Purpose: Processes and peer data are available to address patient satisfaction in the inpatient setting, but evaluating satisfaction in the outpatient setting has been historically over-looked. Our outpatient apheresis unit has established a mechanism to assess patient satisfaction and address the unobserved needs of our patients.

Methods: We have developed patient satisfaction cards that are given to patients upon completion of their procedure. Patients have the opportunity to rate their care by answering the following questions:

Was the procedure thoroughly explained by the apheresis staff?
Were your needs met during the procedure?
Were you treated in a courteous and professional manner?
Can you please rate the overall apheresis experience?

Ratings are on a scale from 1 to 5 with 1 being 'very poor' to 5 being 'very good'. Patients are also given the opportunity to provide comments regarding their procedure and the entire apheresis process. The self-addressed scorecards are sent directly to our program's quality management coordinator for review and evaluation. Survey participants are anonymous with names being optional.

Results: The goal of our hospital is to have a 'good' or 'very good' response on 90% of all patient satisfaction surveys. Our goal is to exceed the needs of each patient and stay in-line with the hospital's desired goal. Tabulated results are reviewed with the apheresis staff and are presented quarterly at our transplant program's quality management meetings. Results and comments are posted within the apheresis unit for continuous visualization of patient satisfaction. Comments for improvement are entered into our unit's complaint log and are reviewed during our department meetings.

Conclusion: Improved patient satisfaction is a high priority at our institution. Patient satisfaction assessment is an excellent mechanism for quality improvement activities. Evaluation of care, planning for improvement and documentation of actions taken are a required quality improvement activities for FACT accreditation for our blood and marrow collection facility. Comment cards give our patients an opportunity to express their appreciation for the care provided by our staff. This provides an excellent affirmation of a job well done.

444

GROWTH OF A BMT UNIT IN TOUGH ECONOMIC TIMES: SUCCESS WITH A STRUCTURED PROGRAM AND INNOVATIVE SOURCES OF FUNDING

Beaupierre, A.[1], Thirlwell, S.[1], Gillespie, M.[1], Jones, G.M.[2], Reardon, M.B.[1] [1] Moffitt Cancer Center, Tampa, FL; [2] Moffitt Cancer Center, Tampa, FL

In the past year, the Blood and Marrow Transplant (BMT) program at our NCI-designated Cancer Center increased its inpatient bed capacity by 80% and additional nursing staff was needed. Given the challenges of the nursing shortage, the present economic climate and the reality that nurses with BMT experience are uncommon, the Director of BMT and Critical Care Nursing, the BMT Clinical Nurse Specialist (CNS) and the BMT Patient Care Manager (PCM) formulated a plan to recruit and orient nurses to meet our increased need and sought novel ways to fund this initiative.

Safe and effective BMT nursing requires excellence in assessment, critical thinking and care of acute and critical complications as well knowledge in complex BMT treatment plans and skills in communication with patients, families and an interdisciplinary team. BMT Nursing Leadership created a structured BMT Internship Program to support successful recruitment and attainment of BMT nursing proficiency. The program included didactic education, an orientation manual and clinical orientation with a dedicated preceptor. Clinical orientation was designed according to a BMT Orientation Pathway, with three tracks individualized and varied in length according to prior nursing and BMT experience, if any (see Table 1).

Clinical orientation requires a significant financial investment and the length of orientation became a concern. Nursing Leadership partnered with Human Resources and the local unemployment office to investigate opportunities for economic stimulus funds to partially fund the internship program. An ongoing partnership with the local unemployment office will also create local sourcing and networking opportunities for viable nursing candidates, as well as the potential to receive funding through other designed programs.

Over a 15-month period, 41 nurses were recruited for the BMT Internship Program and were orientated according to the appropriate track (see Table 1). The program had a 90% success rate with 37 nurses as new members of the BMT inpatient nursing team. Successes and challenges of the BMT Internship Program have included preceptor burnout and organizational issues as well as a change in nursing culture. Future directions include preceptor support and continued growth of the individual and collective BMT nursing expertise.

Table 1. BMT Orientation Pathways

	Type of RN	Length of Orientation	Number of Orientees
Track 1	Novice (New RN or Nurse < 2 years)	15 - 24 weeks	15
Track 2	Advanced Beginner (Nurse with experience in Med-Surg, Heme/Onc, or Critical Care)	7 - 14 weeks	22
Track 3	Expert (Nurse with BMT experience)	4 - 6 weeks	4

445

USE OF "RAPID-CYCLE" FAILURE MODE AND EFFECTS ANALYSIS (FMEA) AND SIMULATION TO SAFELY TRANSITION HEMATOPOIETIC STEM CELL (HSC) PROCESSING SERVICES

Halverson, T.[1], Barnard, C.[2], Collins, J.[1], Duerst, R.[1,3] [1] Children's Memorial Hospital, Chicago, IL; [2] Northwestern Memorial Hospital, Chicago, IL; [3] Northwestern University, Chicago, IL

When Children's Memorial Hospital (CMH) closed their hematopoietic stem cell (HSC) processing laboratory and contracted with the affiliated Northwestern Memorial Hospital for processing services, it required substantial practice changes and introduced potential safety risks. The 3-month transition timeline required the transplant program to make optimal use of time and resources. "Rapid-cycle" FMEA followed by simulation was used to evaluate, refine and test the process changes required for this transition.

Failure mode and effects analysis (FMEA) is a systems-oriented, prospective approach to process improvement and risk reduction. FMEA identifies potential process fail-points, assesses their level of risk, and helps prioritize response with the goal of reducing error occurrence and/or mitigating harm. Traditional FMEA is effective but time-intensive. The "rapid-cycle" adaptation focuses on efficient use of FMEA meeting time and reduces clinician stakeholder's involvement to two meetings (see table 1).

To keep the scope manageable, two "rapid-cycle" FMEAs were conducted. An inter-facility FMEA focused on information and cell hand-off, and included representation from the hospital, processing facility, and courier company. A second, intra-facility FMEA focused on process changes occurring within the clinical program.

The joint FMEA sessions identified 51 potential failure modes. Failure modes were scored for severity, frequency and detectability; those identified as high or moderate severity were corrected. The two items identified as highest risk were (1) incomplete or inaccurate chain of custody documentation and (2) incomplete information hand-off between the two institutions. These fail-points were part of a new process step that required hand-off of cells from CMH to the outside processing facility via courier. The process was revised using recommendations developed during the FMEAs, then tested before the move using simulation.

Sequential use of "rapid-cycle" FMEA followed by simulation allowed the stem cell transplant program to 'design out' potential