complaints by the physician teams, improved touch preps as described by the pathologists, validated patient satisfaction and improved RN satisfaction. Formal outcomes are forthcoming as well as the proposal for a research study.

<table>
<thead>
<tr>
<th>Table 1. Patient Satisfaction Survey Results</th>
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<tr>
<td>Survey Question</td>
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<tr>
<td>Use of Anxiolytic Agents %</td>
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<tr>
<td>Average Pain Score</td>
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<tr>
<td>Felt Relaxed</td>
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<td>Compare experience to outside facility</td>
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STANDARDIZING CARE FOR CUTANEOUS aGVHD AND PERIRECTAL BREAKDOWN
Brook, B. Stanford Hospital & Clinics, Stanford, CA

Background: Acute cutaneous graft versus host disease (aGVHD) is a potential complication for allogeneic transplant recipients. More than half of BMT recipients will be affected by aGVHD. Darrieh associated with aGVHD of the GI tract and the high dose preparative regimen can result in perirectal skin breakdown. There are no published nursing standards of skin care for cutaneous aGVHD or perirectal skin breakdown. Nursing management and documentation is inconsistent due to the lack of a standardized protocol.

Purpose: The goal of this evidence-based practice project was to improve the care of BMT recipients with cutaneous aGVHD and perirectal skin breakdown. An education plan was implemented to improve the nurses knowledge and comfort in the management and documentation of skin care. The education plan consisted of the three components:

1. Review of cutaneous aGVHD and perirectal breakdown risk factors,
2. Documentation and assessment requirements,
3. Development and implementation of a standardized skin care protocol for cutaneous aGVHD and perirectal skin breakdown.

Interventions: A protocol for aGVHD and peri-rectal breakdown was developed and implemented. Nursing staff completed both a pre and post test knowledge assessment. In addition chart reviews were conducted before and after implementation of the standardized skin care protocol.

Evaluation: Results of the post-test showed that an education program combined with a standardized protocol for skin care improved nurses knowledge as well as the assessment and documentation of skin care.

Discussion: Education regarding skin care for aGVHD and perirectal breakdown and reinforcement of the use of the standardized protocol must be ongoing. Limitations of this project included the small number of cases of cutaneous aGVHD during the education period. An additional limitation is finding time for nursing staff during their busy assignments to receive education regarding the standardized skin care protocol.

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PROBLEMS AND NEEDS RELATED TO PHYSICAL AND PSYCHOSOCIAL REHABILITATION AT LONG-TERM FOLLOW-UP UNIT (LTFU) NURSING CONSULTATION FOR ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANTATION (HSCT) RECIPIENTS IN JAPAN
Morikawa, A., Wada, N., Kashiwabara, T., Araki, M. National Cancer Center Hospital, Tokyo, Japan

Purpose: To clarify problems and needs related to physical and psychosocial recovery and rehabilitation after a discharge in allogeneic HSCT recipients.

Methods: A retrospective and descriptive study based on medical record information of single cancer institute in Japan. Subject was the allo HSCT patients who visited LTFU nursing consultation in outpatient clinic between Apr 2009 and Mar 2010.

We examined various clinical information including patient background, stem cell source, conditioning, GVHD prophylaxis, and contents/correspondences at consultation. We simply tabulated and categorized all items qualitatively and inductively, and compare them according to the timing after allo-HSCT.

Results: Forty-nine patients (male 25/ female 24) who underwent allo-HSCT with myeloablative (n = 15) or reduced-intensity (n = 34) conditioning regimens visited LTFU nursing consultation once (n = 25), twice (n = 12), or 3-times or more (n = 12).

Timing of their visit was within 6 months (n = 42), 6-12 months (n = 15), 1-2 years (n = 24), or more than 2 years (n = 19) post-transplant.

Frequently reported problems and needs for rehabilitation after a discharge included “incorporate strategies to prevent infectious complications”; “control symptoms related to GVHD and late effects”; “promote recovery in social activities”; “enhance recovery of physical activities by exercise”; and “manage their anxiety”. Problems were more variable in patients within 6 months after allo-HSCT than in those at 6 months or later. Our correspondences to the patients within 2 years after HSCT included “adjust daily life according to recovery of physical functions”; “promote a physical rehabilitation”, and “expect changes in psychosomatic conditions”, while those to the patients at 2 years or later included “acknowledge daily effort to chronic symptoms and highly acknowledge psychosomatic recovery”.

Discussion: As the patients encounter many problems related to GVHD and immunodeficiency during the first 2 years after allo-HSCT, it is important to assess their psychosomatic changes adequately and to incorporate effective interventions into daily life.

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ICU UTILIZATION IN BMT – UPDATE ON A BMT ICU UTILIZATION PROJECT
Jenkins, T. Stanford University Hospital, Stanford, CA

Transferring a BMT patient to the ICU is a complex and critical decision. The decision is challenging for patients and families, who view transplant as the last resort. They view themselves as “fighters” and are willing to accept significant risks. Consents outline the serious risks involved including life-threatening infections, bleeding, organ damage, and GVHD. The mortality risks of allogeneic transplant approach 50% in the first year.

It is equally difficult for BMT physicians to make decisions about the ICU, as they approach transplant using cutting edge technologies, the latest research and clinical trials in their effort to care. Knowing the probabilities of survival, when considering ICU care for BMT patients, makes it critical for the medical team to provide clear communication and establish clear goals of care.

Communication in the ICU can become fragmented between medical teams, patients and families. The mixed messages and conflicting recommendations are confusing and stressful for patients and families. They need clear and consistent communication in order to make educated decisions regarding care. One consequence of poor communication is an over utilization of the ICU for non-beneficial care.

Appropriate resource utilization is critical with rising health care costs and the scarcity of ICU beds. Guidelines are needed for the appropriate transfer of BMT patients to the ICU.

Guidelines for appropriate use of the ICU for BMT patients were developed by our team 5 years ago based on a review of current literature, data on prognosis and to address our increase in ICU utilization. A process was outlined to improve communication between the teams, patients and families. The plan consists of joint rounds with the BMT and ICU team and scheduled meetings with the families every 2-3 days.

Our ICU length of stay has decreased by 50%. The percentage of ICU days to total days is now 3.4 down from 5.1. The total annual BMT ICU days decreased to 209 from 443. Based on the guidelines, of 36 patients sent to the ICU, 16 met criteria, 19 met criteria for limitation of ICU and 1 did not. Twenty-five of these 36 patients (69%) were discharged from the ICU. We are now analyzing the six month and one year survival of these patients.