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POSTER

GCP: sensible documentation or bureaucracy ?J.M. Maaskant. *The Netherlands Cancer Institute/Antoni van Leeuwenhoek Hospital, Amsterdam, the Netherlands*

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.

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POSTER

Continuous education of nursing staff on prevention of phlebitis on patients undergoing intravenous chemotherapyS. Estrada¹, P. Coria², E. Farias³. ¹FUNDALEU, Nursing, Buenos Aires, Argentina; ²FUNDALEU, Nursing, Buenos Aires, Argentina; ³FUNDALEU, Nursing, Buenos Aires, Argentina

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 discomfort.

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 satisfactory level required a performance 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 successful for stimulating the knowledge of the guidelines for prevention of phlebitis in our centre.

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POSTER

Phlebitis related to chemotherapy in oncological patientsE. Farias, E. Gonzalez, S. Estrada. *FUNDALEU, Nursing, Buenos Aires, Argentina*

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) electrolyte solutions containing more than 40 mEq/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 appropriate record forms

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

1) Phlebitis occurred 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.

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POSTER

The contribution of the cancer support nurse to the cancer care teamE. Stickland. *Austin & Repatriation Medical Centre, General and Specialist Surgery, Melbourne, Australia*

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.

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POSTER

Central venous access ports: a nursing perspectiveL. Myburgh¹, M. Janse van Vuuren¹, J.I. Raats². ¹Private Medical Oncology Practice, Nursing, Panorama, South Africa; ²Private Medical Oncology Practice, Oncologist, Panorama, South Africa

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