

Methods, Intervention, & Analysis: In order to optimize the best outcome of selection and placement of the right CVC for BMT recipients, a nurse-initiated protocol for CVC selection was developed. CVC options and patient risk factors that nurses utilize in the care and maintenance of CVCs. The CVC selection protocol is based on the specific requirements of the patient's road map for transplant. Application of manufacturer's guidelines for each device and collaboration by a multidisciplinary team were used to identify the best CVC choice for the patient with reference to the patient's planned therapies. For example:

Autologous BMT Patient Criteria	CVC Type
Standard mobilization and collection	High flow temporary CVC for mobilization/ collection
No undiluted etoposide	Double lumen power injectable peripherally inserted central catheter (PICC)

To implement the protocol, the BMT RN Coordinator starts with a review of the patient's road map for transplant in collaboration with the BMT pharmacist. After the review the RN selects the appropriate CVC based on the protocol table that pairs the correct CVC with patient criteria. Once the selection is made the BMT RN Coordinator enters the order for the CVC type into the electronic medical record. The order is then accessed by the surgeon, interventional radiologist and/or nurse placing the CVC.

Findings & Interpretation: N/A

Discussion & Implications: The goal of this quality improvement project is to eliminate occurrences of inappropriate CVC placement in autologous and allogeneic transplant recipients.

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Follow-up of Related Stem Cell Donors One Week Post Donation

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Topic Significance & Study Purpose/Background/Rationale: It has been observed (Blood, 5/01; Blood 10/2012) that unrelated bone marrow and peripheral blood stem cell donors experience similar levels of mild/moderate discomfort post donation with bone marrow donors having a longer period of discomfort post donation. FACT standards now recommend long-term follow-up of donors. This center cares for approximately 70 related donors a year. Previous to this project, nurses assessed the donors (both apheresis and marrow) the day post donation, and instructed them to call if they had questions thereafter. To improve follow up, nurses caring for the donors initiated a trial to conduct a telephone interview assessment of all donors a week after their final clinic visit.

Methods, Intervention, & Analysis: In October 2013 a pilot was undertaken to actively assess related donors post donation. A questionnaire was vetted and approved to be used in telephone follow up by the Clinic RN who had cared for the donor. All donors were called 1 week following donation and monitored for symptoms of discomfort. If any

symptoms were reported, follow up continued until resolved. This pilot was also used as a quality audit tool, asking the donors if there was anything we could have told them that would have been helpful, and if there was anything they thought we could improve upon.

Findings & Interpretation and Discussion & Implications: At the time of this submission, we have made 35 follow up calls; of those 24 had no symptoms, 8 reported symptoms of discomfort and 3 were unable to be contacted. Over 1/4 of the patients had mild to moderate discomfort at one week post donation. Follow up contact with donors provides an ongoing link with the clinical team and yields useful information for addressing the needs of donors.

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Optimizing Transplant Ambulatory Care Utilizing Multidisciplinary Rounds

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Topic Significance & Study Purpose/Background/Rationale: Multidisciplinary rounds (MR) are a standard model used in hospitals. Our Transplant Center performs approximately 500 Hematopoietic Cell Transplants (HCT) annually. Care of the HCT patients has moved from the inpatient setting to the ambulatory clinic. In the clinic, complex care is managed for HCT patients coordinating clinical care, nutritional needs, medication management, psych-social issues and scheduling. Labs, radiology, medications, pathology, and symptom management require close observation and review at 24 hour increments. This complex patient care management is best implemented with the utilization of MR.

Methods, Intervention, & Analysis: Each patient is followed by a team comprised of an Attending MD, Primary Care Provider, RN, Pharmacist, Registered Dietician, Social Worker and Team Coordinator. The team meets daily for 30 minutes to review current status of all patients, each discipline providing input and making suggestions for care adjustments needed. There is full team discussion of any issues—medical, nursing, social, financial, compliance—that impact care on any level. Anticipated workups that need orders, upcoming procedures that require teaching such as chemotherapy or dressing changes, as well as any recent pertinent results are also briefly discussed so orders and appointments can be obtained in a timely fashion.

Findings & Interpretation: Daily MR in the outpatient HCT clinic has been found to provide an opportunity to make adjustments to the patient's care and allow for more HCT care to be performed in the outpatient setting as evidenced the ability to perform HCT sometimes solely in the outpatient setting, with no admission to the hospital. Satisfaction with this care is evidenced by Patient Satisfaction scores.

Discussion & Implications: The inpatient model of daily MR can be replicated in the outpatient HCT setting. A Team RN acting as the care coordinator facilitates the outpatient care and serves as the patient voice. This can safely increase the time a patient is able to spend outside the hospital which decreases costs and increases quality of life.