Greater ease in assigning patients on individual units

As the unit continues with the development of the tool, the importance of objectivity, statistical validity, documentation, and the ability to discriminate between patients is emphasized.

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BLOOD AND MARROW TRANSPLANTATION FOR HIGH-RISK SICKLE CELL DISEASE: CLINICAL CHALLENGES

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Patients with sickle cell disease (SCD) continue to have increased morbidity and mortality secondary to clinical complications. HLA matched sibling allogeneic bone marrow transplant (BMT) has been investigated in young patients with high risk SCD patients. Patients with high-risk SCD patients commonly have had a cerebral vascular accident (CVA), acute chest syndrome (ACS), or recurrent painful crisis (VOC). Our institution has performed 20 allogeneic BMT in children with high risk SCD. Patients with SCD have additional challenges beyond the standard BMT supportive care. Astute nursing assessment, management, and patient-family education specifically related to SCD BMT is crucial to a successful outcome. Education includes the treatments, side effects, and BMT routines. SCD patients are at increased risk for cerebral vascular accidents due to thrombocytopenia and hypertension. High-risk SCD patients have often received chronic transfusion therapy before BMT; many have developed antibodies to red blood cells and platelets. Careful screening of donor units is essential. It is suggested that hemoglobin be maintained >10 and platelets >50,000, so proactive planning is required to assure an adequate supply of blood products. In SCD, a determined attempt to prevent GVHD is warranted. Cyclosporine (CSA) is administered as GVHD prophylaxis, close monitoring of CSA pharmacokinetics is essential. CSA, especially at higher serum levels, often causes hypertension and decreased serum magnesium, which can lead to seizures if not treated promptly. Strict blood pressure parameters need to be observed and serum magnesium must be monitored closely. Compliance is essential during BMT; noncompliance has been shown to lead to GVHD, hypertension, and seizures. Families are counseled on the importance of compliance prior to BMT with reinforcement throughout the BMT process. Patients and families are given written, daily, medication schedules that require charting and review prior to discharge to help enhance compliance. BMT has been successful in high-risk SCD patients. However, vigilance must be maintained to avoid complications of BMT, which may be far worse than sickle cell disease itself.

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IMPLEMENTATION OF DISCHARGE VIDEOS FOR PEDIATRIC PATIENTS UNDERGOING BLOOD AND MARROW TRANSPLANTATION: BRIDGING THE GAP BETWEEN INPATIENT AND OUTPATIENT CARE

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The transition between inpatient and outpatient care for children post blood and marrow transplantation is a stressful time for their primary caregivers. Caregivers are required to provide complex care including intravenous infusions, intravenous medication administration, and physical care of central lines and other devices. Education of the caregiver requires a coordinated effort between the home care/home infusion company, the outpatient clinic, and the inpatient team. Ideally, teaching should begin weeks prior to discharge. The purpose of this abstract is to describe the Duke Pediatric Blood and Marrow Transplant Program's Discharge Teaching initiative. In conjunction with classes and one-on-one teaching by the home health discharge nurse, the key component of this program is an instructional DVD that provides detailed education on the key components of care that will be required after discharge. These include central line dressing changes, cap changes, and blood draws. The caregiver is required to view the instructional DVD prior to being discharged from the hospital. The inpatient care nurse is responsible for providing additional education based on each caregiver's needs. Caregivers are then required to successfully demonstrate that they are able to perform these tasks prior to discharge.

The instructional DVD is the catalyst for the second phase of education which includes intravenous pumps and medications. The nurse discharge planner also begins that phase of teaching while the child is inpatient. The implementation of this video has greatly improved patient and staff satisfaction. Caregivers are able to watch the video and practice the skills on their own time. Staff articulated that their teaching time was more efficient and that caregivers were better prepared for the discharge process. The discharge planner was able to spend more time on the more complex issues such as intravenous infusions. Overall, this video has made teaching time more efficient and has improved parents' satisfaction in the discharge planning process.

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COMPASSION FATIGUE: CARE FOR THE CARING

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Compassion fatigue is the emotional and physical response, which can develop in individuals exposed, through their work or other types of support, to people who are suffering. It is commonly seen in health care professionals working with individuals suffering from the consequences of a serious illness, traumatic event, or death, particularly of a child. Professionals who work with people who are suffering must contend with not only the normal stress or dissatisfaction of work, but also with the emotional and personal feelings for suffering (Gentry, 2001). One group that is often overlooked in the aftermath of a traumatic event is the healthcare professional. Compassion fatigue can result in a preoccupation or tension with the individual or event. Healthcare professionals often report feelings of burn-out and frustration. Staff will experience physical and emotional manifestations of this syndrome. Many will leave the field because of compassion fatigue. The purpose of this poster is to describe compassion fatigue and the impact it has on the healthcare professional (specifically nurses). The signs and symptoms of the syndrome will be described. An additional goal of this poster will be to define strategies and copings skills for the management of compassion fatigue. Finally, the Duke Pediatric Blood and Marrow Transplant compassion fatigue model will be described. This program was developed in 2004 in an attempt to reduce burnout and turnover among nursing staff.

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PATIENT CONTROLLED ANALGESIA BY PROXY

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Patient controlled analgesia (PCA) is an effective and efficient method of controlling pain. When used as prescribed and intended, the risk of over sedation is low (JCAHO 2004). Pediatric BMT patients experience pain from mucositis, skin GvHD, VOD, and other complications. Effective pain management in a pediatric BMT unit is often complicated by the fact that many young patients are unable to either physically push the PCA button or developmentally understand the association of pain relief with pushing the button. In many BMT units, including our own, the parent administers PCA "by proxy". Recently JCAHO and other patient safety organizations have focused on PCA by proxy. Serious adverse events have been reported when family members, caregivers, and others administer the analgesic for the patient. The Joint Commission's Sentinel Event database contains only one medication error related to PCA by proxy. The U.S Pharmacopeia (USP) medication database reported fifteen cases of error with PCA by proxy. Twelve were from family/parent controlled PCA, 2 were RN administered, and 1 was by pharmacy (JCAHO 2004). One death involving a nurse administered PCA has been reported involving a post-op elderly patient with multiple medical issues. The purpose of this abstract is to describe the Duke Pediatric Blood and