities that have to be performed are described, as well as the responsibilities of the different health care workers.

All procedures are followed by continuous quality control. The compliance with the procedures are checked regularly with the help of short questionnaires. The quantified results of the quality control are starting points for improvements (if necessary). This can either be logistic changes or instructions to different health care workers involved in the execution of the trial.

The Good Clinical Practice guideline demands a certain amount of documentation, but we should not lose sight of it's aim. Documentation is not to protect the health care worker but the patient, and should be limited to improve the patient care and the quality of the research.

1498 POSTER

Continuous education of nursing staff on prevention of phlebitis on patients undergoing intravenous chemotherapy

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Purpose: To evaluate the results of an educational programme performed by nursing staff, for the prevention of phlebitis in patients undergoing intravenous chemotherapy with short catheters.

Methods: In March 1997, the Nursing staff of FUNDALEU implemented rules for the prevention of phlebitis during and after intravenous chemotherapy:

a) The site of puncture should be away from joints. b) the catheters should be size 22, or 20 G., c) the hydration plan should have as lower amount of electrolytes as possible, d) the catheter should be washed after each drug infusion with 20 cc of saline solution in intermittent push. e) catheter change after one of the following signs or symptoms: pain, heat, swelling or disconfort.

In March, 1998, through a questionnaire, we evaluated the level of knowledge of 27 nurses performing this technique. It was after this, that a plan for continuous education was implemented which included:

a) Filling in a follow up form including all the details of the patients who underwent intravenous chemotherapy, b) Implementation of a new protocol for the treatment of phlebitis and the production of a new follow up chart c) bibliographical investigations performed by 8 nurses about the incidence and risk factors of phlebitis. d) nursing staff were asked about proposals for the prevention of phlebitis. e) supervision of the programme by senior staff.

In March 2001, another questionnaire was circulated for a second evaluation.

A statisfactory level required a perfomance of 80% of correct answers.

Results: In March 1998, an year after the introduction of the programme 59.-% (16/27) obtained an unsatisfactory level of knowledge. In the second evaluation, in March 2001, only 18.5% (5/27) did not know the guidelines. (test Chi Square) $p < 0.004$.

Conclusion: The results of this study suggest us that the introduction of a continuous educational programme was succesful for stimulating the knowledge of the guidelines for prevention of phlebitis in our centre.

1499 POSTER

Phlebitis related to chemotherapy in oncological patients

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Objectives: -To determine the incidence of phlebitis in oncological patients undergoing intravenous chemotherapy through short catheters and to identify the risk factors for the development of phlebitis.

Methods: The present is a prospective study performed in Fundaleu between May 1998 and December 2000. Seventy three intravenous chemotherapy infusions with short catheters were controlled in oncological patients. Phlebitis was defined as one, or more than one of the followings signs: pain, burn, swelling, heat and redness. The following risk factors were evaluated: 1) composition of catheters, 2) electrolite solutions containing more than 40 meEq/l of KCl and HCO3 and 3) chemotherapy: the procedures were divided in two groups: group 1: regimens with > or = to 3 irritant drugs and Group 2: < or = to 2 irritant drugs. Data were collected by nurses in appropiate record forms

Results: From 73 procedures performed, 26 developed phlebitis (35,6%). Risk factors were studied by univariate analysis.

1) Phlebitis ocurred in 21 out of 44 procedures (47.7%) of those patients with teflon catheters and in 5 out of 29 procedures (17.2%) of poliuretane material. RR= 2.27 ($p<0.001$).

2) Phlebitis was observed in 8 out of 16 procedures (50%) with infusions containing high concentration of electrolytes and in (18/57) procedures (31%) (p NS) with low concentration of electrolytes.

3) Regarding to chemotherapy, the incidence of phlebitis observed in group 1 (regimens with > or = to 3 irritant drugs) was 46.3% (19/41) and in group 2 (< or = to 2 irritant drugs) was 21.8% (7/32) RR=2.12 ($p<0.001$).

Conclusion: This study shows us that the incidence of phlebitis is related with the catheter material and irritant antineoplastic drugs.

1500 POSTER

The contribution of the cancer support nurse to the cancer care team

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There is increasing recognition by health professionals of the supportive and complex needs of individuals with cancer. Nursing's contribution in addressing these needs in particular has been acknowledged as critical. A number of studies of the Breast Care Nurse (BCN) in particular have provided level one and level two evidence that the BCN can contribute to improved patient outcomes (1,2). The Recent Psychosocial Clinical Practice Guidelines recommend the presence of the specialist BCN as they reduce psychological morbidity and improve wellbeing (3). The purpose of this paper is to describe the model of the Cancer Support Nurse (CSN) role implemented at the Austin and Repatriation Medical Centre (A&RMC) in Melbourne, Australia. This model was established to address support needs of newly diagnosed patients with any cancer type.

The development and implementation of the Cancer Support Nurse Role at the A&RMC will be discussed in the context of the scope of practice and will identify key dimensions of the role. These include: Facilitating Communication, Coordination and Referral, Identifying the information and support needs, Providing emotional support, Breaking Bad News, and Education.

The CSN provides a vital link within the cancer care team in many ways. The role enables the provision of expert resources, support and development opportunities to staff involved in the care of patients with cancer. Specific needs of newly diagnosed patients with cancer, their families and carers are identified and addressed. The CSN contributes to the knowledge of the nursing team through formal education and provides support for less experienced team members, regarding coping with reactions to a new cancer diagnosis.

The CSN also provides support to medical colleagues in the confronting role they face often without a clearly identifiable supportive framework.

1501 POSTER

Central venous access ports: a nursing perspective

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Introduction: Central venous access ports (CVAP) are commonly used in modern oncology practice. These devices facilitate administration of cy-

tostatic treatment, especially prolonged treatments. The need arises due to poor availability of peripheral veins. However, placement of a CVAP is costly and may lead to life-threatening complications. We studied the complications and the influence of nursing practice on the prevention of these complications.

Methods: 120 patients with CVAP were studied. The median age was 50.5 years. Tumour types were breast, lymphoma, lung, melanoma, soft tissue sarcoma, gastro-intestinal and genito-urinary. Positioning of the CVAP was assessed by means of a chest X-ray. The time interval between implantation and the first chemotherapy delivered through the device was +- 24 hours. If early complications occurred, chemotherapy was delayed until resolution of the problem. Blood samples were sent for culture in case of suspected infection.

Results: Median implant duration was 204 days. Complications were devided into two categories. EARLY: Defined as intra operative and post implantation period to first use. LATE: Defined as after first chemotherapy administered. Seventeen (14.17%) CVAP were removed before the expected time.

Complications included:

1. Symptomatic infection in 10.8%.
2. Venous thrombosis in 3.3%.
3. Mechanical problems in 3.3% of patients. No patients died due to CVAP complications.

Conclusion: CVAP have become essential in the treatment of cancer patients. Complications are infrequent but still occur. Infection is the most common complication of these devices and the leading cause of early removal. Adequate patient information and meticulous nursing practice contributes towards a lower complication rate.

1502 POSTER

Motivation of patients in clinical oncology trials

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Introduction: As oncology trials are usally long term in nature, it is vital to ensure that continuing follow up of the patients is achieved to monitor both side effects, quality of life and disease progression.

Materials and Methods: The important factors are

- The nursing and medical teams involved
- Clinic Environment
- Transport to and access to the Care delivery point.
- Adequate information to and communication with the patient covering the trial, the follow up and potential complications.
- Continuity of staff
- Patient selection at entry to trial
- Acess to self-help groups

Discussion: Attention to the above factors can maximise the proportion of patients completing follow up, minimising the drop out rate. This will therefore maximise the power of the study.

By utilising these protocols we have managed to keep our drop out rate below 5%

1503 POSTER

Cancer patients' experiences of participation in care

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The purpose of this study was to explore the experiences of cancer patients about participation in care and the preconditions for this participation. The data were collected in focused interviews, and the analysisi of the data was based on qualitative content analysis. The sample comprised 34 voluntary cancer patients from haematological and oncological wards of one university hospital in Finland. The mean age of the respondents was 44 years.

The results revealed that the patients' views of participation varied considerably. Some of the patients had the opinion that their participation in care was impossible. Some considered participation either in terms of being involved in decision making or in terms of expressing their views on treatment options.

The preconditions for participation in care were analysed through factors promoting and restricting participation. Promoting factors included good health, access to information, assertiveness, good interactive relationships with nurses and physicians, and engouragement of the staff to participate in care. Restricting factors of patient participation were poor health, ignorance, anxiety, age, time pressure of staff, lack of time, high staff turnover and poor interactive relationships with staff.

The results considering patient participation showed that there were three kind of participants:1) minor of patients participate actively in decision making,2) some patients gave active consent and 3) the most of patients gave passive consent to medical decisions.

1504 POSTER

Information for patients and their relatives before starting radiation therapy

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For 15 years a group of nurses have been offering one hour long information session for patients who are to start radiation therapy.

The invitation to the session is given to all patients with curative cancer when preparing for the treatment during the CT (computer tomography). Relatives and friends are welcome as well. No register in advance is necessary.

The information includes:

A short history of our department.

What the preparations for the treatment entails such as dose planning, mask, fixatives and the purpose of them.

Why there is a need for a waiting period before the start of treatment.

How the treatment is beeing delivered.

Routines such as doctor appointments, bloodtests and contact with other care professionals.

Side effects and how to minimize them.

Travelling to treatment and travel allowances.

The visitors also are invited to a tour of the department as well as a visit to a treatment room.

A questionnaire was used to evaluate the information given to patients. The result shows that patients that came for the information session perceived less stress and were much calmer and relaxed at the start of the treatment.

1505 POSTER

PICCs (peripherally inserted central catheter) or Hickman catheters - a comparison of patient comfort and experiences

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Purpose: Eighteen months after setting up a PICC insertion service for patients receiving chemotherapy, an audit was undertaken to assess the need and experience of PICC insertion, against our original Hickman catheters.

Method: A questionaire was developed and used for each patient who had a PICC or Hickman placed, to establish where the catheter was inserted (either within the Medical Oncology outpatient clinic, or in radiology),whether the place of insertion would have any bearing on any future problems, whether the patient actually had any problems, and for how long the catheter functioned. The questionaires were completed by the sister in the Oncology department, by accessing the patients notes, on all line insertions over a three month period.

Results: In the three month period of the audit, 67 catheters were inserted. Some patients received more than one catheter. Approximately equal numbers of PICCs and Hickman lines were placed.

Conclusion: Although the results of the audit are not yet available, preliminary results show that the problems occurring happened in about similar numbers for both Hickmans and PICCs. Very few patients from the numbers inserted had any problems at all. PICCs appear to be advantageous, however, as they are less obtrusive, inserted by a skilled,trained nurse, better tolerated, and with no necessity for a general anaesthetic or sedation.The procedure is quick and relatively painless.

1506 POSTER

Re-expression of HLA class I antigens and restoration of antigen-specific cytotoxic T lymphocytes in melanoma cells following 5-AZA-2'deoxycytidine treatment

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Cytotoxic T cells (CTLs) play a central role in the elimination of virally