out the reception area and front desk informing patients their time is valuable to us. Recent results have demonstrated an increased satisfaction regarding the patient wait times and their perception of why they are waiting. Continued monitoring of the Patient Satisfaction surveys on a monthly basis with a weekly review of Comment Cards provide direction for additional improvements.

280 APHERESIS PATIENT SATISFACTION SURVEY: AN ONGOING QUALITY IMPROVEMENT PROCESS
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Patient Satisfaction Surveys (PSS) measure the quality of care delivered. The Apheresis PSS was a joint survey distributed to outpatient Blood and Marrow Transplant (BMT) patients and those in Apheresis. Staff felt the survey had a narrow focus as it measured the patient’s experience at M D Anderson for that day only. Additionally, there was no mechanism in place to track the number of surveys distributed and returned.

Apheresis staff revised the survey to obtain information relevant to the Apheresis unit. Surveys were distributed monthly, results tracked and discussed in monthly staff meetings. Results were graphed and displayed on a “story board” using the institutional quality improvement process of “Plan, Do, Check, Act.” This allowed for an on-going process of identifying and resolving problems.

Scores remained high for all categories throughout the year, which gave the staff a good indication of how they were doing. The lowest score noted was for waiting times after arriving to the Apheresis unit. It was determined these scores were the lowest for those patients undergoing Lumbar Punctures (LP). The plan for distribution was revised and each patient undergoing a LP was given a PSS to complete. Education was done and the scores were tracked and trended to identify a change based on the education provided. Surveys were given to all other patients quarterly. Scores were also tracked, trended and actions taken based on the results.

All scores remained high and the wait time scores improved for the LP group.

PSS are now distributed quarterly to all patients and the results tracked, trended and reported to the staff and the BMT Quality Improvement Committee.

The next step is validation of the PSS. A resident nurse researcher is assisting the staff in this process. The plan is to reformat the survey to assure each item only asks one question and to identify the areas that are important to the patient. The survey will again be distributed monthly to determine its validity, track and trend the results, and begin action plans as indicated.

281 DEVELOPING NURSING STANDARDS OF PRACTICE FOR BLOOD AND MARROW (BMT) PATIENTS THROUGH A SHARED GOVERNANCE COUNCIL STRUCTURE IN PREPARATION FOR THE FOUNDATION FOR THE ACCREDITATION OF CELLULAR THERAPIES (FACT) INSPECTION
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The inpatient, unit-based self governance clinical practice council was very actively involved in the preparation for the Foundation for the Accreditation of Cellular Therapies (FACT) inspection at our large NCI designated cancer center by developing and formatting nursing Standards of Practice (SOP). These SOP’s were in compliance with FACT standards that all relevant nursing procedures have written policies. The clinical practice council met bi-monthly to develop the standards. Each topic was assigned to a different member who researched and developed the SOP having done a literature search with the assistance of the research council to maintain that our practice was evidence based. The draft was presented to our council members and discussed until a completed version was developed. The completed SOP was then formatted according to FACT standards. Upon completion, it was reviewed by a committee consisting of the BMT Clinical Coordinator, Medical Director, Center Administrative Director, Nurse Manager and Assistant Nurse Managers and the BMT Compliance Officer for final approval. Once approved, the educational council introduced the SOP’s to the nursing staff. All the nursing staff were then required to review and sign off on each SOP. This included all the units that care for BMT patients throughout the institution (i.e. Intensive care Unit, Protective Environment, Pediatrics-inpatient unit and outpatient clinic, Outpatient BMT Clinic and Pheresis Unit). The development and implementation of these standards was the result of a strong collaborative effort that included other unit based self-governance councils—the education, communication and research councils in addition to other areas within the institution such as the Pediatric Department, the Outpatient Clinic, Pheresis Unit and the Protective Environment. Our goal was to ensure the highest quality of care for our BMT patients and continuity of that care across the entire BMT program.

282 SUSPECTED CATHETER RELATED BLOOD STREAM INFECTION (CRBSI) IN HEMATOLOGY STEM CELL TRANSPLANT PATIENTS: TRACKING RATES AND OUTCOMES
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Central venous catheters (CVC) are a necessity for patients undergoing treatment for hematological diseases and stem cell transplant, but place patients at an increased risk for infection. The incidence of CRBSI varies with clinical factors such as catheter type and patient’s underlying disease and acuity (CDC, 2002). Due to a perceived increase in CRBSI, patients undergoing peripheral blood stem cell transplant or immunosuppressive therapy were followed for suspected CRBSI over a period of approximately 4 months (March, 2002-July 2002) to determine the prevalence of CRBSI, the treatments implemented, and outcomes. Adults (N = 105) participating in a clinical trial were admitted to an inpatient unit with various hematology and oncology diagnoses. Thirty (29%) were identified with new fever and/or blood cultures for suspected CRBSI with no other sources evident. These patients were evaluated by the vascular access device team and hospital epidemiology service. Eleven patients (37%) had temporary CVCs and nineteen (63%) had tunneled CVCs. Patients with tunneled catheters were more likely to present with signs and symptoms consistent with CRBSI greater than fifteen days post catheter insertion as compared to temporary lines (n = 14 vs. n = 2). Patients with temporary catheters were more likely to present with signs and symptoms consistent with CRBSI less than 15 days post catheter insertion (n = 5 vs. n = 9). Of the 30 suspected CRBSI, 63% (n = 19) had negative CVC blood cultures. Sixteen of these patients had IV antibiotic therapy initiated upon admission. Ten (33%) CVCs were removed due to suspected CRBSI; four of them subsequently had negative blood cultures. This project drew attention to the important issue of CVC assessment and care within the interdisciplinary team caring for this population. Policy, procedures, and educational materials were updated to reflect current standards of practice. The CVC standard of practice and patient teaching tool were revised, and included a new dressing change technique and schedule. A new tracking method via the occurrence reporting system was implemented with an organization based system for continuous quality monitoring for patients with CVCs.

283 NON-MYELOABLATIVE STEM CELL TRANSPLANT PATIENT EDUCATION
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Non-myeloablative stem cell transplantation is being studied in a number of transplant centers. The reduced intensity of the conditioning regimen offers the opportunity for transplantation to patients who are older or have comorbid conditions that previously would have precluded stem cell transplantation (Neiderweiser et al 2003). While this approach holds promise it is still investigational (Devine et al 2003).

The less intense chemotherapy and/or radiation reduce the in-