Purpose: On a 36-bed stem cell transplant unit at a small NCI-designated medical center, the shift report was unstructured, variable, time-consuming and often repetitive. Research has shown that incorporating change of shift report at the bedside not only identifies safety concerns but also facilitates continuity of care, and drives staff accountability and responsibility. By having two nurses examine the patient in unison at the change of shift, it was hypothesized that a decrease in falls and medications errors, and miscommunication would occur.

Intervention: After conducting a literature search regarding bedside handover, the educator for the stem cell unit worked with the unit based council of the unit to create a process for implementing bedside handover. A survey was conducted to evaluate the knowledge of the nursing staff regarding bedside handover as well as their willingness to change practice. Newsletters, flyers, and discussions at staff meetings were done two months before roll-out. Scripts were created along with letters to the patients to provide a level of comfort this change would bring. Staff would review the highlights of the night in their standard format at the nursing station but would then go to the bedside to focus on pertinent issues such as泵 settings, skin assessment, and a safety check.

Evaluation: A 3 month trial period was conducted with overall positive results. Staff was re-surveyed at the end of the three months to assess the change and solicit suggestions for improvement. Results of these evaluations will be discussed.

Discussion: As patient co-morbidities increase and acuity continues to rise, bedside clinicians need to be vigilant in keeping patients safe. It was important to implement a process that would have positive results for both the staff and patients. Incorporating bedside handover into the shift report process has been well received and is now a standard part of shift report.

510 MANAGEMENT OF EMERGENT PATIENT CARE IN THE OUTPATIENT SETTING

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The transplant process in the outpatient setting can be very challenging. Given our ability to treat a wider range of patients increases these challenges. In a traditional inpatient, hospital setting there is a clear, defined process for dealing with medical emergencies. Typically there are two levels of response: an RRT – a rapid response team which can be called when a patient decompensates prior to their full arrest and the classic CODE team which responds to patients in full arrest. In the outpatient setting, particularly one that is removed from the main hospital campus these options do not exist. In an attempt to improve the response to these patients an emergency plan was developed.

The outpatient clinic has two traditional code carts available. As their full contents are rarely needed and their cost can be significant, staff was provided an emergency kit which could be easily carried to the patient in an emergent situation. This mobility is of vital importance in a clinic that is large and covers a variety of patient care areas. This kit has all the basic supplies to initially stabilize a decompensating patient. It includes IV fluids, vascular access supplies and oxygen delivery devices. Also available are an AED and mobile blood pressure and basic 3 lead cardiac monitoring.

Due to the fact we are separate of the hospital campus in some ways and others not, confusion ensued when patients required transport to the hospital. Arrangements have been made with our affiliated Life Flight team and local EMS for transport of our patients who require medical care beyond the scope of our clinic. Our hospital Life Flight ground transport team is contacted to provide transport for patients who need hospital admission but are clinically stable for treatment in our inpatient BMT unit. The local county EMS is contacted for patients who require care in an emergent life threatening situation. The use of these two entities has greatly streamlined the transport process for patients who require different levels of emergent care.

By eliminating confusion in an emergent situation improved care is provided to the patient. All materials are readily available to staff and there is a clear, defined plan for patient transport when needed.

511 JUST IN TIME TRAINING, TRAVEL NURSES: UNIT SPECIFIC COMPETENCY FOR ADULT INPATIENT BONE MARROW TRANSPLANT

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Significance & Background: Travel nurses are often used to supplement staffing requirements in hospital settings. The Adult Bone Marrow Transplant inpatient unit at this NCI-designated Comprehensive Cancer Center required the use of Travel nurses to ensure an adequate nurse to patient ratio. Bone Marrow Transplant patients have complex care needs requiring specialized nursing knowledge. One advantage of utilizing Travel RN’s is the rapid stabilization of staffing ratios.

Purpose: The purpose of this Just in Time Travel RN Orientation was to ensure the delivery of competent, high quality nursing care and continue to maintain a high level of patient satisfaction in the category “skill of the nurse”.

Interventions: Implementation of the program began in the second quarter of 2011. It was developed to provide a didactic component to equip Travel RN orientation incorporating unit specific workflow and specialized core competencies. To support teaching and serve as a resource for the Travel RN an educational binder was created. To evaluate competency a written exam was developed and administered post training. An RN is assigned daily to function as a resource for the Travel RN to facilitate continued learning and independent care delivery.

Evaluation: Anticipating significant RN functional vacancies the use of Travel RN’s provided an effective staffing solution. Following implementation of the Just in Time orientation program staffing needs are being met with the addition of two full-time Travel RN’s. The post training competency exam has been administered with satisfactory results. Measurement of patient satisfaction of the component “skill of the nurse” remains high.

Discussion: We believe this unique program ensures the ability of Travel RN staff to work together with core staff as a cohesive unit delivering competent and skillful nursing care to the complex bone marrow transplant patient.

512 FACIAL MANAGEMENT DEVICES AND SEVERE GRAFT VERSUS HOST DISEASE

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We present our updated experience of the Flexiseal® faecal management device (FMD) in the care of patients with acute GVHD vs Host Disease (GVHD) of the bowel. Acute GVHD complicates allogeneic haemopoietic stem cell transplantation (HSCT) in 10-80%. The gut, along with skin & liver is targeted & lower gut involvement is characterised by profuse diarrhoea. Faecal incontinence (FI) increases the risk of perineal ulceration. In their study of 2,189 patients, Maklebust & Magnan (1994) found that FI was a stronger predictor of ulcer risk than other factors, including impaired mobility & malnutrition. The risk of ulceration was 22x greater if FI was present. The FMD is a temporary containment system consisting of a soft flexible, silicone catheter with a low-pressure balloon, filled with water to aid retention & attached to a stool collection bag for < 28 days. The FMD is easy to insert & promotes a) patient comfort & dignity, b) reduced infection rates, c) release of nursing time & d)cost reduction (Blins, 2007, Padmanabhan, 2007). The application of the FMD post-HSCT was not previously reported until 2010 (Wood, EBMST, 2010). We update our report of the use of the FMD in FI due to GVHD. All four patients had severe acute GVHD bowel (>1500 mls of diarrhoea/day with abdominal pain &/or ileus). We observed the use of the FMD in the critical care setting in the management of GVHD post-liver transplant. In our own practice we then used an
FMD in the palliative management of an unconscious patient with Glucksberg Grade IV GVHD gut post HSCT. Use of the device over the final 5 days of life was uneventful. Following this experience we have gone on to use the FMD successfully in 3 further patients with severe acute GVHD gut post-HSCT. Observed direct benefits for the patients include promotion of dignity, facilitation of uninterrupted rest, absence of odour, reduction of embarrassment and more comfortable access to visitors. Clinical benefits included improved accuracy of fluid balance assessment, maintenance of skin integrity, absence of healthcare associated infections & the ability to devote more nursing time to the other needs of the patient. Our only negative finding was that the FMD can leak, however this is minimal, and can be reduced by regular flushing of the device. The device was replaced every 28 days and was in use for up to 63 days, without complications. We have found the FMD to promote the effective & compassionate care of patients with severe GVHD gut.

513 COLLABORATING WITH OUR COLLEAGUES TO ENHANCE CARE: A MULTIDISCIPLINARY WORKFLOW FOR BUSULFAN PK SERUM LEVELS

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Significance and Background: Busulfan is administered as part of a myeloblastic conditioning regimen for allogeneic hematopoietic stem cell transplant. Plasma pharmacokinetic analysis (PK) is used to determine a patient’s Busulfan serum level. Maintaining therapeutic levels of Busulfan decrease the risk of Busulfan related toxicity, graft rejection and disease progression. In 2011 this NCI-designated Comprehensive Cancer Center initiated processing of PK levels instead of sending them to another facility almost 3000 miles away. We believe patient care is improved as the results are obtained the same day instead of the next day providing the opportunity to adjust the 4th dose versus the 7th dose. This practice change required effective collaboration between nursing, medicine, pharmacy and the clinical laboratory.

Purpose: The purpose of in-house pharmacokinetic analysis (PK) is to obtain results the same day and adjust the dose as necessary to maintain a therapeutic serum level.

Interventions: A multidisciplinary team developed a new RN workflow for obtaining specifically timed specimens, an LIP order set, a workflow for storing and transporting the specimens to the lab and a workflow for the lab to verify receipt of specimens. A multidisciplinary education plan was developed educating the medical, nursing, pharmacy and clinical laboratory staff regarding the new in-house Busulfan PK level process.

Evaluation: As a result of the new Busulfan PK level process, levels are obtained with the first dose of Busulfan and results are reported in the afternoon. On evening rounds, a determination is made whether to adjust the 4th dose of Busulfan considering the PK result.

Discussion: We believe that being able to adjust the dose of Busulfan earlier in the treatment process may help maintain a therapeutic serum level enhancing the chance of a successful transplant outcome.

514 SAME QUALITY, FEWER RESOURCES: PREPARING PATIENTS FOR DISCHARGE AFTER HEMATOPOIETIC STEM CELL TRANSPLANT

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Background: Preparing for hospital discharge following hematopoietic stem cell transplantation (HSCT) involves extensive multidisciplinary teaching to patients and caregivers. Historically this has been accomplished with printed materials, individualized teaching, and formal group classes held weekly on the HSCT inpatient unit—a strategy that is labor and resource intensive, and inconvenient for out of town caregivers.

Purpose: The nursing leadership on a 64 bed HSCT unit at a NCI-designated cancer center identified a need for patient/caregiver educational methods that provided opportunities for patients to view repeatedly, and for their caregivers to view from home.

Intervention: A multidisciplinary health care team from the HSCT unit developed scripts for 16 minute discharge films aimed at either allogeneic or autologous patients that could be viewed on television through the patient education system in patient rooms, or could be accessed as 2 minute segments in links through the institutional intranet. Caregivers receive access from HSCT patients to view the web based chapters that cover all aspects of care after discharge.

Evaluation: For one month HSCT inpatients viewed both the video, and attended the existing 1 hour discharge class, and then completed an evaluation of which form of education they preferred. Of the 38 evaluations returned, patients overwhelmingly reported that the content covered in the video prepared them for discharge, and appreciated the ability to view it repeatedly in the comfort of their room. Patients did, however, request an opportunity to ask questions in a live format. Based on these results, 30 min weekly question and answer sessions were scheduled that patients/families may attend after viewing the video. Attendance at these sessions has been low, as many patients feel the videos adequately addressed their concerns.

Discussion: One of the biggest challenges facing healthcare organizations in today’s economic climate is maintaining high quality patient care programs with fewer financial resources. Preparing HSCT patients for discharge from the hospital involves extensive education of complex post transplant guidelines. Moving from labor and resource intensive individual classes to film and web based applications are useful ways to assure patient education content is thoroughly covered. Providing 30-minute weekly scheduled question and answer sessions allows patients an opportunity to have concerns addressed.

515 NON-PHARMACOLOGICAL STRATEGIES TO PREVENT NEUTROPENIC FEVER IN HEMATOLOGIC MALIGNANCY

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Neutropenia is often an inevitable part of treating hematologic malignancies. It is the most common cause of limiting the dose of chemotherapy and if neutropenia occurs, it puts a patient at a much higher risk of developing an infection that can quickly become life threatening. As such, it is a goal for nurses to prevent neutropenic infections as much as possible. Because the first sign, and often only sign, of a neutropenic infection is fever, oncology staff use a fever as an objective measure to gauge the health status of the patient. In the past, common nursing interventions used to prevent neutropenic fever have included protective isolation and neutropenic diet. However, there is little data to support the use of either. In addition, these measures are difficult to adhere to and create a feeling of isolation in the patient. The purpose of this review of literature is to critically analyze current literature to determine if there are data that indicate that neutropenic diet and protective isolation are effective forms of preventing neutropenic fever. CINAHL, MEDLINE and the Cochrane database were searched for key words “neutropenia”, “fever”, “infection”, “prevention”, “isolation”, and “diet”, with a time limitation from 2001 until present. Additional articles were identified from the reference lists of these articles. Twelve articles were identified as being pertinent to the subject matter. Both qualitative and quantitative studies were included in the review. The data found in the literature review does not support the use of neutropenic diet or reverse isolation for the prevention of neutropenic fever. Instead of using resources and time on these interventions, nurses should emphasize that patients employ proper hand hygiene and that fruits and vegetables are thoroughly washed before eating them.