Addressing ongoing patient concerns with the entire team can be problematic on a busy, 52-bed inpatient BMT unit. Two methods that have been successfully initiated are long-term care conferences, where multiple patients are discussed, and formal individual patient care conferences. Instituted by the nursing staff with input from the ethics committee, the long-term weekly conferences allow all disciplines to be involved in a discussion of a group of BMT patients with unique problems that affect quality of life, discharge plan, and overall outcome. Patients selected to be presented on the basis of length of stay (≥ 50 days), unresolved/prolonged acute complications, and patient/family concerns. The clinical nurse provides pertinent details about the patient’s history, which can assist in developing criteria for patient-directed objectives in the plan of care.

Formal care conferences are designed to include not only the interdisciplinary team, but also the patient/family in keeping everyone informed about a formalized plan of care and expectations for the patient. Care conferences are an avenue that affords the nurses an opportunity to advocate on the patient’s behalf when various factors indicate a need for discussion to revise the previous plan of care. A sample care conference will be presented demonstrating steps initiated to develop a plan of care for a specific BMT patient and its end result.

Talesized BMT Patients

The medication regimen of a bone marrow transplantation (BMT) patient is unlike most other cancer patients. The number of medications can be extensive and complicated. Many of the patients have anywhere from 15 to 20 medications at scheduled intervals throughout a 24-hour period. One of the challenges to the inpatient nurse is to administer the number of medications in a safe and timely manner. New RN graduates on the BMT floor recognized the need for a quick-reference compatibility chart for the common medications given. The goal was to provide a quick reference chart for both experienced nurses and new graduates.

The decision to create a quick-reference chart was based on the time-consuming method of searching through the MDACC formulary handbook and the online medication databases. Drug compatibility information is located in the online medication database on MDACC computer systems. However, these systems are not always complete and at times are down, leaving the information unavailable.

Chemotherapy, a key component of the transplantation process, also has specific guidelines for administration, and thus a chemotherapy reference chart was created. This includes information about preparing, administering, and disposing, as well as educational information that the nurse can provide to the patient. Decreasing medication errors, avoiding medication incompatibilities, and managing time are all essential components of the nursing responsibilities during the BMT process. The quick-reference compatibility chart and the chemotherapy reference chart have proven effective based on the initial informal response from the nursing staff.

Tools to Assist with the Medication Management of Taledized BMT Patients

Grill, K., Mishin, K. University of Texas M.D. Anderson Cancer Center, Houston, TX.

The medication regimen of a bone marrow transplantation (BMT) patient is unlike most other cancer patients. The number of medications can be extensive and complicated. Many of the patients have anywhere from 15 to 20 medications at scheduled intervals throughout a 24-hour period. One of the challenges to the inpatient nurse is to administer the number of medications in a safe and timely manner. New RN graduates on the BMT floor recognized the need for a quick-reference compatibility chart for the common medications given. The goal was to provide a quick reference chart for both experienced nurses and new graduates.

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Pediatric Blood and Marrow Transplantation: A Roadmap to School Reentry

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Children who have undergone blood and marrow transplantation (BMT) face many challenges. Often, the physical challenges become the primary focus of the posttransplantation phase, and the emotional and psychosocial needs of childhood, a time of growth and discovery, are often overlooked. Posttransplantation, the child is often unable to attend school, which can cause the child to feel isolated and unsupported. Developing a posttransplantation treatment plan that addresses all aspects of the child’s life is of the utmost importance. School attendance provides the opportunity for the child to achieve the social, emotional, and academic milestones necessary to his or her development. Attending school gives the child a sense of hope and purpose. The development of a formal school reentry program enables the pediatric BMT team to effectively address the many psychosocial needs of the transplantation patient. The purpose of the program is to provide education about the transplantation process to teachers, school nurses, classmates, and other school members with the goal of increasing awareness and understanding and alleviating any fears and misconceptions that may exist. The expected outcome is to have an increased level of support from the posttransplantation child’s peers and school personnel, and facilitation of a smooth reentry into school posttransplantation.

Nurse Retention in the BMT Setting: One Possible Solution

Clegg, C.E. University of Texas M.D. Anderson Cancer Center, Houston, TX.

Nurse retention is key in providing excellent nursing care. An emerging concept to improve the retention rate for inpatient nurses is to allow each nursing staff member to submit a written request for their specific work schedule. The requests are then compiled by an elected committee of peers, who attempt to provide adequate staffing for a 52-bed inpatient unit. The committee is made up of 5 clinical RNs, 1 inpatient service coordinator (ISC), and 1 nursing assistant. The main objective of the committee is to provide adequate staffing for a 4-week period for all of the nursing entities on the BMT inpatient unit.

The process of staffing involves 3 steps. The first step requires input from each nursing staff member, each ISC, and each nurse assistant. The second step of the process involves the tedious task of compiling all of the requests and successfully staffing the floor for a 4-week period. The third step of the process falls back on the responsibility of the staff to view the posted schedule and then make trades with other staff. Each staff member is provided the opportunity for accountability and responsibility for their work schedule.

Maintaining professional relationships between the committee members, management, and the nursing staff is another objective of the self-scheduling process. Communication, fairness, maturity, and patience are key aspects to the scheduling process. Many unforeseen problems occur in the process and are dealt with accordingly. Guidelines were designed and implemented to create a positive attitude and an atmosphere of fairness and teamwork. Measurement of the success of the committee process is also addressed. Through self-scheduling, nursing staff members can experience more flexibility and autonomy.

Alternative Management of Hemorrhagic Cystitis with Hyperbaric Oxygen Therapy and Activated Factor VII in the Allogeneic BMT Patient

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Hemorrhagic cystitis (HC) is a common complication after allogeneic BMT, occurring in 16%-40% of this patient population. In the allogeneic bone marrow transplantation (BMT) patient, the syndrome can occur early or late during the transplantation process and can have a significant impact on morbidity. Numerous risk factors can contribute to an increased likelihood of HC. These risk factors include chemotherapy, total body irradiation (TBI), type of BMT, and viral infection. This last risk factor being the most frequent contributing factor. Because of these risk factors, it is essential that the clinical nurse caring for these patients be knowledgeable regarding the symptomatology and treatment options necessary in successful management of this challenging complication.

At our comprehensive cancer center, where more than 500 BMT patients are treated and cared for each year, the unit-based Clinical Practice Council has developed a standard of care for hemorrhagic cystitis that identifies nursing practice guidelines. These interven-
tions typically involve continuous bladder irrigation (CBI), frequent platelet transfusions, and medications for symptom control. Because effective management for HC has not been established, other alternatives, such as the use of activated factor VII and hyperbaric oxygen therapy, are being examined. Hyperbaric oxygen therapy provides a noninvasive approach to the management and resolution of this problematic complication. A case study will be presented to demonstrate the necessity of further understanding of these approaches for the treatment of HC.

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THE NURSE’S ROLE AS COORDINATOR IN THE SAFE AND EFFECTIVE MANAGEMENT OF PATIENTS WITH COMORBIDITIES UNDERGOING ALLOGENEIC STEM CELL TRANSPLANTATION
Rambo, C.; Cook, L.; Shethburne, N.; Becans, M. National Institutes of Health, Bethesda, MD.

Allogeneic stem cell transplantation (SCT) is an intense treatment offering a potential cure for leukemia. Transplantation-related complications (TRCs), in addition to the effects of the underlying disease, are common during transplantation. To avoid secondary complications such as falls, intense monitoring by the patient, family, and health care team are required. Blindness, a rare but serious toxicity of leukemia and associated treatments, can further complicate the patient’s experience during transplantation and put him or her at increased risk for injury.

Before admission of a leukemia patient with new-onset blindness, a team of clinical research nurses recognized the unique degree of personal, emotional, and physical dependence of this high-risk patient. This high level of dependence required a commitment by the patient, family, and health care team beyond that normally expected. This generated a need for a unique education plan related to the environment, activities of daily living, and communication approaches. To develop this plan and ensure a safe environment, the clinical research nurses used a collaborative care model to involve the health care team. An important element in this model was the inclusion of all disciplines involved in patient care and community resources.

The purpose of this project is to share a collaborative care model that improves the management of allogeneic SCT patients with comorbidities such as blindness. The success of this model was based on the inclusion of supportive care personnel normally outside the transplantation team. This presentation will outline the nurse’s role as coordinator of an expanded multidisciplinary team in managing unique and complex patients undergoing SCT. These include achievement of functional independence, injury prevention, and improved psychological well-being for the patient and family.

The oncology nurse is in a key position to identify the risk level of unique patients undergoing allogeneic SCT and bring together multiple resources, in the hospital and community, to support the patient and family. This collaborative care model demonstrates the effectiveness of the oncology nurses’ role as a coordinator of the multidisciplinary team in achieving high-quality patient and family care. This model can be applied to other high-risk cancer patients that may be at increased risk of injury due to other comorbid conditions as they present for SCT.

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UNDERSTANDING VENO-OCCCLUSIVE DISEASE IN THE BLOOD AND MARROW TRANSPLANTATION POPULATION: THE NURSE’S ROLE
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Veno-occlusive disease (VOD) is a serious, often fatal complication of blood and marrow transplantation (BMT). It has been reported that VOD is the third-leading cause of transplantation-related mortality in allogeneic patients, after graft-versus-host disease and infection. Research indicates the reported incidence of VOD may be as high as 54%. Onset of symptoms usually occurs within the first 30 days posttransplantation; however, reports of VOD occurring after day 30 have also been documented. The diagnosis of VOD is made after other potential complications of transplantation are ruled out. Clinical features may include fluid retention, weight gain, ascites, right upper quadrant pain, and jaundice. Once a diagnosis of VOD is made, aggressive treatment is necessary. Therapeutic goals are aimed at maintaining renal perfusion and intravascular volume while limiting extravascular fluid accumulation, and inhibiting the coagulation cascade.

New therapeutic approaches to the treatment of VOD continue to be examined. Studies using the drug defibrotide have shown it to be highly efficacious, while minimizing toxicity. A case study will be presented that reviews the use of defibrotide on a matched unrelated donor transplantation recipient diagnosed with VOD. The diagnosis can have a major impact on the treatment and care of these patients. Knowledge of the risk factors, pathophysiology, and clinical features of this syndrome can assist nurses with early detection, symptom management, supportive care, and patient and family education.

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THE EXPERIENCE OF INTENSIVE CARE UNIT FOR HEMATO-ONCOLOGY PATIENTS

We established in intensive care unit for hematopoietic-patient since 1999. In fact, we have concerned about transfer intensive care unit in spite of leukopenic status the reason why infection. We reviewed the medical records of 110 patients, there were the data, initial diagnosis, cause of admission and reason to ICU, admission duration, need for mechanical ventilation and cause of death, from January 2003 to April 2004 for 13months to identify efficacy of intensive care and further direction. The mean age was 38.9 years old, 174(56.5%) of them were men and 136 of them were women. The distribution of disease was orderly AML(41.94%), ALL(50.16.13%), CML(27.81%), AML(21.67%), MDS(17.54%) and so on. The type of treatment was Chemo-therapy(102(32.9%), Post HSCT(97(31.3%). The admission duration was 8.19 days, there was no significant between HSCT and chemotherapy. However, comparably HSCT group was higher than conservative care group.

The reason for transfer to Hematology ICU was interstitial pneumonia 88(28.38%), sepsis 76(24.52%), organ failure 61(19.68%). The mechanical ventilator care group of them was 138(44.5%). The reason of them was interstitial pneumonia 48(34.78%), sepsis 27(19.57%), organ failure 24(17.39%). The mortality of ventilator care group was 111(80.43%), P=

One hundred four patients(33.55%) of subject were improved. Yet, 160(51.61%) were died and 46(14.84%) were hopeless discharged. The direct and contributing cause of death was Multi-organ failure 91(56.88%), sepsis 33(20.63%). The mortality of HSCT group was 66(68%) and chemotherapy group was 49(48%). The mortality of HSCT group was relatively higher than chemotherapy group. Ninety-one of Non-ventilator group were improved the meaning was better than ventilator care group. There were different of mortality compare with between Mechanical ventilator group 111(69.37%) and Non-ventilator care group 49(30.63%).

In conclusion, we suggest that a classification tool should be developed to predict prognostic factor of specific hematopoietic intensive care.

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A COMPETENCY-BASED ORIENTATION TOOL FOR INITIAL ORIENTATION TO THE CARE OF BLOOD AND MARROW TRANSPLANTATION PATIENTS
Griffin, J.M.; Braunig, N.; Kebue, B.; Poonosamy, S. Jewish Hospital, Cincinnati, OH.

Blood and marrow transplantation (BMT) nursing requires a specific set of competencies to provide effective care to BMT patients. The development of a competency-based-care (CBO) specific to BMT is one strategy to standardize the orientation of nurses new to BMT. A BMT-specific CBO facilitates the