

# 2013 Oncology Nursing Society Annual Congress: Administration/Leadership Development Abstracts

Each abstract has been indexed according to first author below.

Abstracts appear as they were submitted and have not undergone editing or the *Oncology Nursing Forum's* review process. If any errors or omissions have been made, please accept our apologies. Abstracts that are not being presented do not appear.

Digital Object Identifier:10.1188/13.ONF.E142-E172

## Administration/Leadership Development Abstracts Index by First Author

Abbasi, T. ....	131556	Dimond, E. ....	129284	Keith, J. ....	122386	Rodgers, G. ....	115020
Agbakoba, V. ....	136694	Dunne, M. ....	135203	Kendrick, S. ....	113668	Rodriguez, G. ....	135395
Aldredge, P. ....	136429	Engelking, C. ....	136725	Kennedy, J. ....	136207	Rowe, T. ....	136347
Arata, J. ....	128031	Fradkin, M. ....	137017	Kim, G. ....	117732	Selm-Orr, D. ....	137149
Askren, H. ....	117198	Fries, E. ....	137031	Klemanski, D. ....	136713	Shuey, K. ....	113668
Banavage, A. ....	128290	Galassi, A. ....	136091	Lee, J. ....	84127	Smith, L. ....	136492
Basinger, H. ....	137060	Ginex, P. ....	134333	Licitra, C. ....	136139	Strom, M. ....	134974
Bell, K. ....	119079	Grabowski, M. ....	136187	Lombardi, C. ....	80071	Tucci, R. ....	91898
Bittner, B. ....	131574	Grant, B. ....	137101	Love-Retinger, N. ....	136932	Umeda, M. ....	134487
Blecher, C. ....	137525	Greenfield-Webster, R. ....	136941	Mazanec, S. ....	129310	Viall, A. ....	116700
Boris, L. ....	135277	Gustafson, S. ....	114999	McCaulley, L. ....	132640	Weber, S. ....	136646
Bryant, L. ....	119603	Henderson, D. ....	127976	McEneaney, S. ....	136035	Williams, J. ....	127729
Childress, S. ....	80214	Hendrick, W. ....	136443	McLaughlin, T.M. ....	137081	Wolf, T. ....	136776
Chism, L. ....	135248	Houlihan, N. ....	135558	Miano, W. ....	118128	Wood, G. ....	129464
Colligon, S. ....	116838	James, S. ....	136675	Moore, K. ....	135341	Woolridge-King, M. ....	136184
Coyne, T. ....	136667	Johnson, T. ....	116670	Moore, P. ....	135414	Woolridge-King, M. ....	136251
Coyne, T. ....	136867	Karius, D. ....	113139	Muscari Desimini, E. ....	118414	Zandstra, F. ....	113282
Deitrick, G. ....	115056			Muscari Desimini, E. ....	118470		
DeRiso, R. ....	136491			Ramrup, N. ....	136508		
Devine, J. ....	136061			Rettig, A. ....	135366		

80071 (Poster)

### IMPLEMENTATION OF AN INTRAVESICULAR CHEMOTHERAPY ADMINISTRATION POLICY IN THE UROLOGIC ONCOLOGIC AMBULATORY SETTING.

Christine Lombardi, MSN, RN, OCN®, Hospital of the University of Pennsylvania, Philadelphia; Regina Cunningham, PhD, RN, AOCN®, Hospital of the University of Pennsylvania, Philadelphia

**Significance and Background:** The administration of chemotherapy and biotherapy are high-risk, high-alert activities. Ensuring safety and consistency in chemotherapy practices is essential. This topic is important because it provides a framework for the delivery of consistent nursing practice. A standardized approach to intravesicular chemotherapy and biotherapy administration helps to minimize any errors in handling, administration, or documentation when these agents are delivered to urologic oncology patients. Standardized approaches to care delivery in this setting serve to improve the quality and safety of care delivery. Nursing can contribute greatly in this area by developing and implementing intravesicular chemotherapy administration guidelines to assist with ways to deliver these agents safely to patients. A review of literature indicated that there few nursing practice guidelines and/or policies at many institutions around the country that specifically address the delivery of intravesicular chemotherapy agents in either the in-patient or ambulatory setting. Moreover, the Oncology Nursing Society Chemotherapy and Biotherapy course does not specifically address best practices on how to safely deliver agents, via the intravesicular route, and there needs to be a consistent procedure for nurses to follow when caring for patients receiving these intravesicular agents. The 2012 ASCO/ONS standards recommend that organizations have a comprehensive education and competency assessment plan that outlines requirements for practitioners involved in the administration of chemotherapeutic agents, including those administered via the intravesicular route, however, specific practice guidelines in this area have not been clearly identified. The experience at a large academic medical center demonstrates significant variations in practice in urologic oncology ambulatory areas where clinical staff administer these agents.

**Purpose:** To describe the process of developing and implementing an intravesicular chemotherapy administration policy for clinical staff to use in the urologic oncology ambulatory setting. The policy has an associated competency validation that clinical staff need to complete during their orientation process as well as annually. The rationale behind the development of this policy and associated competency was to decrease variations in practice by having all clinical staff administer and handle these agents in a correct and consistent manner. This approach has the potential to improve outcomes for our patients and eliminate unnecessary exposures.

**Interventions:** Implementation of the newly developed policy was accomplished by: a) providing didactic learning to the urologic oncologic clinical staff who are responsible to administer these agents; and b) having the clinical staff demonstrate safe administration by following the technique that is stated in the policy via completion of a clinical competency validation. The interventions are appropriate for this topic because staff are given the education and nursing practice guideline to follow on how to safely administer these agents while preventing unnecessary exposure to themselves, their patient's and other patient's that may be treated in the same setting.

**Evaluation:** The goals of the project are to provide clinical staff with the resources that they need to safely administer chemo and biotherapeutic agents via the intravesicular route. The specific measures include an effective demonstration of proper technique, an understanding of the pharmacologic implications of these agents, and strategies to create a safe environment for anyone who may be potentially exposed to

these agents. Nurse satisfaction and patient outcomes will be assessed following six months of implementation of the practice guideline.

**Discussion:** Clear practice guidelines, education and evaluation of clinical nursing staff who are responsible for administering intravesicular chemotherapeutic and biotherapeutic agents, can promote a safe environment for staff members and support the delivery of quality patient care. With a nursing practice guideline and/or policy, education and competency validation, every clinical staff member who administers these agents knows the proper technique and what to do in the event of potential exposure. Also, patient restrooms are shared in many ambulatory practices. To further support the need to implement and develop a practice guideline for clinical staff who administer intravesicular agents, you can prevent other patient's from exposure to these drugs by having an intravesicular chemotherapy administration policy in place which explains how to safely handle these types of situations.

80214 (Poster)

### OPENING AN ONCOLOGY ICU ONE YEAR OUT.

Susan Childress, RN, MN, OCN®, Huntsman Cancer Institute, Salt Lake City, Utah; Julia Beynon, RN, BSN, University of Utah, Salt Lake City, Utah; Estelle Harris, MD, University of Utah, Salt Lake City, Utah

**Significance and Background:** Cancer treatments have become more complex and aggressive with the goal of seeking greater survival rates. Many of these treatments have resulted in a greater need for critical care support that also understands the special needs of cancer patients. Most oncology administrators do not have the critical care background to open an oncology intensive care unit (ICU) without some guidance. Staff engagement and interprofessional collaboration with intensive care colleagues, and recognizing and respecting the difference between the two specialties was key to a successful outcome.

**Purpose:** With the opportunity of the cancer hospital adding a new wing that included an intensive care unit, nursing administration accepted the challenge of leading the development and implementation of an oncology intensive care unit that would provide care for medical, surgical, bone marrow transplant, and neurological cancer populations. Utilizing the Synergy Model for Clinical Excellence that originated out of the critical care literature, nursing staff from the oncology hospital and the critical care units joined forces to prepare nurses and other disciplines for this unique unit.

**Interventions:** A steering committee was formed with the medical director and oncology nursing director as co-leaders. Members included: staff nurses, managers, staff educator, pharmacists, respiratory therapy, social worker, and a chaplain. The group started meeting approximately a year before the planned opening. Each member of the group was responsible for different aspects of practice. A common goal identified early by the group was establishing a culture of clinical excellence and providing the training necessary for a credible unit.

**Evaluation:** After one year of operations this oncology ICU defines their success through Press Ganey patient satisfaction scores consistently in the 90 percentile, low infection rates (ventilator associated pneumonia, central line infections, and catheter associated urinary tract infections), and high staff and provider satisfaction with the unit. Length of stay and mortality rates are lower than any of the other ICU's in the system.

**Discussion:** Lessons learned from a successful Oncology ICU program will be shared along with critical steps in planning and implementation. Staff engagement and interprofessional collaborations will be highlighted as a key foundation to the process.

84127 (Poster)

### REDUCING INPATIENT CHEMOTHERAPY DIRECT ADMISSION WAIT TIME: A LEAN SIX SIGMA APPROACH.

Joyce Lee, MSN, RN, OCN®, Texas Health Presbyterian Hospital Dallas, Dallas, Texas; Nergis Soylemez-Sayed, LSSBB, CQE, Texas Health Presbyterian Hospital Dallas, Dallas, Texas; Patricia Kelly, DNP, APRN, CNS, AOCN®, Texas Health Presbyterian Hospital Dallas, Dallas, Texas

**Significance and Background:** Patients receiving intravenous chemotherapy protocols with lengthy infusion times (> 6 hours) or scheduled every 12 hour infusions usually are admitted to the hospital. Providing efficient quality care for these patients requires communication and coordination among personnel in multiple locations, e.g. oncologist's office, admissions, laboratory, pharmacy, and inpatient oncology unit. Chemotherapy is a high-alert medication requiring verification and safety checks. Patients expect chemotherapy to start soon after admission. At our hospital, patients and physicians were dissatisfied with wait times. Our facility deploys Lean Six Sigma methodology and trains staff on process improvements to eliminate waste and reduce process variations.

**Purpose:** To reduce inpatient chemotherapy direct admission wait times by 50% using Lean Six Sigma methodology.

**Interventions:** We collected baseline data (n=10 patients) and found an average wait time of 8.6 hours (range = 4.27 to 10.67). An inter-professional team (nurses, oncologists, pharmacists, quality improvement specialists, admissions staff) and Lean Six Sigma Black Belt met to address the waste issues and processes. The team identified non-value added processes and issues related to equipment and work time, mapped the current state, and used fishbone diagrams to identify root causes. The team met 10 times over three months and made changes using an advanced admission scheduling tool and required that all chemotherapy orders be faxed by noon on the prior business day. Nurses changed from 8 to 12 hour shifts to increase continuity of care, and the oncologists initiated chemotherapy order templates to reduce pharmacy processing times and avoid verification phone calls. Hospital information technology specialists provided electronic health record admission order entry education for oncologists.

**Evaluation:** After making the above changes, the average wait time for two patients was reduced by 43% to 4.92 hours. Admission processing time was reduced by 73% from 26 minutes to 7 minutes. Approximately 3.5 hours of pharmacy and nursing pre-work was eliminated with new processes. No order verification phone calls were required.

**Discussion:** Prolonged wait times frustrate patients and physicians and reduce efficiency and profitability. Lean Six Sigma helped streamline processes and strengthen inter-professional communications. We will continue to collect data and improve processes to meet our 50% reduction goal.

91898 (Poster)

### SERVICE PROJECTS WITHIN ONS CHAPTERS: WHOM DO WE SERVE?

Rosemarie Tucci, RN, MSN, AOCN®, Lan-kenau Medical Center, Wynnewood, Pennsylvania; Patricia Frank, RN, BSN, University of Pennsylvania (retired), Philadelphia, Pennsylvania; Peg Rummel, RN, OCN®, MHA, CAN, University of Pennsylvania, Philadelphia, Pennsylvania

**Significance and Background:** Oncology experiences healthcare disparities that are significant not only to those experiencing the problems, but to those trying to care for them. Nursing has always looked to ourselves to help - but the question is HOW? The care being given to the people of this Navajo reservation is what most would consider less than adequate. The Navajo nation is divided up into 8 service units. One serves about 20,000 clients. The difference between this system of healthcare

and the other public health programs is that they are either federal or have just become independent of the federal system and are now part of private corporate health care organizations. They are actually employees of the executive branch of the Navajo Tribal Government. What that means is that they have to depend on the federal system for funding. So, resources are less than if they practiced elsewhere. They are able to get most medical supplies, but newer things like the samples available at conferences don't come their way. The federal government programs can't accept donations at all and that includes things from drug companies. So, no visits from drug representatives and no information on new products. There is also no cancer care such as chemotherapy or radiation (on the reservation) so people go into Flagstaff, AZ (3 hrs); Farmington, NM (3 hrs); or Phoenix, AZ (6 hrs) for care.

**Purpose:** Healthcare for Native Americans in general has never been funded at a comparable level to that of the general population. In fact, in 2009, American Indians in the IHS system received 55% of per capita funding required. The Federal government, in its 2010 National Healthcare Disparities Report states that healthcare quality and access are sub-optimal, especially for minority and low-income groups and that while quality is improving somewhat, access and disparities in prevention and access to care are not. Native Americans under 65 years of age are at 1.7 times higher risk for not having health care insurance and 1.6 times higher risk for not receiving the standard colo-rectal screenings. The theory of health as expanding consciousness is stimulated by concern for those for whom health as the absence of disease or disability is not possible. The theory asserts that every person in every situation, no matter how disordered and hopeless it may seem, is part of the universal process of expanding consciousness - a process of becoming more of oneself, of finding greater meaning in life, and of reaching new dimensions of connectedness with other people and the world. This conceptual model of nursing is the over-riding point of the service project discussed and others like it. To know that there are many groups in need of assistance that most people are unaware of and to be responsible to address them fits with Newman's belief in the expanding consciousness. There are issues that need to be raised and addressed in order for healthcare disparities to be resolved. Nurses can take the lead in bringing the issue to the forefront and starting grass-roots efforts to initiate change.

**Interventions:** After hearing about conditions on the Navajo reservation related to oncology care, a request was sent to all local ONS chapter members for donations of books, up-to-date medical journals, teaching models, and other supplies. The response was overwhelming. The delivery coordination was seamless. Phone calls were made to our contacts to check for any additional needs, and updates on the project were indicated as the needs arose. Two ONS chapters sold tee shirts with a Navajo tapestry made by the reservation residents printed on them to raise money to support the health care program's activities. Educational materials, medical supplies and personal items were collected at frequent intervals at local ONS chapter meetings and sent to the reservation to support ongoing care. Gas cards have been provided for use by people who need to travel 2-6 hours for treatments, who could not otherwise afford the expense.

**Evaluation:** Our efforts to help the people of the Navajo Nation have made a small difference in their lives, but with their guidance on their ongoing health care system needs, we hope to continue this effort, thereby supporting more than just the cancer patients we see daily in our own communities.

**Discussion:** The challenge for us all is to look around; ask questions such as, "Is there something or someone I can help?"; and to work together. It can start with one person or one idea, but if local chapters take on the service mission, no one person works alone. The prevalence of health care disparities exists,

along with a newly developed focus on minimizing them. Access to a high-quality system of health care may reduce these disparities, but this may be a long time coming. The overriding point of this service project, and others like it, is to know that most people are unaware of the many groups in need of assistance throughout this country. Whether the care is provided on an Indian reservation, in a rural farming area, Appalachia, or an urban center, there are issues that need to be raised and addressed in order to resolve health care disparities.

**109174** (Poster)

**CREATION OF A “CENTER OF EXCELLENCE” IN STEM CELL TRANSPLANT FROM DAY ONE.**

Selma Kendrick, RN, MS, OCN®, Cancer Transplant Institute at Virginia G. Piper Cancer Center, Scottsdale, Arizona; Denice Gibson, RN, MSN, OCN®, AOCNS®, Cancer Transplant Institute at Virginia G. Piper Cancer Center, Scottsdale, Arizona; Michelle McCreary, RN, BSN, Cancer Transplant Institute at Virginia G. Piper Cancer Center, Scottsdale, Arizona

**Significance and Background:** A Center of Excellence in stem cell transplant identifies the program with that has competitive edge by demonstrating leadership, outcomes, and best practices in patient care. These ideals are driven by the team who take ownership for all processes. This is particularly important in the new care models in which reimbursement is based upon quality outcomes, efficiencies, cost, and patient experiences.

**Purpose:** New cancer services have the opportunity to “do it right” from the beginning. A small team performed a literature review and consulted with other successful cancer providers to identify steps in establishing a stem cell program viewed as a Center of Excellence from the opening day. The strategic plan was to attract community referrals from physicians and maintain high levels of satisfaction, appeal to all transplant payers, and achieve high patient experience levels.

**Interventions:** In late 2011, a community healthcare organization in the southwest established a new stem cell transplant program. An experienced team was recruited immediately and transplant leaders strategically planned to become a Center of Excellence in the community. A review of information from the Advisory Board Company® demonstrated that cancer patients most valued patient education information, state of the art technology, reputation of physicians, the percentage of ONS certified nurses, a patient friendly facility, reputation of hospital, superior survival rates, psychosocial care, and clinical research access. All of these factors will be highlighted for this young program. Examples include obtaining FACT (Foundation for the Accreditation of Cellular Therapy) within two month of opening, obtaining most major payers with a status of Center of Excellence and superior survival rates. Greater than 80% of the RNs hired were OCN® certified and 70% have their Bachelor’s degree contributing to superior outcomes.

**Evaluation:** The strategy of pursuing the status of excellence focuses on providing an exceptional standard of quality and experience to both patients and referring physicians. The model utilized can be replicated in other cancer centers adding new programs.

**Discussion:** Leaders in oncology nursing must identify efficient and cutting edge mechanisms to differentiate their facility for any new cancer program. All leaders need to evaluate carefully their strategies for building their cancer programs.

**113139** (Poster)

**RESPONSIVENESS, IMPROVING CULTURE AND THE PATIENT EXPERIENCE IN A CANCER INSTITUTE.**

Diana Karius, RN, MS, AOCN®, CHPN, Cleveland Clinic, Cleveland, Ohio; Kathy Day, RN, BSN, OCN®, Cleveland Clinic,

Cleveland, Ohio; Ann Fitz, MSN, MBA, RN, CHPN, Cleveland Clinic, Cleveland, Ohio; Patti Akins, BSN, RN, OCN®, Cleveland Clinic, Cleveland, Ohio; Julie Fetto, MSN, MBA, RN, CHPN, Cleveland Clinic, Cleveland, Ohio

**Significance and Background:** Responsiveness is an increasingly important issue for both patients and employees. Not only is it a matter of providing high level quality care but will soon be linked to value based purchasing and re-imbursement. The responsiveness rates in oncology at our institution where consistently low. The purpose of this project was to improve this score with a goal of having a consistent range in the 90th percentile. Issues and challenges identified included: unit design, lack of real-time tracking, limited engagement of health unit care coordinators (HUCs), and current unit culture not being customer service focused.

**Purpose:** The purpose of this project was to improve this score with a goal of having a consistent range in the 90th percentile. Issues and challenges identified included: unit design, lack of real-time tracking, limited engagement of health unit care coordinators (HUCs), and current unit cultures not being customer service focused.

**Interventions:** Improved communications with patients regarding their expectations by including the HUCs in setting the initial customer service example through introduction and orientation of the patient to the unit. Nurse Managers were involved on many levels including sending post-discharge letters to patients asking their opinions of the service they received during their stay and recommendations for improvement. The plan was to have all call lights answered within 5 minutes. Any deviations were logged by the HUC including the reason for the delay and an escalation process for calls over the target time was put into place. Discrepancies in the 5 minute rule were discussed in problem-solving huddles with all staff on a daily basis. A focus on culture shift from “my patients” to “our patients” were role modeled by nursing leadership. Technological adjustments to the locator /phone system allowed increased support for best practices by increasing the visibility, tracking and communication of all unit staff. RN’s and patient care assistants were assigned in pairs to increase expedient response to calls.

**Evaluation:** Results: Responsiveness scores continued to be tracked showing 4 months of performance above 70% (73% represents the 90th percentile).

**Discussion:** Implications for nursing: Providing the best care in a timely manner continues to be one of the major challenges in the healthcare industry. Our data supports that a cohesive plan which includes engaging all unit employees in the process along with making improvements in error tracking and technology can overcome this challenge and improve the patient experience.

**113282** (Poster)

**FROM HANDWRITTEN DOCUMENTATION TO ELECTRONIC MEDICAL RECORDS: ONCOLOGY NURSES ENTERING A NEW AGE OF INFORMATICS TECHNOLOGY IN SURVIVORSHIP CARE.**

Fran Zandstra, RN, MBA, OCN®, The University of Texas MD Anderson Cancer Center, Houston, Texas; Maria Alma Rodriguez, MD, The University of Texas MD Anderson Cancer Center, Houston, Texas; Ludivine Russell, MS, The University of Texas MD Anderson Cancer Center, Houston, Texas; Jacklyn Flores, BS, The University of Texas MD Anderson Cancer Center, Houston, Texas; Guadalupe R. Palos, RN, LMSW, DrPH, The University of Texas MD Anderson Cancer Center, Houston, Texas

**Underwriting or funding source:** Funded by NCI Contract No. HHSN261200800001E

**Significance and Background:** As the use of health information technology (HIT) rapidly increases, oncology nurses will be

expected to have expertise in HIT and data mining (DM). Oncology nurses often lack technical knowledge and experience needed to effectively mine data from survivorship care plans, electronic health record systems (EHRS), and handwritten or free-text documentation. Here we describe our experience with integrating informatics technology with a DM process specifically designed for a cancer survivorship program.

**Purpose:** To discuss the process, benefits, and challenges encountered in mining clinical data and health information to electronically share among multiple clinicians providing survivorship care.

**Interventions:** DM was defined as the collection, management, analysis, and reporting of quantitative and qualitative data. DM was used to enhance clinical services, improve survivors' care, and standardize performance metrics across clinics. Data sources included institutional electronic databases, clinicians' documentation, and survivors' care plans. The latter was a two-page, PDF formatted document linked to institutional order sets and EHRS. Our DM process included: data integrity, integration, mapping, manipulation (e.g. querying, SQL, reporting), warehousing, and reporting. Outcome measures were: 1) number of arrived and missed appointments; 2) number of care plans completed; 3) number of providers per clinic, and 4) number of care plan versions and fields. A skilled technical and analytical team structured the DM process. No patient identifiers were used in this analysis.

**Evaluation:** Results indicated creating a system to access, store, and share information from non-standardized clinical documentation and EHRS is a dynamic, complex, and resource-intensive process. Mining clinical data from electronic, written (free-text), and other manual data sources revealed both challenges and benefits. Major challenges included the inability of institutional systems to communicate with one another and the lack of a standardized information exchange infrastructure. Key benefits included improved data integrity and long-term analytical sustainability.

**Discussion:** Oncology nurses have clinical, research, and theoretical expertise relevant to patient care and nursing practice. As the demand for data mining increases, oncology nurses' expertise can be enhanced with leadership and competency development in HIT. When data are adequately managed and collected, their analysis and interpretation can support evidence-based nursing practice and ultimately, improve outcomes in survivorship care.

### 113668 (Poster)

**CHEMOEMBOLIZATION: IMPROVING PATIENT SATISFACTION AND SERVICE DELIVERY.** Kathleen Shuey, MS, RN, AOCN®, Baylor University Medical Center, Dallas, Texas; Stephen Lopez, MS, RT(R), Baylor University Medical Center, Dallas, Texas; Allison Walls, PharmD, BCOP, MD Anderson Cancer Center, Dallas, Texas

**Significance and Background:** Chemoembolization is a technique for providing local chemotherapy directly to a tumor. An interventional radiologist inserts a small catheter into the vessel that supplies the tumor (usually hepatocellular carcinoma or GI tumors that have spread to the liver). DC Bead® is a drug-eluting bead that releases a high concentration of chemotherapy in a controlled manner. Beads are loaded with doxorubicin for the dual purpose of occluding blood flow to the tumor and delivering a local dose of chemotherapy. Depending on the patient dose, DC Bead® can take 30 to 120 minutes to load (saturate) with doxorubicin. Patients expressed dissatisfaction related to prolonged procedure wait time and NPO status.

**Purpose:** Decrease length of stay to less than 23 hours for patients undergoing chemoembolization by:

- Consistent availability of pre-procedure outside scans evening prior to procedure

- Availability of saturated beads to radiology
- Elimination of duplicate nursing paperwork.

**Interventions:** A multidisciplinary team was convened to determine improvement opportunities in the chemoembolization treatment process. A cross functional flow chart was developed through patient interview and by walking the process with a patient. Areas involved in treatment delivery included the physician office, admitting, pre-admit nursing area, radiology, nursing, and pharmacy. Interventions focused on three specific areas: nursing (communication with the physician office, updates on procedure time during the admission, and availability of laboratory results prior to the procedure), pharmacy (advance notice of procedure, begin loading process earlier, minimize drug waste by recycling unused product), and radiology (triage procedure to early appointment time, provide MRI/CT scans night before for review by radiologist).

**Evaluation:** Patients are admitted to observation status. Actual bed time was 33 to 40 hours. After implementation of the updated process, bed time decreased by 8 hours. Patient satisfaction results no longer reflected a patient issue.

**Discussion:** The use of a multidisciplinary team involving members from all areas where the patient was seen resulted in the identification of previously unknown issues. Bringing all team members together resulted in improved planning for the patient experience. Departments garnered insight into issues within other clinical areas. Flexibility of the team resulted in improved service delivery.

### 114999 (Poster)

**IDENTIFYING WORKLOAD IN AN AMBULATORY ONCOLOGY CLINIC.** Socorro Gustafson, MSN, RN, OCN®, Northshore University Health System, Evanston, Illinois

**Significance and Background:** Cancer patients have complex needs and are receiving complicated treatments. The advent of oral therapies in oncology has increased the responsibilities of nurses in the ambulatory setting. There is an increase of non direct patient care activities of oncology nurses. Oncology nurses need to continuously provide the best care to their patients. Identifying the workload of nurses will assist nurse managers in defining the staffing needs of the unit and also improve patient care.

**Purpose:** The purpose of this presentation is to identify the non-direct activities and responsibilities of oncology nurses. The presentation will also offer state of the art recommendations on how to measure the workload of oncology nurses.

**Interventions:** Identifying the non -direct activities and responsibilities of oncology nurses were acquired by direct observation of the duties of oncology nurses in the workplace. Information was also obtained from peer-review articles.

**Evaluation:** The increase in non-direct patient care has not been clearly defined and measured in the ambulatory setting. There are no standard models or tools in measuring workload of nurses.

**Discussion:** One recommendation is to continue with future studies possibly incorporating time management models from other disciplines. Nurses need to identify the needs of their patients and to advocate for their patients. Measuring and identifying the workload of oncology nurses will improve patient outcomes and will also promote patient safety and satisfaction.

### 115020 (Poster)

**UTILIZATION OF VALUE STREAM MAPPING TO IMPROVE THROUGHPUT IN AN AMBULATORY ONCOLOGY INFUSION CENTER.** Georgina Rodgers, BSN, RN, OCN®, Cleveland Clinic Taussig Cancer Institute, Cleveland, Ohio; Linda Boutton, RN, OCN®, Cleveland Clinic Taussig Cancer Institute, Cleveland, Ohio; Carrie Cingel, RN, OCN®,

Cleveland Clinic Taussig Cancer Institute, Cleveland, Ohio; Jessica Hess, RN, Cleveland Clinic Taussig Cancer Institute, Cleveland, Ohio; Barbara Melena, RN, OCN®, Cleveland Clinic Taussig Cancer Institute, Cleveland Clinic, Ohio; Keith Spalsbury, Cleveland Clinic Taussig Cancer Institute, Cleveland, Ohio; Jeanne Berton, RN, OCN®, Cleveland Clinic Taussig Cancer Institute, Cleveland, Ohio

**Significance and Background:** Our goal is to provide patients with high quality, compassionate, patient-centered care in a healthcare climate that is constantly seeking opportunities to perform “better, faster, cheaper”. In the outpatient oncology infusion setting nursing care plays a vital role in managing the overall care of the patient. Each obstacle creates a less value added experience for the patient and can decrease the overall engagement of the team members vital to carrying out the necessary to the patients.

**Purpose:** The goal of this project was to take a global view from the patient presentation to the infusion clinic through discharge and significantly reduce the interruptions to patient flow through the ambulatory oncology clinic. The team wanted to identify and eliminate waste, improve communication, build relationships, and increase throughput.

**Interventions:** A cross functional team was developed to create a value stream map and corresponding improvement opportunities. A value stream map: creates an “end-to-end” process view. It’s purpose is to highlight waste, or interruptions to patient flow. Examples of waste include: rework required for incomplete information, staff searching for needed information, high skill/expertise pulled away from patient care and unnecessary patient movement. A cross functional team was developed to create a value stream map and corresponding improvement opportunities. A value stream map: creates an “end-to-end” process view. It’s purpose is to highlight waste, or interruptions to patient flow. Examples of waste include: rework required for incomplete information, staff searching for needed information, high skill/expertise pulled away from patient care and unnecessary patient movement.. The value stream mapping team meetings also allowed for cross-functional collaboration and teamwork and through the process we were able to identify and implement impactful improvements to reduce the problems that interrupt patient flow. Weekly huddles are held to discuss the overall progress and determine next steps for improvement.

**Evaluation:** Creation of the value stream map for the outpatient infusion area has allowed us to clearly identify ideal state workflows and current state workflows. The end goal is to reduce/eliminate waste thus improving the overall patient experience throughout the continuum of care and improve the overall engagement of the clinical nursing staff.

**Discussion:** The overall implications for oncology nursing practice are to utilize this technique in other outpatient infusion centers as a mechanism of continuous improvement and project management.

#### 115056 (Poster)

**INTERVENTIONAL ONCOLOGY: COLLABORATIVE PRACTICE TO DEVELOP A CONCURRENT NURSING CONFERENCE.** Ginna Deitrick, MSN, CRNP, AOCNP®, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania; Diana VanHouten, MSN, CRNP, CCRN, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania; Deborah Fleischer, RN, BSN, MA, ACNP-BC, Memorial Sloan-Kettering Cancer Center, New York, New York; Nicole Kowalewski, RN, BSN, MSN, ACNP-BC, Memorial Sloan-Kettering Cancer Center, New York, New York; Matthew Kennedy, RN, BSN, MA, ACNP-BC, Memorial Sloan-Kettering Cancer Cen-

ter, New York, New York; Erica Bland, RN, BSN, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** Interventional oncology (IO) is a subspecialty important to the collaborative care of oncology patients. Nursing practice in interventional oncology incorporates surgical, radiological and general oncology nursing knowledge and skills. IO nurses and advanced practitioners serve as experts in IO/IR patient care. Patients undergo procedures including venous access placement, embolization, chemoembolization, radioembolization and ablative therapy for solid tumors and bony metastases.

**Purpose:** We developed a concurrent nursing conference at the WCIO 2013 Annual Meeting with the goals of increasing nursing awareness and improving networking in the IO and radiology nursing subspecialties.

**Interventions:** A collaborative team was formed with interventional radiology (IR) nurse practitioners (NPs) and nurse leaders at the University of Pennsylvania Health System and Memorial Sloan-Kettering Cancer Center with the assistance of the WCIO Board of Directors. Discussions of common questions and concerns related to oncology populations were held via email and teleconferencing. The top four topics identified were: tumor ablation, tumor embolization, venous access and irreversible electroporation. Content outlines were developed, and NP and physician networks were used to select and invite expert presenters for the conference.

**Evaluation:** Session evaluations, using Likert scale scoring, and verbal feedback will be collected and analyzed, including topic ideas for future conferences. As the target audience includes oncology nurses, the feedback will be representative of this population.

**Discussion:** IR and IO are important aspects of oncology care that require an expansion of scientific- and practice-based knowledge, and engagement of experts to direct future work in nursing research, standardization of nursing practices, and strategies to improve patient outcomes. This conference is a major step in defining competencies and scope of practice for IR/IO nurses and advancing subspecialization within oncology nursing. Moreover, this conference and future meetings serve as a foundation for building a special interest group within ONS for IR and IO nurses.

#### 116670 (Poster)

**A COLLABORATIVE MISSION: NURSING CERTIFICATION SUCCESS.** Theresa Johnson, RN, BSN, CBCN®, UT MD Anderson Cancer Center, Houston, Texas; Julie Nguyen, MSN, RN, OCN®, UT MD Anderson Cancer Center, Houston, Texas; Jennifer McKenzie, MSN, RN, CBCN®, UT MD Anderson Cancer Center, Houston, Texas

**Significance and Background:** Nursing certification is an objective way to demonstrate and highlight the nurse’s knowledge, skill, and experience in a specialized field. Research validates that nurses who are certified in their practice setting improve patient outcomes, nursing retention, workplace empowerment and job satisfaction. However, there are existing barriers that can challenge the nurse when becoming successful. The poster presentation will address those barriers and show an example of an approach that was used and resulted in successfully increasing the nursing certification success rate.

**Purpose:** The purpose of the presentation is to share the best practices in developing and implementing a certification educational program with multidisciplinary collaboration. In addition, the authors want to present to other nursing leaders their own experiences and the importance of their role in the support of making nursing certification successful for nursing staff.

**Interventions:** The interventions and methods will clearly describe the accomplishment of the authors’ purpose. The

presentation will outline the curriculum development utilized in increasing nursing certification success rate. It will describe the nursing leadership support, which is essential for the success of increased nursing certification success. The presentation will provide a table describing the collaborative tasks and the designated role for each of multidisciplinary workgroup. These interventions and methods will be appropriate for the topic of nursing leaders supporting a certification educational program with a collaborative approach and its correlation to increasing nursing certification success rate.

**Evaluation:** The presentation will provide the results of the certification educational program implemented in an area of practice at a comprehensive cancer institution. The results will include the data results of the successful and unsuccessful rate of nurses who participated in the certification educational program. Additionally, the presentation will include the personal experience of nurses and leaders who participated in the certification educational program.

**Discussion:** The implications for oncology nursing practice are identified by providing strategies of nursing certification success and its benefits to patient outcomes and satisfaction, nursing retention, workplace empowerment, and job satisfaction.

### 116700 (Podium)

**IMPLEMENTING AN INNOVATIVE LEADERSHIP MODEL TO ACHIEVE STRATEGIC OUTCOMES RELATED TO PERFORMANCE, CLINICAL PRACTICE, AND OPERATIONS IN ONCOLOGY SERVICES.** Abby Viall, RN, MSN, OCN®, Northwestern Memorial Hospital, Chicago, Illinois; Kristopher Goetz, Northwestern Memorial Hospital, Chicago, Illinois; Barbara Holmes-Gobel, RN, MS, AOCN®, Northwestern Memorial Hospital, Chicago, Illinois; Yvonne Rucker, RN, MSN, OCN®, Northwestern Memorial Hospital, Chicago, Illinois

**Significance and Background:** Healthcare is experiencing change at a rapid and unprecedented pace 1. We now live in a world where innovation and creativity are more important than perfectibility 2. However, antiquated nursing leadership models have not evolved with the dynamic care environment. Evidence suggests a significant association with positive leadership practices and increased patient satisfaction and reduced adverse events.

**Purpose:** Northwestern Memorial Hospital (NMH) created an innovative nursing leadership model that fosters a highly professional, collaborative, coordinated roles resulting in the accountability to outcomes related to quality, patient safety, staff engagement, fiscal targets, and evidence based practice. The nursing division evolved from a siloed cost center management structure to a model focused on the achievement of strategic outcomes.

**Interventions:** The innovative structure strategically aligns like populations under a collaborative leadership team with dedicated, specific roles focusing on the functions of operations, performance to quality and fiscal outcomes, and evidence based practice and physician partnerships. At NMH Oncology Services includes an inpatient oncology/hematology/palliative care unit, an inpatient oncology/hematology/stem cell transplant unit, an inpatient women's cancer/surgical care unit and an outpatient blood/apheresis center. The following management team structure in Oncology Services was developed:

Manager, Operations

- Recruitment / retention
- Human resource management
- Scheduling and productivity
- Team building and staff engagement

Manager, Performance

- Quality metrics

- Financial Performance
- Patient satisfaction
- Throughput and length of stay
- Regulatory compliance
- Annual goal development
- Manager, Practice
- RN and assistant practice
- Orientation
- Nurse certification
- Staff development
- Patient Centered Care Model
- RN/MD Co-leader

**Evaluation:** Financial outcome have indicated a hospital wide 4% improvement in hours per patient day, decreased nurse manager turnover, decreased RN turnover, and improved nurse engagement hospital wide. Furthermore, since implementation of the new manager model all quality indicators have outperformed NDNQI benchmarks. For NMH Oncology Services FY 12 nurse turnover was 2.2%, patient satisfaction scores met or exceeded FY11 scores with > 66% good or very good responses, and there was 0% nurse manager turnover.

**Discussion:** The model has leveraged the individual skill sets within specific leadership roles and responsibilities. Partnerships between the oncology performance manager and oncology practice manager have identified trends in data such as patient falls, and allowed the practice manager to tailor education to address identified times of day and practices that impact fall rates. Partnerships between the oncology operations manager and oncology practice manager have allowed for new hires to be carefully selected and trained within the department based on unit needs and staff specialty preferences.

### 116838 (Poster)

**CAN A STAFF RETREAT ASSIST IN IMPROVING COMPASSION, PREVENT BURNOUT AND REDUCE SECONDARY TRAUMATIC STRESS?** Susanne Colligon, RN, MSN, FNP, OCN®, CJW Medical Center, HCA Virginia, Richmond, Virginia

**Significance and Background:** Oncology nurses cope with death and dying on a daily basis and, therefore need a venue to rejuvenate themselves in order to continue to assist this population. Assessing their current level of compassion fatigue is necessary so adjustments can be made to help prevent stress and burnout. These include tools and reminders to take care of themselves in order to care for others.

**Purpose:** This retreat was developed to give the oncology nurses a renewed focus and assist them in continuing to care for their patients as well as to offer techniques and coping strategies for self care. The Professional Quality of Life Scale (PROQOL) was used to assist in identifying current coping, burnout and stress both pre and post staff retreat.

**Interventions:** A six hour retreat was provided off-site with a motivational speaker, chaplain and social worker which was attended by fifty oncology staff members consisting of nurses, nursing assistants, oncology social workers and advanced practice nurses. During this retreat, there was a reinforcement of the impact the staff have on patients and families and the difference they make. The lectures focused on caregiver self-care with relaxation techniques, meditation, art therapy and journaling.

**Evaluation:** Attendance at the retreat was mandatory. Ninety percent of staff attended. The use of the Professional Quality of Life Scale (PROQOL) to assess the staff's compassion satisfaction, burnout and secondary traumatic stress in dealings with the diagnosis and frequent deaths of cancer patients. Overall the compassion satisfaction, burnout and secondary traumatic stress improved when reassessed one month after the retreat. The compassion scale improved by 44%, burnout and secondary traumatic stress decreased by 74% respectively. The staff all

commented that this retreat should be done on a yearly basis and felt it revitalized their practices.

**Discussion:** Oncology nursing can be stressful and depressing. Holding a retreat that reinforces their commitment to compassionate care and need for self care helps prevent burnout and secondary traumatic stress. It is imperative that nurses learn and continually practice self-care techniques which allows to stay fresh and focused in oncology.

### 117198 (Poster)

#### DEVELOPING A CHEMOTHERAPY TASK FORCE TO IMPROVE NURSE SATISFACTION AND PATIENT CARE.

Heather Askren, NP-C, RN, OCN®, Franciscan St. Elizabeth Health, Lafayette, Indiana; Alycea McNary, RN, Franciscan St. Elizabeth Health, Lafayette, Indiana

**Significance and Background:** Since 2009 we have been completing work on compassion fatigue. Over the last year we have noted more chemotherapy trained staff were feeling burnout and developing compassion fatigue. We were having a high turnover rate of our chemotherapy trained nurses who had been there 4 years or less. On exiting interviews the staff were reporting not feeling like they were part of discussions to improve quality of care. Unhappy with policy changes and staffing patterns were the most common complaints. Staff who stayed were verbalizing similar complaints. Feeling like administration was making all the decisions and not involving the bedside nurses.

**Purpose:** We have a 20 chemotherapy trained nurses and 30 nurses who are not trained to administer chemotherapy on our 2 medical units. After speaking with staff and unit leadership it was decided to develop a task force. This group will collaborate, share decision making and accountability for improving quality of care, safety, and enhancing work life. It was decided that only chemotherapy trained nurses would be part of the initial task force.

**Interventions:** The intent was to keep the chemotherapy trained nurses involved and part of decision making. We asked for volunteers and the advance practice nurses and unit manager also asked a few team members to join the group, based on years of experience and interaction with other nursing staff. Nurses were chosen from both day and night shift. At the inaugural meeting each member of the group was given a copy of the commission on cancer standards. Discussion took place on the standards that directly affected nursing care. Outlines were driven and developed by the group. Meetings were set up for a monthly bases to start with the plan to be bi-monthly in the future.

**Evaluation:** Our initial goal was to engage staff in decision making. We asked each member of the group to attend at least 75% of the meetings. At this point we have had 90% attendance. Each team member is asked to address a topic they feel needs improved. The group has revised policies related to oncology nursing, clinical trials, and teaching. All of which have improved patient care. The nurses have reached out to pharmacy and registration to work on improved throughput. Nurses have worked directly with the patient advocate to develop a plan for psychosocial distress screening. Nurses are doing research and looking at staffing patterns for inpatient and outpatient oncology care. Each team member has a better understanding of the commission on cancer standards.

**Discussion:** This task force has empowered our nurses. We have nurses who are engaged and making good choices. Staff scores on compassion fatigue questionnaires have greatly improved. We have seen less staff turnover since this team was developed. We see more nurses wanting to join the task force and other task force groups are developing within the unit and the facility. Using this information staff should be able to identify ways to engage their staff. Administration should be willing to let the bedside nurses make more decisions and develop ways to improve quality of life of patients and the nurses.

### 117732 (Poster)

#### CHEMOTHERAPY PROCESS IMPROVEMENT: THE SAFETY OF CHEMOTHERAPY AMONG PATIENTS AND NURSES AND THE EFFECTIVITY OF NURSES' WORK.

Gwi-Lan Kim, MS, RN, Asan Medical Center, Seoul, California; Soon Heang Lee, MS, RN, Asan Medical Center, Seoul, California; Ji Hyun Yun, RN, Asan Medical Center, Seoul, California

**Significance and Background:** The major treatment of the nursing 5 team unit in AMC is about hematology and oncology. The main work of the unit is related to chemotherapy. Chemotherapy is a highly toxic therapy which generally causes genetic toxicity, carcinogenicity or teratogenicity, and reproductive system disorder in case, especially, workers who dispense or inject the drugs are easy to expose to the chemotherapy agents. Also, it could bring about hazard to patients because of an exposure of chemotherapy drugs. So, they must protect themselves by wearing personal protective equipment (PPE) and by practicing universal precautions. Although there are precautions, nurses are still under higher work pressure. For these reasons, the better way to improve more effective work and decrease work pressure or nurses who check the chemotherapy orders and inject chemotherapy drugs into patients should be needed for the safety of chemotherapy.

**Purpose:** The nursing 5 unit in Asan Medical Center suggests the safer way of the chemotherapy system to prevent exposure to the chemotherapy drugs by checking orders, dispensing, and injections of the chemotherapy drugs exactly and to improve the work process more effectively.

**Interventions:** There are four improvements about:

- 1) revised OCS (order communicating system) programs
- 2) the developed prescribing, dispensing, and injections of chemotherapy medications
- 3) the development of Y formed leur-lock infusion set with multiple needleless ports
- 4) increasing of nurses' satisfaction

**Evaluation:** The exact prescribing, enhanced dispensing process, and administration of chemotherapy medications should be required to provide safe chemotherapy administration to patients and workers in hospitals. The nursing 5 team unit which uses the most chemotherapy drugs implemented the system improvement of changes of the chemotherapy protocol and hospital processing programs by analysis of PSR and questionnaires related to injections of the chemotherapy drugs. Moreover, workers in hematology, oncology, and pharmacy team contributed to reduce work pressures by improving process related to chemotherapy treatments.

**Discussion:** If we found the better way about prescribing for chemotherapy drugs which cannot be split, using the Y formed leur-lock infusion set with multiple needleless ports only for chemotherapy drugs which is not developed yet, and making a safe environment for injections without separation of needle and infusion set, we could apply the way to other wards and prevent the exposure of chemotherapy medications including reducing the needle stick injuries of nurses in hospitals.

### 118128 (Poster)

#### ADVANCED PRACTICE RN (APRN) INDEPENDENT PROVIDER MODEL OF CARE IN AN NCI COMPREHENSIVE CANCER CENTER—LEVERAGING APRN EXPERTISE AND UTILIZATION.

Wendy Miano, DNP, MSN, RN, AOCN®, University Hospitals Seidman Cancer Center, Cleveland, Ohio

**Significance and Background:** University Hospitals Seidman Cancer Center (UH SCC), a large urban academic NCI Comprehensive Cancer Center was charged with maximizing Advanced Practice RNs (APRNs) in the oncology outpatient setting. APRNs represent an essential workforce in oncology



services. Based on graduate educational training, they demonstrate patient care coordination and interventions reflecting a subspecialty knowledge base and core competencies. Historically, UH SCC APRNs worked directly with collaborating physicians, and billing was predominantly collected by physicians. A pilot project with two APRNs as independent providers successfully demonstrated that revenue sufficient to cover salary was achieved within the first two years. Over the course of this past year (2012), APRNs were moved to the faculty practice employment model. This transition resulted in an APRN and collaborating physician joint practice model of care.

**Purpose:** The purpose of this project was to define patient management parameters and productivity metrics for an APRN independent provider model of care.

**Interventions:** Patient management parameters were defined with input from both APRNs and collaborating physicians. A proposed practice algorithm was established to clearly define physician and APRN appropriate patient management. Outpatient clinic volume guidelines were specified. In the first year of practice, an apprenticeship role was defined, taking into account the learner's role. Infrastructure support through clinical secretary and nursing support were identified. Education was provided to APRNs to ensure knowledge in billing metrics and structured revenue generating unit (RVU), used to measure productivity.

**Evaluation:** A successful transition in employment model and practice structure has been observed. Established productivity benchmarks and clear patient parameters in defining a joint practice enhanced APRN performance. RVU productivity reports have aligned APRNs for success in independent patient management. In addition, this model of care change has afforded APRN opportunities in clinical privilege development, subspecialization, and disease team expertise.

**Discussion:** The APRN independent provider model positions UH SCC for success in management of oncology patients over the trajectory of cancer therapy, surveillance, and/or end of life care. This model of care provides appropriate utilization, efficiency and APRN professional development in an oncology outpatient setting.

#### 118414 (Poster)

**ESTABLISHING A BREAST CARE NETWORK: COORDINATION AND COHESIVENESS OF BREAST IMAGING SERVICES IN A MULTI-FACILITY HEALTH SYSTEM.** Esther Muscari Desimini, RN, MSN, BC, APRN, HCA Virginia Health System, Richmond/Spotsylvania, Virginia

**Significance and Background:** Oncology Nurses are in unique positions to trend and improve upon their patients' experience. The skills of process improvement and patient advocacy combined with caring and compassion empower nurses to impact positively on the 10% of women called back from routine screening mammography for radiologic findings, and the subsequent 3-5% who result in hearing a breast cancer diagnosis.

**Purpose:** The HCA Richmond Division is comprised of 4 hospitals, 4 Imaging Centers and 2 Ambulatory Surgery Centers. Mammography Screening Services are offered at 9 facilities with all the facilities directed by different managers, each reporting to various administrators and vice presidents. Due to dropping patient volumes, fragmentation of information and care from one center to the next, limited availability of radiologists specialized in mammography and different patient experiences depending upon facility, an assessment and standardized approach was taken in response to these problems.

**Interventions:** This presentation describes the project implemented in order to create a collaborative, smooth and cohesive experience for patients across all the HCA facilities when presenting for a screening mammogram and/or follow-up for an abnormal finding. The goals of the project were to: 1) Ensure

a superior patient experience with mammography screening and diagnostic services at every and all HCA facilities; 2) Guide and support the patient in their entire mammography experience by assisting with retrieval, transporting of films and evaluation at tertiary care settings; and 3) Standardize the processes (scheduling, orders, verbal and written patient communications, etc.) across the larger Richmond division. Success involved establishment of a leadership team, open and respectful communication between facility workers, detailed, controlled communication to referring physicians, cohesive commitment to change, positive collaboration and a willingness to work.

**Evaluation:** Evaluative measures include: time reduction from one intervention point to the next, improved and enhanced patient volumes, improved patient satisfaction, referring physician volume growth, and physician satisfaction.

**Discussion:** Process improvement on behalf of patients is oncology nursing. Assessment of the experience, incorporation of the literature, and benchmarks for performance, resulted in operationalizing a plan that was successfully implemented for the woman experiencing an abnormal screening mammogram and/or breast cancer diagnosis. The Breast Care Network has continued to improve and evolve as the leadership and sales team incorporate referring physician and patients feedback.

#### 118470 (Poster)

**RETURN ON INVESTMENT: SUPPORT FOR THE NAVIGATOR POSITION.** Esther Muscari Desimini, RN, MSN, BC, APRN, HCA Virginia, Richmond/Spotsylvania, Virginia

**Significance and Background:** Although care coordination and nurse navigation has been used periodically in various subspecialties of oncology nursing, such as bone marrow transplant, it has not been commonly used in other subspecialties. Making the business case in areas that might not have had navigation previously can be challenging.

**Purpose:** The purpose of the navigator position was to improve upon the patient experience while also decreasing patient outmigration, enhancing patient retention, and ultimately breast cancer volume growth. The purpose of this presentation is to explain the variables and measures used for financial analysis and support of the position. A review of reasons why 20 women/month were leaving a breast imaging facility at a large hospital resulted in an experienced oncology nurse navigator position being created for a trial period of one year. At the end of the year, clinical and financial outcomes supported continuation of the position and expansion to other "sister" hospitals.

**Interventions:** The experienced oncology nurse navigator was part of a comprehensive program that included 24 hour callback personal phone calls, one on one education, follow up appointment scheduling, pre-admission testing visits, a pre-operative educational class, and individual patient coaching.

**Evaluation:** Outcome measures were directly correlated to the reasons why women were leaving and patients were tracked from the moment they were contacted by the nurse navigator. After 12 months the net reduction in patients leaving the system was 212, translating to over \$250,000 in contribution margin. In addition as we tracked these patients beyond the 12 months and noted increased retention year over year and increased breast cancer cases in the cancer registry. Following expansion to a sister facility we were able to track and measure the outcomes of two different models of follow up—one being episodic and limited to the imaging center and the other extending the 12 months post call back. Patient retention and the quantity of services utilized at the hospital were each 10% higher in the model where the navigator was constant in the continuum 12 month period as opposed to the "episodic" model. The contribution margin was \$3,500 higher per case in the cancer continuum model due to patient retention and volume of services over time. Other

outcome measures of reductions in time from suspicion to diagnosis and treatment supported the quality initiatives to extend the program to more facilities.

**Discussion:** The growth witnessed in breast imaging and cancer treatment services along with the financial analysis supported the full time position and made the case for additional oncology nurse navigators. Additionally, hard to measure benefits included forgiveness of the system, enhanced trust, old fashioned customer service, improved physician satisfaction, clinical pathway guidance, enhanced relationships with referring physicians and specialists. The reality of needing to prove the business case is universal and the processes we employed in order to financially evaluate the position is applicable across any facility.

#### 119079 (Poster)

**PUBLIC POLICY LEADING ADVOCACY.** Kate Bell, RN, University of Texas School of Nursing, Austin, Texas

**Significance and Background:** Nurses are affected daily by policy that is implemented in their hospital systems, the city they reside in, their state and the National government. It is important for nurses to be a part of the policy making process not only to give a voice to their patients, but also to their profession. Engagement in public policy for oncology nurses is crucial because lawmakers need to be educated by experts on issues like chemotherapy shortages, research funding and workforce challenges.

**Purpose:** The purpose of this leadership development project is to learn, through active participation, the role of the oncology nurse in Federal affairs.

**Interventions:** Nurses can engage in public affairs affecting oncology nursing at the National level as an intern for Oncology Nursing Society (ONS). Working directly with ONS's policy director, interns can fulfill the goals of the organization through public affairs in Washington D.C. The University of Texas Archer Graduate Program in Public Policy is designed to engage graduate students in the policy making process by immersing fellows in federal public affairs. This summer, a nursing graduate student was awarded the fellowship and was the first nurse to receive this honor. With the support of this fellowship, ONS engaged their first intern that was also an ONS member and a nurse.

**Evaluation:** Nursing practice can be enhanced by learning important issues facing oncology nurses and the ways that nurses can impact the legislation. The expertise learned in D.C. will stimulate members to be leaders in the oncology community by engaging in public affairs.

**Discussion:** This presentation will illustrate one member's experience as an ONS policy associate and demonstrate how the experience improved their nursing practice through communication, leadership and advocacy skills.

#### 119603 (Poster)

**UTILIZING VOLUNTEERS AS PATIENT CARE PARTNERS (PCPS): A NURSE-LED UNIT BASED PROGRAM TO ENHANCE THE VOLUNTEER AND PATIENT EXPERIENCE.**

Laurie Bryant, RN, MSN, OCN®, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins Hospital, Baltimore, Maryland; Gina Szymanski, RN, MS, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, Maryland

**Significance and Background:** A Patient Care Partner (PCP) is anyone responsible for the patient care experience. Volunteer applicants seeking interaction with oncology patients to enhance their future careers in healthcare (e.g. students interested in medicine, nursing, healthcare administration and research) are ideal

volunteer PCPs. The nurse is uniquely positioned to partner with volunteers and provide mentorship. Volunteer PCP's must understand the patient's need for support and information, and their thoughts and concerns regarding their planned care.

**Purpose:** The purpose of this program is to train and mentor volunteer PCPs within the institution's patient care mission; to provide a healing environment where the patient's perceptions, their hopes and goals drive the interactions we have with them. The trained volunteer PCP provides companionship, conversation, and diversional activities that are not always available from busy direct care providers.

**Interventions:** Qualified volunteer candidates are screened through a central hospital volunteer program. The candidates are interviewed by an oncology clinical nurse specialist (CNS). Candidates are selected based on their desire to pursue a caregiving profession in healthcare, availability at least 2-4 hrs/wk, and ability to self-manage and work enthusiastically with patients/families. Selected candidates participate in a 3 hour didactic training program and a shadowing experience to learn expectations. Standard monthly diversional activities such as volunteer led music concerts, movie night, and bingo are co-lead by the volunteers and the CNS coordinator.

**Evaluation:** The evaluation of this unit based program is measured with the following criteria: PCP time and attendance, a communication journal book where quality and patient centered focus is summarized, participation of monthly patient and family diversional activities and hospital patient satisfaction scores.

**Discussion:** The healthcare environment teaches volunteer PCPs that they have the most to learn from being present for those they serve, and actively listening to what patients and families tell them. Witnessing the interaction of the oncology nurse providing patient and family centered care is a necessary opportunity for those with future careers in healthcare. It is oncology nursing's responsibility to help change the trajectory of how care is planned by creating volunteer programs that teach and mentor future health care providers in patient and family centered care.

#### 122386 (Poster)

**CHANGING THE PARADIGM: CLINIC NURSE TO TREATMENT NAVIGATOR.** Jeannie Keith, RN, MSN, AOCN®, NEA-BC, Memorial Hermann, Texas Medical Center, Houston, Texas; Wendy Haydon, RN, MSN, OCN®, Memorial Hermann, Texas Medical Center, Houston, Texas

**Significance and Background:** Given the current, ever changing health care delivery models, oncology nurses are faced with a variety of challenges as they strive to move their patients through the complex healthcare setting. Oncology nurses are seeing an increased number of treatments performed in the outpatient arena. The oncology clinic nurse is a consistent care team member that develops a strong relationship with both patients and their families; assisting with transition from diagnosis, through treatment, to ongoing surveillance.

**Purpose:** The purpose of this presentation is to describe how one cancer center utilized the oncology nursing standards of care to develop an integrated treatment navigation model of care for a large, outpatient oncology clinic. By attending this presentation, nurses will be able to view a completed job description and see how this clinic identified specific roles and responsibilities that maximized the coordination of care between patients, families, physicians and other healthcare providers.

**Interventions:** Previously, Registered Nurses who provided direct patient care in this clinic were already involved in roles of care coordination. However, this center realized that there were frequent tasks that were delegated to others and in this process many necessary duties were missed or delayed during the patient clinic visits. The leadership team worked with staff to identify a more comprehensive, patient focused care model. The main goal of this model was to facilitate translation of informa-

tion between physicians to patients, families and other care providers including the infusion and imaging departments. The job description was enhanced and the role of the Treatment Navigator was defined. Education was provided to both the nursing staff, physicians and unlicensed personnel.

**Evaluation:** As this care model was just recently implemented, the ongoing evaluation of the patients and families perception of improvements will be monitored by utilizing our current patient satisfaction surveys. Ongoing evaluation will include monitoring of symptom management needs and timely treatments.

**Discussion:** The role of the Outpatient Oncology Treatment Navigator is to support the physician and interdisciplinary team in facilitating patient care, with the underlying objective of enhancing the quality of clinical outcomes and patient satisfaction. The role integrates and coordinates care facilitation and survivorship planning functions.

#### 127729 (Poster)

**REDESIGNING THE MEDICAL ONCOLOGY MODEL OF CARE—NURSES NAVIGATING THE WAY.** JoAnn Williams, RN, OCN®, Mayo Clinic, Rochester, Minnesota; Patricia Jensen, RN, Mayo Clinic, Rochester, Minnesota

**Significance and Background:** The role of the oncology nurse is a new addition for our ambulatory care practice. Although we have a large chemotherapy treatment unit with many staff, nurses were not assisting the oncologists in the care of patients in the clinic setting. We entered into a quality project charter this past year to create and implement a redesigned care team model for the department of medical oncology.

**Purpose:** The vision of the Redesign Project was to develop a patient centered, comprehensive, medical oncology care team model that could be replicated across the division.

**Interventions:** Using the DMAIC process, the roles of all care team members were evaluated and realigned. Collaboration between nursing, the department of oncology, and ambulatory operations allowed for piloting and implementing the project. The implementation of the nurse was an integral piece of this project. The original goals for the Registered Nurse were to be able to provide a main point of contact, patient assessment, emotional support, education, and appropriate referrals that have been missing in the present care team model. The potential for improvement in the care provided the patients when followed by a nurse in the new model will also include increasing the number of patient interactions and new patient visits, increasing patient and staff satisfaction, and improving timeliness of care. According to the Mayo Nursing Care Model, the nurse enhances the continuity of the patient's care through coordination and prioritization of events for the patient's episode of care.

**Evaluation:** Nurses will be introduced into the redesigned model of care in the medical oncology ambulatory setting. Nurses are the core of the care team model. The care team model provides improved continuity of care for the oncology patient. The process of developing the care team model can be used by oncology nurses for quality improvement projects in other settings.

**Discussion:** We will share how nurses were involved in introducing a new model of care in the ambulatory setting. This model may be replicated in other ambulatory settings.

#### 127976 (Poster)

**AN NCI COMPREHENSIVE CANCER CENTER DEVELOPS A CANCER SPECIFIC COMMUNITY HEALTH NEEDS ASSESSMENT.** Denise Henderson, MEd, BSN, RN-BC, Karmanos Cancer Institution, Detroit, Michigan

**Significance and Background:** Recent healthcare legislation mandates that all non-profit healthcare organizations perform a comprehensive community needs assessment and develop a service-based performance improvement plan by 2013. The Kar-

manos Cancer Institute's Patient and Community Education Department was charged with the task of designing, implementing, evaluating the survey that was used to comply with that mandate.

**Purpose:** Public health survey methods were used for the project. Initial data collection came from stakeholder focus group interviews which gleaned community thoughts, issues and concerns related to cancer care. Using that data, a "from scratch" community health needs assessment was developed, tested and refined. To be relevant to the services provided by the Institute, the needs assessment was honed to reflect the cancer knowledge, awareness and self-care activities of the populations served by the Institute.

**Interventions:** A timeline and budget were developed and presented to Leadership for approval. A population sample was identified using zip code data. Surveys distributed methods included direct mail, email, online survey. Select community education events were used also used for survey distribution. Based on data analysis, a process improvement plan was developed and will be made available to the community in 2013.

**Evaluation:** Assessment analyses identified four primary themes across the population served. These included awareness, cultural sensitivity, lack of access to services and customer service. As primary providers for patient and community education and outreach, the nurses of the Patient and Community Education Department will have a major impact on improving awareness of Institute services, patient navigation, support, health literacy and knowledge.

**Discussion:** Nurses who work as Patient and Community Educators play a major role in helping cancer patients and families navigate, understand and process complicated cancer-related information. It is important that we become familiar with the methods used to conduct meaningful community health needs assessments.

#### 128031 (Podium)

**IMPROVED PATIENT SATISFACTION, CONTINUITY OF CARE, AND COST THROUGH USE OF AN INTERNAL MEDICINE BASED ACUTE CARE CLINIC.** Joan Arata, RN, BSN, MBA, University of Utah, Huntsman Cancer Institute, Salt Lake City, Utah; William A. Dunson, Jr., MD, University of Utah, Huntsman Cancer Institute, Salt Lake City, Utah; Donald Milligan, MBA, University of Utah, Huntsman Cancer Institute, Salt Lake City, Utah; Sarah Kehl, RN, BSN, University of Utah, Huntsman Cancer Institute, Salt Lake City, Utah; Majda Larsen, MBA, University of Utah, Huntsman Cancer Institute, Salt Lake City, Utah; Shawna Francom, RN, University of Utah, Huntsman Cancer Hospital; Amanda Blais, RN, BSN, University of Utah, Huntsman Cancer Institute, Salt Lake City, Utah

**Significance and Background:** Oncology patients commonly require urgent medical care for symptoms related to their disease or treatment. These patients historically were directed to emergency departments (ED) often leading to long wait times, lack of care continuity, and possible avoidable inpatient admissions. As a result, ED visits can have negative fiscal and patient satisfaction implications. To address these concerns, this academic cancer hospital, opened an Internal Medicine based Acute Care Clinic (ACC).

**Purpose:** The Acute Care Clinic was developed to support Huntsman Cancer Institute (HCI) patients with urgent medical, post-surgical, or post-radiation symptoms as an alternative to the emergency department.

**Interventions:** A clinic comprised of four critical care beds and 2 exam rooms was opened November, 2011. Staffed by a physician, nurse, and medical assistant team, this referral based clinic is open Monday through Friday, 0900-1900. The ACC nurse triages all referrals. The physician reviews internal patient

records, performs a history and physical, directs medical care, and sends follow-up summaries to referring providers within 12 hours. ACC is a supportive service for all multidisciplinary cancer teams. Philosophically, the approach is not stabilization and referral back to the primary team, but rather diagnosis, implementation of comprehensive treatment, follow up to ensure improvement, and integration into the primary multidisciplinary team following the patient. Close coordination with HCl's Supportive Oncology Service allows discussion of palliative approaches when appropriate even in the acute setting.

**Evaluation:** ACC patient satisfaction is at the 99th percentile compared to the ED at the 42nd percentile. Same day appointments are available eliminating emergency department visits and even some inpatient admission. Reduced cost per case is realized when patients are treated in ACC and discharged to home as compared to ACC visit with inpatient admission. Referring physicians report high satisfaction with service citing value of internal medicine support, follow-up communication, and oncologic care continuity.

**Discussion:** National health care reform and associated decreases of financial reimbursement from Medicare call for hospitals to meet quality measures for patient access, satisfaction, and readmission rates at reduced costs. An Internal Medicine based acute care clinic within a cancer center has been found to help meet these goals at The Huntsman Cancer Institute.

### 128290 (Poster)

#### THE IMPACT OF WORKFLOW REDESIGN ON PATIENT AND NURSING SATISFACTION IN AN INFUSION AREA.

Adrienne Banavage, MSN, RN, OCN®, The Emily Couric Cancer Center at the University of Virginia Health Systems, Charlottesville, Virginia; Leann Bauer, MT(ASCP), The Emily Couric Cancer Center at the UVA Health System, Charlottesville, Virginia; Dennis Haynes, RN, The Emily Couric Cancer Center at the University of Virginia Health System, Charlottesville, Virginia; Michele Bascle, BSN, RN, The Emily Couric Cancer Center at the University of Virginia Health System, Charlottesville, Virginia; Tamara Fisher, RN, The Emily Couric Cancer Center at the University of Virginia Health System, Charlottesville, Virginia; Jody Reyes, MSBA, RN, OCN®, The Emily Couric Cancer Center at the University of Virginia Health System, Charlottesville, Virginia

**Significance and Background:** Patient satisfaction has been an area of focus for some time in acute care settings however it is becoming just as important in the outpatient setting as well. Patients are better informed and the marketplace is more competitive.

**Purpose:** This workflow redesign was based on the University of Virginia's care delivery system; relationship based care. Focus was on the enhancement of the caring and healing environment as well as the teamwork principle within this conceptual framework. Patients endured significant wait times and delays in treatment within their visits. Furthermore there was a "disconnect" between the nurses and the patients related to a remote scheduling process and a lack of connection between the needs of the patients and the realities of the workflow in an outpatient infusion area. The purpose of this abstract is to present the process changes undertaken to improve the patient experience in an outpatient infusion area and enhance nurses' work flow while improving patient satisfaction score

**Interventions:** After analysis of the workflow, a trial of an enhanced assignment process was implemented. The pilot consisted of a small cadre of nurses within one geographical area, a "pod". Patient acuity, duration and complexity of treatment were all considered for each pod's assignment allowing for a balance within the pod as well as the unit. This trial was rapidly extended to include the entire unit.

**Evaluation:** Patient satisfaction data was reviewed for the time period prior to implementation and then after implementation. This revealed an increase in overall patient satisfaction from 88.4 to 92.4, an increase from 87.5 to 91.9 on the item "RN gave information when needed" and an increase in the item "staff worked together" from 93.4 to 95. The percent of patients who started treatment on time increased from 60 to 70%. 91% of the nurses either agreed somewhat or fully that they could be proactive about planning their patients care.

**Discussion:** Utilizing creative staffing plans can help to improve patient and staff satisfaction, as well as patient nurse communication. Our complex environment demands the exploration of all options for the well-being of our patients and staff.

### 129284 (Podium)

#### THE NATIONAL CANCER INSTITUTE COMMUNITY CANCER CENTERS PROGRAM: THE ROLE OF ONCOLOGY NURSING LEADERSHIP IN ADDRESSING UNDERREPRESENTED ACCRUAL TO CLINICAL TRIALS.

Eileen Dimond, RN, MS, National Cancer Institute, Division of Cancer Prevention, Bethesda, Maryland; Diane St. Germain, RN, MS, NCI, Division of Cancer Prevention, Bethesda, Maryland; Andrea Denicoff, MS, RN, NCI, Division of Cancer Therapeutics and Diagnostics, Bethesda, Maryland; Brenda Adjei, MPA, EdD, NCI, Center to Reduce Cancer Health Disparities, Bethesda, Maryland; Angela Carrigan, MS, RN, SAIC-Frederick, Inc., Frederick, Maryland; Rebecca Enos, RN, MPH, The Emmes Corporation, Rockville, Maryland; Worta McCaskill-Stevens, MD, MS, NCI, Division of Cancer Prevention, Rockville, Maryland

**Significance and Background:** Adult enrollment to cancer clinical trials is less than 5%. Enrollment of underrepresented populations is even lower. Oncology nursing leadership can play a key role in identifying these populations, documenting the barriers to their enrollment into trials, and tailoring multidisciplinary efforts to address these issues.

**Purpose:** Describe specific assessment tools and strategies used to address underrepresented accrual within the NCCCP Network.

**Interventions:** The following assessment tools/strategies were developed and utilized by the NCCCP sites over the initial six years of the program:

- SWOT analysis: Minority Matrix SWOT analysis to identify precisely who their site's underrepresented populations were, and what opportunities existed for outreach.
- Best Practices Matrix: Developed for clinical trial infrastructure benchmarking, the matrix incorporates nine indicators, one of which addresses underrepresented accrual and strong community outreach and involvement in trials.
- Screening and Accrual Log: Used to collect information on patients screened for a key set of NCCCP-endorsed trials, including demographics, reasons for non-enrollment, screening methods, and patient navigator referral. Use of the Log facilitates nursing identification of barriers to underrepresented accrual and promotes the development of strategies to address them.

A "clinical trials culture" was nurtured in the Network through NCI "Clinical Trials 101" training for non-research staff and patient navigators; cultural competence and disparities education; multidisciplinary (MD) engagement through inclusion of clinical trial eligibility discussions at MD conferences, and research nursing outreach to community providers about relevant and available clinical trials.

#### **Evaluation:**

- All sites assessed their catchment area populations and strengths/weaknesses for underrepresented accrual.

- 28 sites utilized the Best Practice Matrix in 2011 and 2012 for clinical trial infrastructure self-assessment.
- Analysis of almost 5000 Screening Log entries shows early success in narrowing accrual gaps for Log trials among demographic subsets (elderly, African American), and a race distribution of screened patients that resembles the race distribution of the 2010 US Census.

**Discussion:** Oncology nurse leaders can impact site efforts to improve underrepresented accrual to clinical trials. Key to these efforts are having a strong understanding of site underrepresented populations, barriers to trial enrollment, clinical trial infrastructure gaps, physician/administration buy-in, and focused community outreach and education.

### 129310 (Poster)

**DESIGNING AND IMPLEMENTING NURSING SHARED GOVERNANCE IN A NEW CANCER HOSPITAL.** Susan Mazanec, PhD, RN, AOCN®, School of Nursing, Case Western Reserve University, Cleveland, Ohio; Anne Kolenic, BSN, RN, OCN®, Seidman Cancer Center, University Hospitals Case Medical Center, Cleveland, Ohio; Wendy Rowehl Miano, DNP, MSN, RN, AOCN®, Seidman Cancer Center, University Hospitals Case Medical Center, Cleveland, Ohio

**Underwriting or funding source:** Allos Therapeutics, Astellas, Bristol-Myers Squibb, Celgene, Genentech, Eli Lilly, Merck, Pfizer, and Novartis

**Significance and Background:** The shared governance model has been endorsed by the American Nurses Credentialing Center Magnet Recognition Program as a means to assure quality patient care and strengthen professional practice. A consolidation of inpatient and outpatient cancer services into one new cancer hospital in June 2011 brought the opportunity to create a new shared governance culture.

**Purpose:** The purpose of this project was to design and implement nursing shared governance in a National Cancer Institute designated Comprehensive Cancer Center, involving inpatient, outpatient, and community sites.

**Interventions:** In February 2012, a subcommittee of staff nurses representing all cancer center areas, managers, and nursing leaders was convened to draft the proposed governance structure and process. The subcommittee used a conceptual model of an inverted wedding cake to envision the shared governance structure with a bottom-up approach to management. The largest layer consists of six unit-level councils, followed by six standing committees and a 17-member central cancer center nursing coordinating council. Streamlined communications within the cancer center's structure and linkages to other councils within the academic medical center were priorities for the subcommittee. A retreat was held to educate 40 nurses, who were identified as champions for shared governance, and to guide them in their initial work constructing unit-level councils. In June 2012, a new committee of nurses representing the unit-level councils and cancer center committees was formed to oversee the implementation phase of shared governance, including finalization of the shared governance charter and election of officers for the central council.

**Evaluation:** An iterative evaluation process was used during the design and implementation phases to assess feasibility of the proposed structure and monitor progress in meeting developmental milestones. Committees identified gaps early and took steps to resolve them. Strategies included placing senior mentors on each committee and offering leadership skills workshops to nurses involved in shared governance.

**Discussion:** Foundational work including early identification of champions for shared governance, support from nursing managers, and staff education using a clear conceptual model was critical to the successful implementation of shared gover-

nance. Shared governance is a multi-faceted, evolving process that requires vigilant monitoring and sustained engagement by oncology nurses.

### 129464 (Poster)

**NURSING PROJECT MANAGEMENT: BENEFITS OF A PROJECT COORDINATION TEAM.** Geri Wood, PhD, UT MD Anderson Cancer Center, Houston, Texas; Mamie J. Gatlin, UT MD Anderson Cancer Center, Houston, Texas; Stacy A. Perez, UT MD Anderson Cancer Center, Houston, Texas; Tammy S. Dawson, UT MD Anderson Cancer Center, Houston, Texas

**Significance and Background:** Project management has become the new standard for identifying and achieving deliverables in various industries. In healthcare nursing leaders are consistently tasked with dual roles, effectively balancing management of both clinical and administrative responsibilities. The Division of Nursing (DON) at The University of Texas M. D. Anderson Cancer Center found that some elements of project coordination had become stagnant, while other multi-faceted projects lacked organization and management in order to keep projects focused on proposed outcomes.

**Purpose:** Non-nursing project coordinators skilled and knowledgeable in project management within nursing in their zeal to assist leaders achieve balance, decided to partner with nursing leaders to help move projects forward. To initiate the process, the executive sponsor collaborates with the nursing leader regarding the full scope of a project and the benefit of a project coordinator being assigned.

**Interventions:** In 2009, a Nursing Project Coordination Team was established; and in an intense, collaborative effort the team developed a Project Management (PM) Manual that outlines a 5-step process and four essential PM tools.

**Evaluation:** Working alongside nursing leaders, the project coordination team has effectively managed more than 63 nursing programs and projects of varying scope and financial impact; successfully bringing them to completion. This partnership has enabled nursing leaders to be more adept in aligning multiple tasks and projects with strategies and goals, thereby achieving flexibility in managing both aspects of their practice. While nursing leaders' primary focus continues to be clinical practice, providing optimal care for our patients, the overall success of nursing projects, affecting both patient care and institutional resources, is now a mutual hub for all the Division of Nursing, rather than resting entirely on the nursing leaders.

**Discussion:** The project coordinator begins the "5-Step Process" which includes initiation, planning, implementation, monitoring and completion. In this process the project coordinator is responsible for: a) defining milestones and deliverables; b) measuring and reporting progress; c) tracking key milestones and deliverables; d) documenting and tracking accomplishments, issues, etc.; e) effective communication of multidisciplinary projects; and f) managing key deliverables sign-off. An executive summary signals the successful closure of the project.

### 131556 (Poster)

**EVALUATING THE ACCURACY OF HARM SCORES IN INCIDENT REPORTING.** Toni Abbasi, RN, MBA, MD Anderson Cancer Center, Houston, Texas; Barbara Summers, PhD, RN, NEA-BC, FAAN, MD Anderson Cancer Center, Houston, Texas; Julie Foster, MBA, RN, CHCQM, FAIHQ, MD Anderson Cancer Center, Houston, Texas

**Significance and Background:** Incident reporting is a key initiative to improving patient safety. Medical error is defined as a failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors in the delivery

of health care are a major threat to patient safety. The routine incident reporting system may not provide an accurate picture of the extent and severity of harm reported in patient safety incidents. Little attention has been paid to how this process actually occurs in healthcare organizations. The definition and classification of safety related events may influence information gathering, incentive allocation and data analysis in hospitals. The way in which events are defined and classified in incident reporting systems by nurses influences the ability of a hospital to learn from medical errors.

**Purpose:** The aim of the quality improvement project is to improve the rater accuracy and interrater reliability in an incident reporting system. The purpose of this quality improvement project is to evaluate the accuracy of harm scores entered into the incident reporting system by clinical nursing staff on inpatient units in a comprehensive cancer center.

**Interventions:** The population of interest will be a randomly selected sample of approximately 40 registered nurses (RN's) from two 26 bed inpatient medical and surgical units in an oncology setting. The two selected units have nursing staff with a variety of experience and education levels. The AHRQ Harm Scales v.1.1 and 1.2 survey will be placed in Survey Monkey and sent as a link to the staff of the two medical and surgical units to complete. Only bachelor's prepared (BSN) nurses, who are considered either full-time or part-time clinical nursing staff and employed since the inception of the Patient Safety Net (PSN) incident reporting system will participate in the survey.

**Evaluation:** Unit specific summary of findings and harm score assignments will be presented at unit staff meetings via PowerPoint presentation utilizing tables and graphs. Results of the surveys will be reported in total and at the unit level. The percent completion for each unit will be reported. Inter-rater reliability will be calculated to compare agreements between raters. Descriptive statistics to determine the percent of responses and average score (compare mean). Results will be shared with nursing leadership, 2013. Data will be reviewed and reported at an aggregate level and for comparison. Data will be displayed to compare the inter-rater reliability of Harm Scale v.1.1 to v.1.2. Results will be shared with conference participants.

**Discussion:** The degree to which patient safety incident reports are under reported is not known. Incorrect data may alter the accuracy of error rates and promote invalid measures of patient safety. It is important that staff consistently understand and interpret harm score definitions. The potential for accuracy improves when organizational leaders establish an environment and processes that are focused on monitoring the systems in which the nurse and other health care providers function.

### 131574 (Poster)

**ICU ONCOLOGY FELLOWSHIP.** Bernadette Bittner, APRN, AOCNP®, Huntsman Cancer Hospital, Salt Lake City, Utah; Susan Childress, RN, MN, OCN®, Huntsman Cancer Hospital, Salt Lake City, Utah; Estelle Harris, MD, University of Utah, Hospital Cancer Hospital, Salt Lake City, Utah

**Significance and Background:** The Huntsman Cancer Hospital expanded in November 2011. The expansion included a new 16 bed intensive care unit. In order to meet the staffing needs, provide continuity of care to patients and extend expertise to critical care oncology patients, care providers needed to be confirmed. HCH administration approved a staffing model composed of critical care faculty and ICU trained advanced practice clinicians (nurse practitioners, and physician assistants). The program was developed 2010 and 4 graduates of the program opened the Huntsman ICU in November 2011.

**Purpose:** A fellowship training program was developed for APC's, with input from University of Utah College of Nursing, Physician Assistant Program, critical care division, anesthesia, oncology physicians and nurse leaders. Collaboration between

departments, including an affiliation with the local Veteran's Affairs Hospital, has been essential in building credibility of the program. The foundation of the fellowship includes: clinical rotations, lectures, assigned readings and a variety of formal competencies individualized for each APC. Preceptors for clinical rotations are carefully selected for their expertise, and ability to mentor the APC's for clinical and professional competence.

**Interventions:** Initially, a literature search was completed. Based on patient population and internal resources a draft of this program was presented and approved by critical care leadership and hospital administration. Site specific visits occurred during the planning phases and a program coordinator and facilitator was selected. Over a number of months, the coordinator met with a variety of critical care specialists and oncology specific leaders to confirm support for the APC trainees and overall program.

**Evaluation:** After one year of operations, it is clear the ICU oncology fellowship has been successful. The success is based on quality core measures, patient satisfaction, employee reviews and faculty evaluations.

**Discussion:** This program has been a win win situation for administration, and the professional development of Advanced Practice Clinicians. The ultimate beneficiary has been the oncology ICU patient and their families. The Press Ganey overall satisfaction rating for this ICU is of 97%. The program has also stimulated interest of the local college of nursing and physician assistant program as request for student placements continue to rise.

### 132640 (Poster)

**GUARANTEED COMMUNICATION: IMPROVING CALL LIGHT RESPONSE.** Lauren McCaulley, BSN, RN, OCN®, University Hospitals Seidman Cancer Center, Cleveland, Ohio; Wendy Rowehl-Miano, DNP, MSN, RN, AOCN®, University Hospitals Seidman Cancer Center, Cleveland, Ohio; Terryl Koeth, MS, RN, University Hospitals Seidman Cancer Center, Cleveland, Ohio

**Significance and Background:** The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is a nationally standardized survey capturing patients' perspectives of their hospital care, including communication and relationships with nurses. It is critical for oncology nursing leaders to monitor HCAHPS scores and develop processes for improving patient satisfaction. In our institution, "responsiveness of hospital staff" was below the institutional benchmark of the 55th percentile on all inpatient divisions.

**Purpose:** The purpose of this project was to improve communication between all members of the health care team in order to better anticipate patient needs and provide timely feedback to patient requests.

**Interventions:** A nursing leadership team developed a pilot project. First, the call light response protocol was changed to include personalization and a callback by the secretary to assure that the patient's requests were addressed. Secretaries tracked patient requests on a newly created log, and categorized calls by type of call and by shift. Monthly staff education interventions focused on themes identified in weekly data collection to improve response time. Second, the role of the secretary was expanded to include introduction to newly admitting patients, informing patients and families of healthcare team roles, and commitment to call-light responsiveness. A division-specific bookmark and journal were provided to patients to reinforce the roles of team members.

**Evaluation:** Call light data showed numerous RN-specific needs beyond pain management, bathroom needs or equipment. Thus, mutual goal setting with the patient was reinforced during relationship based nursing rounds. "Responsiveness of hospital staff" scores improved from the 12th percentile in 2nd Quarter to the 67th percentile in 3rd Quarter. Correspondingly,

scores for “relationship with nurses” improved from the 79th percentile in 2nd Quarter to the 97th percentile in 3rd Quarter.

**Discussion:** These interventions were effective in improving communication among the healthcare team. Improvement in HCAHPS scores reflect not only the importance of timely staff response to patient requests, but also the importance of the role of oncology nurses in relationship-based care. Due to the success of one inpatient division over a 5-month period, this intervention will be implemented on all inpatient divisions at this institution.

### 134333 (Poster)

**WE'RE NOT DONE YET! FACILITATORS AND BARRIERS TO PUBLICATION OF RESEARCH AND EVIDENCE-BASED PRACTICE PROJECTS.** Pamela Ginex, EdD, RN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Kimberly Berry, MSN, ANP, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Corey Russell, MSN, RN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** Nurses are increasingly involved in research and evidence-based practice (EBP) projects that have the potential to change practice and impact patient care. The final step in both the research and EBP project process is the dissemination of results and findings. Internal and external presentation of findings is one method of dissemination. However, publication has the potential to reach a broader audience and have the most impact. Publication results in professional growth and development through the writing process and sharing findings has the potential to improve patient outcomes as health care professionals learn from each other. Despite these benefits, many nurses struggle to publish their findings, even after presenting them in poster or podium format at conferences.

**Purpose:** At our institution, nurses often express difficulty turning research or EBP projects into manuscripts. The purpose of this project was to investigate barriers and facilitators to publication in a group of nurses who had presented research or EBP at a national nursing conference.

**Interventions:** A survey will be sent to all nurses who presented a research or EBP project at a national nursing conference (N=118). The goal of the survey is to identify individual and institutional barriers and facilitators to writing a manuscript and publication of research and EBP projects. Topics will include writing skills and confidence, time constraints, interest, administrative support, peer support and mentorship, as well as demographics and clinical/educational history. Based on the findings from the survey, an intervention will be developed to address the identified barriers to publication.

**Evaluation:** The results of the survey will be presented with a plan for an intervention to address the barriers and strengthen the facilitators to publication within a group of oncology nurses.

**Discussion:** There are numerous benefits to dissemination of research and EBP beyond presentation. Nurses need support and guidance to navigate the writing process. Knowledge of facilitators and barriers to writing will lead to a plan that supports nurses as they work towards a publication. The publication of research and EBP projects by nurses advances and promotes the profession and leads to benefits for our patients with improved care.

### 134487 (Poster)

**INSTRUMENT DEVELOPMENT OF COLLABORATIVE CONSULTATION IN CANCER NURSING—SCALE FOR NURSE-CERTIFIED NURSE SPECIALIST.** Megumi Umeda, RN, CNS in Cancer, Palliative Care Partners Co. Ltd., Tokyo, Japan

**Significance and Background:** Consultation of Certified Nurse Specialists in cancer is the introduction of their advanced practice, and an essential function in order to spread uniformly

high-quality cancer nursing. However, the understanding of the nursing field is ambiguous about the consultation. By creating the Collaborative Consultation Scale, to promote the use of consultation.

**Purpose:** This study tested the reliability and the validity of the Collaborative Consultation Scale.

**Interventions:** A questionnaire survey was validated with a group of 235 nurses. The response rate was 66.7%. Course of the analysis is a validation item distribution, verification of reliability, exploratory factor analysis, confirmatory factor analysis, clinical validity, the validity coexist.

**Evaluation:** The result of this study suggest this scale is in need of further refinement, but it is possible to facilitate recognition of the consultation, and the consultant and consul-tee encourage to each other relationship in clinical. Some items, scores of CCS, there was a difference in the nurse and the CNS. Nurses cannot have awareness about the activities of the CNS, have focused on the relationship. The CNS's awareness of its own practice was high, however, the CNS's awareness the autonomy of the nurses was low.

**Discussion:** CCS can be objective about the autonomy of nurses and the collaboration balance in consultation process. The next research step is to explore the relationship between patient outcomes and the CCS. Use of CCS will go ahead with the study of the nature of consultation that will lead to improved patient outcomes.

### 135203 (Podium)

**DEVELOPMENT OF A NEW RISK-BASED MODEL OF FOLLOW-UP CARE FOR BREAST CANCER SURVIVORS: FROM ONCOLOGY NURSE PRACTITIONER TO PRIMARY CARE PROVIDER.** Megan Dunne, RN, MA, AOCNP®, ANP-BC, Memorial Sloan-Kettering Cancer Center, New York, New York; Kathleen Keenan, RN, ANP-BC, Memorial Sloan-Kettering Cancer Center, New York, New York; Joanne Frankel Kelvin, MSN, RN, AOCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Stacie Corcoran, RN, MS, AOCNS®, Memorial Sloan-Kettering Cancer Center, New York, New York; Meghan Newcomer, MSN, RN, AOCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Bridgette Thom, MS, Memorial Sloan-Kettering Cancer Center, New York, New York; Mary S. McCabe, RN, MA, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** With the number of cancer survivors now exceeding 13 million and the anticipated shortage of oncologists, there is an opportunity for nurses to take a leadership role in the design and implementation of new strategies for long-term follow-up care of cancer survivors. Oncology NPs are increasingly providing survivorship care, but with the ever-growing population of survivors, there is a need to identify selected patients who can receive their long-term follow-up care by their PCP.

**Purpose:** This issue became evident for the 7,000 breast cancer survivors in long-term follow-up at this cancer center. In collaboration with medical oncologists and surgeons, our Survivorship team developed a comprehensive plan to transition eligible breast cancer survivors being followed in the NP-led survivorship clinics to their PCPs using a risk-based approach.

**Interventions:** Evidence supporting the willingness, ability, and expectation of PCPs to provide follow-up care to cancer survivors was reviewed. Criteria for eligibility were developed based on absence of disease, time since diagnosis, and low risk of recurrence. Education documents outlining the transition plan were created. Patients identified a PCP to whom their care would be transitioned and continued mammography screening at this center was offered with results to be sent directly to their

PCP. A formal relationship was developed with two, large regional medical groups to promote coordinated transition for patients without a PCP. To assure communication between the NP and PCP, a comprehensive transition note was developed, including breast cancer history with pathologic staging, treatment history, persistent treatment-related side effects, radiology results, medications, and follow-up plan. Patients were assured of smooth communication and rapid return to their oncology provider in the event of recurrence or cancer-related issue.

**Evaluation:** Approximately 50% of patients offered transition agree to follow-up with a PCP. Reasons for declining transition will be discussed and educational strategies to overcome apprehensions and impediments will be described.

**Discussion:** This risk-based model of transition of breast cancer survivors' care to PCPs is feasible and offers a novel approach to long-term follow-up care of breast cancer survivors that can be applied in any oncology setting.

### 135248 (Poster)

**LAUNCHING A NURSE RUN MENOPAUSE CLINIC WITHIN A COMPREHENSIVE BREAST CENTER: FULFILLING AN UNMET NEED.** Lisa Chism, DNP, APRN, BC, NCMP, FAANP, Karmanos Cancer Institute, Detroit, Michigan

**Significance and Background:** According to the Surveillance, Epidemiology, and End Result (SEER) data, it has been estimated that 226,870 women will be diagnosed with breast cancer in 2012. Many therapies used to treat breast cancer will induce early menopause. Chemotherapy induces menopause in approximately 40% of women age 40 and 100% of women age 50. The most prevalent menopausal symptoms reported by breast cancer patients and survivors include hot flashes, night sweats, insomnia, irritability, mood changes, urinary and vaginal symptoms. Although menopausal symptoms interfere with women's quality of life, oncology providers often lack the expertise to recognize and address these symptoms. Advanced practice nurses (APNs) in our comprehensive breast center recognized this gap in practice and the opportunity to address and manage these symptoms.

**Purpose:** The purpose of this program initiative was to launch a nurse run menopause clinic to address and manage the menopausal symptoms of breast cancer patients. This clinic was nurse initiated; nurse developed and is currently nurse managed. Prior to the development and implementation of this clinic, breast cancer patients' menopausal symptoms were not addressed and managed at this level of expertise.

**Interventions:** Development and implementation of this clinic required interprofessional collaboration and administrative approval. Nursing developed approved clinic protocols. Referrals to the clinic are primarily internal from system wide oncology providers. Referrals continue to increase and patients return for follow up to the clinic reinforcing the need for this type of care.

**Evaluation:** The goals of the menopause clinic are outlined in the approved protocols and include counseling, education, and management of menopausal symptoms. Patients express that their quality of life is substantially improved through management of their menopausal symptoms. Metrics are currently in development to evaluate clinic effectiveness with respect to fiscal accountability, patient satisfaction, and growth potential.

**Discussion:** Implications for oncology nursing practice include significant improvement in breast cancer patients' quality of life. Breast cancer survivorship is improved as many menopause symptoms persist for years after treatment. This clinic demonstrates identification of a gap in practice and implementation of a program that exemplifies APNs' contribution to oncology care.

### 135277 (Poster)

**UTILIZING AN EVIDENCE-BASED MODEL OF LEADERSHIP FOR THE DIRECT CARE ONCOLOGY NURSE.** Lisa Boris, MS, RN, Roswell Park Cancer Institute, Buffalo, New York; Megan Hayes, RN, Roswell Park Cancer Institute, Buffalo, New York; Catherine Manocchio, BSN, RN, Roswell Park Cancer Institute, Buffalo, New York; Shirley Crawley, RN, Roswell Park Cancer Institute, Buffalo, New York; Charlene McLeod, BSN, RN, Roswell Park Cancer Institute, Buffalo, New York; Donna Young, RN, OCN®, Roswell Park Cancer Institute, Buffalo, New York; Kenneth Struck, BSN, RN, Roswell Park Cancer Institute, Buffalo, New York

**Significance and Background:** Envisioning a workforce of independent leaders in the care of patients has enabled one oncology institute to achieve success in quality patient care. Nursing leadership utilized Kouzes' and Posner's Model of Evidenced-Based Leadership, to provide direct care nurses opportunities for leadership in educating their unit colleagues. Magnet re-designation brings about challenges including: education of nursing personnel, institute staff, patients and families; dissemination of knowledge to all patient care areas; empowering the direct care nurse to collect data, and representation of each patient care area integrated in the Magnet document.

**Purpose:** The purpose of this project is to sanction direct care nurse leaders to disseminate nursing knowledge while meeting the standards of nursing practice.

**Interventions:** The Institute's Magnet Coordinator requests a volunteer from each nursing area to lead their clinical units towards achieving Magnet re-designation. The Coordinator educates nursing personnel through in-services as well as meetings for Magnet Champions. Educating the Champions permit the dissemination of needed information to their colleagues in preparation for the documentation and the ANCC site visit. Magnet Champions undertake the project of representing their units through presentations. Staff members from nursing units are engaged by the Champions to share thoughts and input regarding the creativity of the unit presentation and how it would best represent their area of patient care. These practices are implemented by the Magnet Coordinator towards the direct care nurses who volunteer as Magnet Champions to ensure a successful initiative for Magnet re-designation.

**Evaluation:** This process is evaluated by an increase in attendance to unit meetings and the generation of new knowledge and innovations. Measurable outcomes are demonstrated by Press Ganey, and NDNQI unit scores.

**Discussion:** Fostering collaborations by building trust and facilitating relationships is part of empowering nurses to provide optimum patient care. This practice allows freedom of choice to the oncology nursing team and in turn gives the team ownership of the project and therefore accountability of the projects success. Allowing the direct care nurse to direct their unit towards nursing excellence ensures autonomy of oncology nursing practice and the creation of direct care nursing leaders.

### 135341 (Poster)

**PILOT PROGRAM: 8-WEEK FITNESS FRENZY.** Krista Moore, RN, BSN, OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Amy Rettig, RN, MSN, MALM, ACNS-BC, CBCN®, OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Ashley Harris, MS, RD, LD, OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Karen Hock, PT, MS, CLT-LANA, OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Misty Nichols, MS, RD, LD,



OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio

**Significance and Background:** Regular physical activity reduces the risk of developing or dying from the leading causes of illness in the United States. Oncology nursing is a calling that exposes the nurse to physical, emotional, spiritual, and intellectual demands. Regular physical activity improves health in the following ways: reduces feelings of depression and anxiety; enhances mental clarity; and promotes psychological well-being. By participating in physical activity programs, nurses become role models for healthy living and in turn “practice what they preach.”

**Purpose:** Relationship-Based Care, a model of caring, guides nursing to create a caring and healing environment by “Caring for Colleagues” and “Caring for Self”, to best care for our patients. Participants in the 8-Week Fitness Frenzy will care for self through a commitment to 10,000 steps a day.

**Interventions:** The 8-Week Fitness Frenzy was an individual program for nurses to count their steps each day—not exclusive to work time. Tools for the program included: pedometers; a step-tracking calendar; a step conversion chart; a guide to the program with frequently asked questions; and information about incentives for insurance purposes. Weekly motivational emails were sent to the participants with suggestions for physical activities. At the end of the eight weeks, participants celebrated together with healthy snacks and fitness stories.

**Evaluation:** The goal of the program was 500,000 steps per participant in an eight week program. Secondary goals included having 50 participants and receiving positive feedback. A total of 61 staff participated in the program logging 7, 498,752 steps. Verbal feedback was positive and included statements like, “I really liked the short time frame and measuring steps is easy.”

**Discussion:** Oncology nursing demands caring for self, both psychologically and physically, to best care for our patients. Providing fitness activities for nurses in this setting can meet those demands. The eight week format was well received and measuring activity through steps was easy. Incorporating nutritional information and an online accessible tracking method were suggested for the next iteration. Future program measures may include: decreased illness time use; decreased burnout and compassion fatigue; and increased patient satisfaction.

### 135366 (Poster)

**PRIMARY NURSING IN AN AMBULATORY INFUSION UNIT.** Amy Rettig, MSN, MALM, RN, ACNS-BC, CBCN®, The OSUCCC-The James, Columbus, Ohio; Kathleen Fowler, BSN, RN, The OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Abigail Dupiano, BSN, RN, OCN®, The OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Kelly McDowell, CQE, SSG, The OSUCCC-The James, Columbus, Ohio; Keri Mast, BSN, RN, OCN®, The OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Lea Eldridge, RN, OCN®, The OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Nicole Muscari, BSN, RN, OCN®, The OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio

**Significance and Background:** Oncology treatment is becoming increasingly personalized – down to the genome. In this paradigm, the needs of the patient become more specific. Added to this is the patient that is savvy to nursing care and staffing issues. Primary Nursing establishes the therapeutic relationship between a nurse and a patient/family across the continuum of care, including the ambulatory infusion unit. Personalization

and patient/family centered plans and goals are enriched. Satisfaction is improved.

**Purpose:** The caring model, Relationship-Based Care, promotes strong professional nursing practice by establishing a Primary Nursing care delivery system. The focus is the nurse-patient/family relationship which strengthens accountability and facilitates involvement of the patient/family in care planning/evaluation.

**Interventions:** A specific work group of oncology nurses was formed to develop and implement this practice change. Relationship-Based Care principles of I2E2, a project planning method, were utilized. Primary Nursing was customized to the patient population of the infusion unit. Scripting and creative teaching aids were developed to assist with implementation and sustainment. Electronic medical record documentation reminders were provided to all staff. Scheduling processes were modified to match daily primary nurse assignments with the patient/family. Callback guidelines were established and multi-clinic hurdles were employed to best navigate patients.

**Evaluation:** Monthly audits were performed to measure: the number of patients with a Primary Nurse; the number of patients assigned to their Primary Nurse; and the patient’s recognition of the contribution of the Primary Nurse. Up to 50% of patients with a Primary Nurse were assigned to their primary nurse on any given encounter. Patient/family responses have been positive with statements like: “My Primary Nurse keeps track of my care even if she is not assigned to me every time.”

**Discussion:** Establishing a therapeutic relationship in an oncology setting is critical with personalized, targeted therapy. Implementing our infusion unit Primary Nursing care delivery system affords the patients/families with a resource person who follows their care throughout the continuum. Trust is built and navigation is enhanced. The Primary Nursing model is an ongoing process improvement endeavor with future attention on staffing models and high acuity.

### 135395 (Poster)

**BUILDING A CULTURE OF SERVICE; CREATING A CUSTOMER SERVICE PARADIGM FOR THE PATIENT EXPERIENCE AT THE AMBULATORY CARE SETTING.** German Rodriguez, MSN, RN, New York University Langone Medical Center, New York, New York; Joan Scagliola, MSN, RN, New York University Langone Medical Center, New York, New York; James E. Loos, CPA, CGMA, New York University Langone Medical Center, New York, New York; Michael J. Zeller, MPS, New York University Langone Medical Center, New York, New York

**Significance and Background:** At this NCI designated Clinical Cancer Center we serve approximately 750 patient visits per day. Located in an urban area our facility offers a combination of services which include: infusion services, radiation therapy, radiology, breast imaging procedures and disease specific consultations for medical and surgical oncology. A group of nursing and administrative leaders were challenged with improving the patient experience at our CCC and shifting patient satisfaction scores from good to excellent.

**Purpose:** The purpose of this “Customer Experience” team was to promote best practices when creating a patient-focused experience. We created a scripted vocabulary that is used by staff at all levels and across all departments when dealing with our customers. Cost effective opportunities easy to implement were identified while raising employees awareness of our unified focus; the patient experience.

**Interventions:** The team reviewed literature on customer service best practices, ran focus groups and conducted patient experience observations in various clinical areas. We conducted interviews with leadership, patients and staff members. We

analyzed Press Ganey® survey results, managers attended team building and brain storming sessions. Our customer experience program was instituted in spring 2011. A culture of living “The Frame”, a conceptual model based on patient positive comments was born.

**Evaluation:** The evaluation of the program started fall 2011. We revamped our employee orientation program and included exercises focusing on the patient experience. We established three initial standards: elevator etiquette, telephone etiquette, and the wait experience. An employee rewards program to recognize and reinforce our culture of creating the best patient experience was instituted. While our patient satisfaction scores have increased, they still show some overall fluctuation in certain areas. This presentation will describe the collaborative efforts of the team and results of ongoing measurement of the impact of this new program.

**Discussion:** Nurses are actively participating in patient satisfaction activities. In today’s health care system patients have the option to choose a preferred health care provider(s). A satisfied patient will exhibit better outcomes during their trajectory of care. Oncology nurses need to positively influence the patient experience and adapt to rapid changes while living in the patient’s shoes when delivering care.

### 135414 (Poster)

**DEVELOPING A NURSING INTERNSHIP PROGRAM FOR AMBULATORY INFUSION CLINICS.** Penny Moore, MSN, RN, OCN®, The James Cancer Hospital and Solove Research Institute, Columbus, Ohio; Amy Singer, MSN, RN, The James Cancer Hospital and Solove Research Institute, Columbus, Ohio; Annette Sawman, MSN, RN, The James Cancer Hospital and Solove Research Institute, Columbus, Ohio; Kris Kipp, MSN, RN, NE-BC, The James Cancer Hospital and Solove Research Institute, Columbus, Ohio

**Significance and Background:** The shift of chemotherapy administration from inpatient to ambulatory infusion clinics over the last twenty years has led to an increased need for skilled oncology nurses. This mid-west comprehensive cancer center has seen an increase in the number of their ambulatory infusion clinics and will be staffing a new cancer center with triple the number of infusion chairs by late 2014. Many experienced senior nurses currently working in ambulatory infusion clinics will be retiring creating a potential nursing shortage for ambulatory infusion.

**Purpose:** This mid-west comprehensive cancer center has an established successful sixteen week inpatient internship program. There was a desire to evaluate the feasibility of having new nursing interns in the ambulatory infusion oncology clinic. The program would be piloted in a disease specific infusion clinic with a senior experienced oncology nursing staff.

**Interventions:** A task force was formed to implement a pilot internship in the ambulatory infusion clinic. A query was done with other comprehensive cancer centers to determine previous experience by others with an ambulatory infusion intern program. Intern candidates were evaluated to determine their interest in ambulatory infusion. Infusion nurses participated in the intern interview process. Infusion nurses, pharmacists, physicians, clinic nurses and nurse practitioners had been prepped regarding the internship to promote acceptance and a positive environment for the interns. Preceptors were carefully selected to promote a positive successful internship. Intern experiences included observations on inpatient units, operating room, pharmacy, medical oncology clinics, and other ambulatory infusion clinics. Weekly meetings were held with the intern, preceptor, educator, and nurse manager to evaluate progress and provide support. The internship was successfully completed after 18 weeks.

**Evaluation:** Two interns successfully completed the internship in ambulatory infusion. Eighteen months later an additional four interns successfully on-boarded in different ambulatory infusion locations. The two original interns have excelled in their roles; serving as unit council chair, charge nurse, and pursuing clinical ladder advancement.

**Discussion:** Ambulatory oncology infusion is an area of growth with a need for recruitment of nurses. Ambulatory infusion internships can be successful. Interest can be generated by collaborating with nursing programs to place nursing students in the ambulatory infusion clinics.

### 135558 (Poster)

**IMPROVING ACCESS TO QUALITY CANCER CARE: IMPLEMENTATION OF A NURSE PRACTITIONER PRACTICE MODEL FOR FACILITATING NEW BREAST SURGERY PATIENT VISITS.** Nancy Houlihan, MA, RN, AOCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Karen Hammerle, MPA, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** At this large NCI designated comprehensive cancer center, new visit appointments are scheduled through a centralized call center. Review of breast surgery service new visit trends identified a significant number of callers seeking an appointment for a new finding. One month’s calls revealed that approximately 40 callers of this type never made an appointment; surgeon availability was one factor. Nurse practitioners play an essential role in breast cancer care delivery at our center. Could NPs fill this need?

**Purpose:** We conducted a pilot to determine feasibility of using NPs rather than surgeons to perform new visits for undiagnosed patients with outside positive imaging; outcome measures included evaluation of space and staffing needs, revenues, NP visit components, and patient acceptance and satisfaction.

**Interventions:** During a one month pilot in March 2012, patients were identified according to set criteria and offered an NP appointment within 48 hours. Two NPs from our ambulatory surgical service saw patients by appointment, which included a history and focused physical exam and review and submission of outside imaging to a breast radiologist. Results and a plan were discussed with patient by phone. Patients with confirmed findings were scheduled for a biopsy; if positive they were sent to a surgeon. High risk patients were scheduled for repeat NP visit and imaging in 6 months according to guidelines.

**Evaluation:** 21 patients were seen in the pilot. All but 2 required additional imaging and/or biopsy; 6 breast cancers were identified and patients had surgery; 8 required a 6 month NP follow up and imaging. Visits were billed at level 3; collection rate was high. 80% of participants responded to a satisfaction survey; 100% were satisfied or highly satisfied with overall experience. As a result of pilot, a regular clinic was established with a full time NP.

**Discussion:** Nurse practitioners have a long history of improving access to quality health care. Our experience utilizing NPs to facilitate the process from positive finding to timely diagnosis and management demonstrates an innovative way to improve care delivery in our community.

### 136035 (Poster)

**IMPLEMENTATION OF NURSE FACILITATOR ROLE: COORDINATING CARE ACROSS THE CONTINUUM FOR CANCER PATIENTS—BLENDING ROLES TO OPTIMIZE PATIENT CARE.** Stephanie McEaney, RN, MSN, GNP, Memorial Sloan-Kettering Cancer Center, New York, New York; Karshook Wu, BSN, Memorial Sloan-Kettering Cancer Center, New York, New York; Natasha Ramrup, RN, MSN,

OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Anna Schloms Schloms, RN, MA, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** At this NCI-designated cancer center, our medical staff rotates every two to four weeks. In an effort to optimize patient care, the facilitator role was created to provide the medical staff with the nursing expertise needed in identifying the issues unique to our patient population.

**Purpose:** Our main purpose in creating this multifaceted role was to support staff in integrating and coordinating the delivery of compassionate and knowledgeable care. The facilitator is the central pivot needed to enhance patient care between all services. The role encompasses the clinical nurse, clinical nurse specialist, administrator, case manager, educator, social worker and consultant.

**Interventions:** As a focal point of contact, the nurse facilitator rounds with the medical team daily, and involves the primary nurse in the discussion and implementation of the plan of care. The facilitator is the advocate for the patient, assisting in the resolution of clinical issues and identifying potential medical concerns. The facilitator consistently communicates with all disciplines throughout the shift to assist in optimizing the plan of care.

**Evaluation:** While serving as a clinical expert, the facilitator not only acts as a nurse-physician liaison, but ensures the unit functions seamlessly by also assuming the role of charge nurse to facilitate continuity of care. This versatile role entails acting as a resource to all staff by assisting with critical events, collaborating with case managers and discharge pharmacists, assisting with admissions and discharges and ensuring patient education is completed prior to discharge.

**Discussion:** Our facilitator role has been in effect for over three years and has evolved into a vital role which bridges the gap between all disciplines. The implementation of the nurse facilitator is a unique and integral part of the delivery of care. They transform the acute care delivery model toward a more collaborative and safe approach by providing an environment for effective relationship based nursing care. This has proven to be a successful role and should be adopted to all DMTs.

### 136061 (Poster)

**IT'S ALL ABOUT THE CULTURE—CREATING A CULTURE OF INQUIRY AND PASSION FOR QUALITY IMPROVEMENT.** Jennifer Devine, RN, BSN, Lehigh Valley Health Network, Allentown, Pennsylvania; Tiffany Lopez, RN, BSN, Lehigh Valley Health Network, Allentown, Pennsylvania

**Significance and Background:** Reimbursement changes from the Centers for Medicare and Medicaid Services and value based purchasing systems have made performance improvement for oncology services more crucial than ever. A voluminous amount of data collection is the norm within acute care environments. However, robust analysis of real time, actionable data and subsequent development of action plans that truly enhance oncology quality outcomes are often lacking.

**Purpose:** This presentation describes a successful Performance Improvement (PI) model within an academic, community Magnet™ hospital, detailing actions and outcomes for a 30 bed medical-surgical oncology unit. The model includes four key elements: prioritization and associated exclusivity; transparency of data; non-hierarchical interprofessional partnering; and, ownership, accountability and incentivization. Structural components are: Chief Quality Officer Rounds; Quality Boards; and the Network Priority and Performance Improvement Council (NPPIC).

**Interventions:** Chief Quality Officer Rounds are conducted daily by the unit-based nurse educator to facilitate real-time learning. The educator, focusing on one prioritized quality is-

sue, assesses each patient and educates interprofessional team members regarding opportunities. All staff is held accountable for improvements via incentivized goals tied to annual performance appraisal. Quality boards in public view display outcome indicators. Compared to traditional executive PI oversight bodies, NPPIC includes senior clinical leaders, as well as patient care unit nurse managers and medical directors. In addition to meeting attendance, nurse managers and medical directors are responsible to co-lead individual project improvement teams, composed of front line, direct care stakeholders. Project goals often are tied to team members' annual goals, incentivized in association with merit pay and financial remuneration. At every NPPIC meeting, key performance metrics are reviewed; work group co-leaders of projects not meeting metrics offer status reports and seek advisory counsel and support from members.

**Evaluation:** Over a three year period, the oncology unit has achieved a steady decline in hospital acquired pressure ulcers, restraints, medication errors, catheter associated urinary tract infections and C-diff rates.

**Discussion:** Take home learnings will allow oncology nurses practicing in varied settings to create a culture of inquiry and passion for quality improvement. Practice implications include pragmatic action items to enhance oncology quality outcomes.

### 136091 (Poster)

**QUALITY IMPROVEMENT IN THE CLINICAL TRIALS SETTING: HOW ONCOLOGY NURSES CAN LEAD THE WAY TO INCREASE ACCRUAL.** Annette Galassi, RN, MA, National Cancer Institute, Bethesda, Maryland; Margo Michaels, MPH, ENACCT, Bethesda, Maryland; Judith Blanchard, MS, ENACCT, Bethesda, Maryland; Gina Pokrashevsky, BS, ENACCT, Bethesda, Maryland

**Significance and Background:** Participation in and access to cancer treatment clinical trials (CCTs) are key measures for delivery of quality cancer care. Yet adult trial participation in the U.S. remains under 3%, with even lower participation rates among minority groups and people over 65. Oncology nurses play a critical role in identifying practical, evidence-based approaches to maximize the efficiency of CCT recruitment, accrual, and retention efforts. The National Cancer Clinical Trials Pilot Breakthrough Collaborative (NCCTBC), based on the Institute for Healthcare Improvement (IHI) quality improvement model, was the first-ever national effort to identify such best practices in a real world setting.

**Purpose:** The purpose of this pilot was to test the feasibility of applying a proven quality improvement process to CCT accrual in order to help more patients access quality cancer care.

**Interventions:** Oncology nurses spearheaded teams at five community oncology practices. Teams at each practice designed, tested and implemented small scale measurable changes to both internal system and community outreach practices. Teams collaborated to share challenges and successes and were provided coaching and technical assistance by national experts.

**Evaluation:** To assess the impact of the changes being made in each practice on overall accrual, and in particular for ethnic/racial minorities and those over 65, ENACCT developed six core measures around both process and outcomes. Teams collected and reported data for each of the measures on a monthly basis.

**Discussion:** Over the course of the pilot, over 40 distinct changes were tested and 10 were implemented as new practices and procedures. Although the ability to assess increases in accrual was limited due to a 10-month time frame, many improvements around accrual processes were made. Improvements were made around data capture, screening, selection processes for new studies to better match population needs, internal and community awareness of CCTs and enhanced communication and collaboration across and within departments. Teams noted that the Collaborative methodology challenges them to look at

their programs, evaluate their strengths and weaknesses and prioritize areas for improvement in a systematic way. Results affirm the feasibility of applying this model to address persistently low accrual needs.

### 136139 (Poster)

**AN EVIDENCED-BASED APPROACH TO TRIAGE ONCOLOGIC EMERGENCIES AND TREATMENT RELATED SIDE-EFFECTS.** Catherine Licitra, RN, MA, Memorial Sloan-Kettering, New York, New York; Janine Kennedy, RN, MA, OCN®, Memorial Sloan-Kettering, New York, New York

**Significance and Background:** The Urgent Care Center (UCC) of a comprehensive cancer center delivers emergency care to oncology patients. This unit averages 24,000 annual patient visits, ranging from treatment-related side effects to oncologic emergencies. In 2011, it was recognized that the triage system provided limited data that was subjective and non-reproducible. The nurses needed a better mechanism to triage patients using an evidenced-based tool that balanced emergency interventions with oncology care.

**Purpose:** Historically, patients in the UCC were triaged using a three-tiered scale based on chief complaint. The majority of patients were classified as urgent, but nurses struggled to assign patients or verbalize the acuity of the care needed. The nursing leadership recognized a better triage scale would expedite patient care and flow.

**Interventions:** After a review of the evidence, the leadership and clinicians decided to follow ENA recommendations and implement the Emergency Severity Index (ESI). The ESI algorithm yields rapid, reproducible and clinically relevant classification of patients into 5 levels: Level 1 (most urgent) - Level 5 (least urgent). This tool provided a guide to triage oncologic patients' chief complaints by both acuity and resource needs. The ESI Implementation group reviewed common oncologic complaints and categorized them into one of the 5 levels. Patients were triaged based on chief complaint, vital signs, and oncologic history. The experienced triage nurse used ones' knowledge and expertise, with the ESI levels assisting them to confirm acuity and resource needs. All RNs were trained and reviewed patient case scenarios to establish ESI competency.

**Evaluation:** In 2012, monthly data was captured to identify the case mix of patients that arrived. On average, 20% of patients are classified as ESI II, thus requiring immediate interventions and increased unit resources. 73% of patients are classified as ESI III, meaning longer lengths of stay and increased resource consumption.

**Discussion:** Future plans are to monitor the ESI data compared to the oncologic case mix seen in the UCC. Based on the high levels of acuity and resource consumption needed to care for these patients, this data would provide the foundation to increase staffing and space to improve care delivery and flow for the oncology patient.

### 136184 (Poster)

**"I WANT TO WORK THERE!!"—CHANGING THE CULTURE AND SPIRIT WITHIN A NURSING UNIT.** Maribeth Wooldridge-King, MS, RN, AOCNS®, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** Nurse retention, nurse satisfaction and patient satisfaction scores are well established benchmarks of a unit's culture and spirit. In 2010, this author became the nurse manager of two chemotherapy units composed of 36 treatment chairs/beds, treating 130-150 patients/day and staffed by one cost center of 29.0 RN FTE's. Geographically located on two different floors, with a history of having 10 nurse managers over the preceding eleven years and a low

nurse retention rate, these units had the reputation of being the "least desirable" nursing units in which to work.

**Purpose:** How does one attract and retain high quality candidates in an environment that is fast paced with a high volume of high acuity patients being treated daily with sophisticated chemotherapy and biotherapy regimens and protocols? How does one change the culture and spirit with such challenging variables? The author will describe the steps taken to successfully achieve such outcomes.

**Interventions:** With shared governance as the operating construct, the initial effort was to set and communicate the vision. To reach that vision, we needed to be clear about our values. With the vision and values identified, this manager maintained a high visibility within the two units as well as articulating the "new spirit" in all conversations throughout the institution. Some of the specific changes included: acquisition of environmental resources, infrastructure development, personnel development within the clinical ladder, and role articulation – all infused with joy and enthusiasm for our work.

**Evaluation:** Over the course of next 30 months, the retention rate stabilized at 90%, the units self-nominated/won a "Best Nursing Team" award, achieved high nurse and patient satisfaction scores and now have a wait list for an RN position on the unit.

**Discussion:** Recruitment and orientation of a nurse is expensive and time-consuming. Creating a work environment that empowers the nurse supports retention and lessens on-boarding costs.

### 136187 (Poster)

**IMPLEMENTING AN EDUCATION AND COMMUNITY OUTREACH PROGRAM IN A NATIONAL CANCER INSTITUTE (NCI) DESIGNATED FACILITY: LESSONS LEARNED.**

Maria Grabowski, MSN, RN, OCN®, UT Southwestern Simmons Cancer Center, Dallas, Texas; Michele Yates, BS, CHES, UT Southwestern Simmons Cancer Center, Dallas, Texas; Stephanie Clayton, MHSM, CMPE, UT Southwestern Simmons Cancer Center, Dallas, Texas

**Significance and Background:** Critical research takes place daily to improve the needs of cancer patients. This drives all facets of the patient care experience from prevention through survivorship. Helping patients and communities understand how research translates to better health is one of the many tasks of a NCI-designated education and outreach effort. The UT Southwestern Simmons Cancer Center received NCI designation in August 2010, and the Office of Patient and Public Education and Community Outreach was established in November 2011. Here we describe key challenges and successes, and share practical lessons from the first year of program operation.

**Purpose:** According to Orem's conceptual framework of nursing, people should be self-reliant and responsible for their own care and that of others they care for. Communication is to be personalized, allowing for the nursing interaction to support therapeutic self-care. Our cancer information service emphasizes individualized nursing care through tailored information. New programs are implemented to address specific facets of the NCI mission.

**Interventions:** Community Outreach builds institutional presence by participation in community events, with opportunities for one-on-one interactions. Cancer prevention and early detection are often the primary goals. Cancer Information Line is a telephone service, staffed during working hours by Oncology Certified Nurses, which supports members of the community with cancer information not related to specific patient calls. Success of this service requires ongoing marketing efforts to promote program offering and access. Speakers Bureau supports community groups through interactions with expert

professionals. Programs must be carefully planned to best use the time of busy health professionals and deliver high impact presentations tailored to group needs. Early detection Lung Cancer CT Screening is provided as a service to at-risk individuals with significant smoking history. Availability is limited by lack of insurance reimbursement. Smoking Cessation has been implemented to support lung cancer prevention. Our initial target audience is hospital and university employees. Next steps include ease of scheduling through the electronic medical record.

**Evaluation:** These Center's programs have reached 2000 individuals in the first 12 months, with educational services provided in a caring individualized manner.

**Discussion:** Understanding the institution's focus and goals is key to establishing effective activities and sound outcomes.

### 136207 (Poster)

**REIGNING THE PASSION OF ONCOLOGY NURSING: ADDRESSING COMPASSION FATIGUE.** Janine Kennedy, RN, MA, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Catherine Licitra, RN, MA, Memorial Sloan-Kettering Cancer Center, New York, New York; Elise Morgan, RN, BSN, Memorial Sloan-Kettering Cancer Center, New York, New York; Mary Finalborgo, RN, BSN, MPH, Memorial Sloan-Kettering Cancer Center, New York, New York; Susan Concannon, RN, BSN, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** Compassion fatigue amongst oncology nurses was identified as an organizational priority based on staff satisfaction and engagement surveys. At the Urgent Care Center of a National Comprehensive Cancer Center, the nursing staff cares for acutely ill adult and pediatric oncology patients. Due to the large volume of 24,000 patient visits annually, the nurses expressed feelings of burnout, stress, dissatisfaction, and fatigue.

**Purpose:** The Nursing Practice Model of Relationship Based Care is the foundation of care delivery at our organization. In this model, the nursing staff is focused on providing exemplary patient and family centered care, while also trying to incorporate care of self. Staff verbalized that due to the increasing acuity, high volume, and emotional attachment, they felt as though there was never enough time to care for self. This was causing decreased productivity, increase in absenteeism, and less empathy and compassion. The nursing leadership recognized that these feelings of compassion fatigue needed to be addressed in order to improve the patient care experience.

**Interventions:** Based upon the results from the staff, the nursing leadership convened the UCC Compassion Fatigue workgroup. The nursing workgroup, along with Integrative Medicine and Nutrition Department, developed the Day of Rejuvenation for all nursing staff to attend. The goals of the day were to provide an outlet for reducing stress, educate staff on methods to refocus, and allow free time during the shift to care for self. The staff participated in massages, stress management classes, relaxation technique classes, chair yoga, and nutritious snacks with soothing music, all away from their patient care assignments.

**Evaluation:** After the Day of Rejuvenation, staff was sent a survey that addressed their initial concerns. 90% of staff felt that their levels of stress decreased after attending the various programs, thus improving morale and the care they provided to their patients.

**Discussion:** The majority of staff would like to see these programs continued monthly and have articulated an appreciation of the nursing leadership and organization in addressing compassion fatigue. As the demands on oncology nurses increases, organizations need to balance increasing patient care needs while providing protected time for nurses to care for self.

### 136251 (Podium)

**AUTONOMY IN ACTION: PREPARING FOR TOMORROW'S CHEMOTHERAPY SCHEDULE.** Maribeth Wooldridge-King, MS, RN, AOCNS®, Memorial Sloan-Kettering Cancer Center, New York, New York; Caroline Clark, BSN, RN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** The largest ambulatory facility within a major metropolitan campus of a comprehensive cancer center provides chemotherapy to 220-250 patients/day. Until 2011, the unit assignments and daily staffing adjustments were centralized and determined by a senior nurse working within the pharmacy department. Patient acuity and patient specific variables as well as individual nursing staff characteristics were not accounted for. Staff nurses were disengaged from a process that impacted daily practice and ultimately the patient experience. A new model was needed.

**Purpose:** Prior to implementing this change, it was essential to identify our values and beliefs. These included tenets such as:

- Patients should be treated by the staff most familiar with them and their respective regimens
- RN's are autonomous professionals responsible for their own practice and to their own unit.

Our new model needed to incorporate these beliefs and support a model of nurse autonomy through a shared decision making process

**Interventions:** A daily charge nurse meeting to review the next day's treatment volume and mix as well as nurse staffing was conceptualized. A representative from each chemotherapy unit joined together to develop the new process and format. Ground rules for participation in the daily meeting and instructions for completing the "Counts" form were outlined. Representatives solicited feedback from peers and reported back at planning meetings. The new process encouraged open communication and trust between units and gave the chemotherapy nurses the authority and autonomy to make decisions and take an active role in their unit's daily operations.

**Evaluation:** After four months, a survey was conducted to determine the effectiveness of this new approach to managing our chemotherapy units. The results were shared at a Chemotherapy Town Hall meeting and subsequent recommendations implemented.

**Discussion:** Autonomy and shared decision making effected a positive change for our patients and nursing staff. This process is applicable to one unit or several units working in concert.

### 136347 (Poster)

**INCREASING PATIENT SATISFACTION BY IMPROVING CARING COMMUNICATION IN INFUSION THERAPY.** Todd Rowe, RN, BSN, The University of Texas MD Anderson Cancer Center, Houston, Texas; Rebecca Dela Cruz, MSN, RN, CRNI, The University of Texas MD Anderson Cancer Center, Houston, Texas; Elizabeth Natividad, BSN, RN, CRNI, The University of Texas MD Anderson Cancer Center, Houston, Texas; Susan Guerrero, MSN, RN, CRNI, The University of Texas MD Anderson Cancer Center, Houston, Texas

**Significance and Background:** Oncology patients experience heightened anxiety during hospital visits due to factors including a multitude of scheduled tests and appointments needed for their care. Nurses are at the forefront of patient care, have an essential role in providing a caring and personal experience, in order to meet the emotional needs of patients undergoing oncologic treatments. A direct reflection of patient experiences are reflected in patient satisfaction surveys results. With a recent increase in patient volumes combined with flat staffing plan,

decreased patient satisfaction scores were found with care provided by the Infusion Therapy Team (ITT), with the common comment of staff being task oriented and lacking compassion.

**Purpose:** The purpose of the project was to improve ITT staff work communication behavior strategies to reflect compassion with patients. Thus adapting a caring conceptual model where nurses both observe and practice new strategies and behaviors to assist with integrating caring communication skills was key.

**Interventions:** The Language of Caring (LOC) is a comprehensive, long-term education program designed to produce sustainable behavior change. We utilized the nine LOC video teaching modules and interactive teaching presentations within the program with the staff. The modules were presented on a monthly basis to provide the staff time to practice each skill before moving to the next level and culminating with the fusion of all modules and skills at the end of the program. The modules activities consist of viewing instructional video on caring communication followed by scenario review, observation, role playing and discussion to reinforce learning and sustain the new behaviors.

**Evaluation:** Results from patient satisfaction survey were monitored three months prior to the initiation of the modules with the staff as baseline, every third month during the LOC course implementation, and three months after the modules were completed. The evaluation reflected significant improvement in patient satisfaction scores from the previous scores prior to implementation of the LOC modules.

**Discussion:** Implementation of the LOC strategies improved ITT nursing staff interaction with patients resulting to increased patient's positive perception of their care experience reflected in improved patient satisfaction survey results.

#### 136429 (Poster)

**EXPERIENCED NON-ONCOLOGY ADMINISTRATOR: SUCCESSFUL TRANSITION TO ONCOLOGY.** Patricia Aldredge, MSN, RN, ANP-BC, Henrico Doctors' Hospital, Richmond, Virginia

**Significance and Background:** As the oncology population grows with increased survival but decreasing reimbursement and available resources, hospitals are looking to meet administrative needs with already established leaders. As an experienced departmental director and Advanced Practice Nurse, one can transition into the subspecialty of oncology after careful introspection into ones' personal and professional attributes and formulate a plan to meet the benchmarks set forth in oncology and the standards of patient care.

**Purpose:** An Advance Practice Nurse can translate their strong clinical knowledge of symptom management and chronic disease into a framework for developing the necessary oncology expertise. Proficiency of leadership skills from past management positions, resulted in the early identification of the differences in the oncology business. These assessments resulted in a successful transition plan into the Cancer Center Director position in a community hospital.

**Interventions:** Utilization of Oncology Nursing Society (ONS) Leadership competencies, the hospital job description, and Cancer Center strategic plan, served as the framework for developing short and long term educational goals. Through self assessment of strengths and weaknesses, and gaps in knowledge and action plan with measurable goals was created with a timeline of one year. This included identification of professional organizations to join, varies literature reviews, learning opportunities and oncology mentors.

**Evaluation:** Evaluation was in a variety of forms dependent upon the goal. These included but not limited to: successful completion of CME online tutorials, ONS chemotherapy/biotherapy certification, membership in National and Regional professional organizations, successful hospital evaluation, contract renewal and plans to sit for AONP in September 2013.

**Discussion:** Advance Practice Nurses are often requested to participate on management teams without formalized preparation. The assessment and process described can be applied in any situation requiring further professional and/or content expertise development.

#### 136443 (Poster)

**DEVELOPING A TOOL TO ENHANCE AND FACILITATE COMMUNICATION BETWEEN HOSPITAL DEPARTMENTS AND ENSURING ADEQUATE NURSE TO PATIENT RATIOS: CREATION OF AN ELECTRONIC INFUSION CENTER DATA BASED SCHEDULING SYSTEM.** Wendy Hendrick, BSN, RN, OCN®, Henrico Doctors' Hospital, Richmond, Virginia; E. Reynell Farrar, BSN, RN, OCN®, Henrico Doctors' Hospital, Richmond, Virginia; Susan McCarthy, BSN, RN, OCN®, Parham Doctors' Hospital, Richmond, Virginia; Kathleen Dunn, BSN, RN, OCN®, Parham Doctors' Hospital, Richmond, Virginia; Nancy Civils, BSN, RN, OCN®, Henrico Doctors' Hospital, Richmond, Virginia; Stephany Schrimsher, CAP, Henrico Doctors' Hospital, Richmond, Virginia; Donn Moore Chip Coutts, BS, HCA ITandS Capital Division, Richmond, Virginia

**Significance and Background:** Outpatient Infusion therapy can be resource intense, time consuming, and complex due to the large variation in treatments, patient acuity, and nursing care needs. Adequately aligning resources, staff, physical space, and care needs in 3 busy infusion centers can be challenging yet critically necessary. The nurse to patient ratio is a delicate balance. The manager is often called by others seeking successful management approaches. A multidisciplinary nursing team from the infusion centers identified the need for an electronic infusion center data based scheduling system (EICDBSS) in community based outpatient infusion centers located across 15 miles and part of one hospital.

**Purpose:** Develop a tool to enhance and facilitate communication between admitting, pharmacy and infusion centers across all sites. Ensure adequate nurse to patient ratios.

**Interventions:** Three infusion centers participated in a Kaizen Project to review current scheduling process beginning with patient experiences from scheduling through discharge. Discussions with infusion, pharmacy and admitting directors provided input. Areas identified of redundancy, lag times, and breaks in communications impacting the scheduling process.

**Evaluation:** The lack of consistency and ineffective communications between hospital departments caused the majority of the delays in providing the patient care. An EICDBSS was developed in collaboration with IT incorporating infusion, pharmacy and admitting input. Templates for each infusion center were developed. An interface was built so staff can toggle between and review the number of patients registered, number of visits are scheduled and medications ordered. A communication tool inside the EICDBSS allows staff to view the staffing pattern and nurses scheduled. EICDBSS helps nurses to identify patient openings that match the treatment lengths.

**Discussion:** The EICDBSS led to a more efficient communication process. It linked all necessary departments to one scheduling system to access patient care information. As we enhance communication with one another, it has led to more collaborative, efficient and safe patient care along with patient, physician, and nursing satisfaction. Nurses evaluate processes, patient volumes, treatment times, and delays in treatment quarterly. This allows further implementation of multidisciplinary nursing team streamlining of care and revision.

#### 136491 (Podium)

**EMERGENCY EVACUATION OF AN ONCOLOGY UNIT DURING HURRICANE SANDY: THIS WAS NOT A DRILL.**

Roseanne DeRiso, MA, RN, OCN®, NYU Langone Medical Center, New York, New York; Frances Cartwright, PhD, RN, AOCN®, NYU Langone Medical Center, New York, New York; Katherine Thewes, BSN, RN, OCN®, CHPN, NYU Langone Medical Center, New York, New York; Michael Wuckovich, BSN, RN, NYU Langone Medical Center, New York, New York

**Significance and Background:** In October 2012, a hurricane was forecast for the east coast. Our Medical Center's Command/Management System (ICMS), which facilitates operations in times of disaster, was activated days in advance. Based on available data, the decision was made to prepare and shelter in place. The storm surge hit New York City: flooding streets, tunnels, and subway lines, causing an unanticipated power outage to a large portion of the city. Despite established backup systems and emergency plans, which were repeatedly tested, the storm exceeded all forecasts; water flooded the building resulting in loss of power, telephones, and computers necessitating the evacuation to neighboring hospitals.

**Purpose:** To describe how nurses led a collaborative effort and safely evacuated oncology patients down 16 flights of stairs without lights, elevators, computers, telephones, while carrying equipment necessary for monitoring and support.

**Interventions:** Before the storm approached, interdisciplinary teams evaluated patients and discharged many.

Those remaining were cohorted in areas where adequate power and protective isolation were available. Nurses followed procedures for blackout and computer down time; including the printing of essential information from the electronic medical record (EMR). Once power and communication systems failed, nurses and other interdisciplinary team members safely evacuated patients, using medical sleds down dark stairwells to waiting ambulances. Immune compromised patients were protected with N95 respirator masks. Patients receiving chemotherapy, bone marrow transplant, and other select patients were accompanied by nurses to the receiving hospital. Hand-off for others patients were accomplished centrally from the ICMS using the summaries copied earlier from the EMR.

**Evaluation:** A total of 26 patients, including one autologous transplant patient and several patients with infusing chemotherapy, were transported to a neighboring hospital without interruption of care. Staff relied on emotional intelligence, expert clinical judgment, and prior disaster training to accomplish this unprecedented task.

**Discussion:** Disaster drills are vital to developing expert judgment, decision making abilities, and creating a team that remains calm under pressure. Nurses, as first responders, lead in times of disaster. The Herculean efforts of this team are an inspiration, demonstrating what can be accomplished when everyone is well trained and focused on the same goal, patient safety.

### 136492 (Poster)

#### GET CERTIFIED! CERTIFICATION FAIR FOR ONCOLOGY NURSES EDUCATES AND PROMOTES CERTIFICATION.

Lisa Smith, RN, MS, AOCN®, CNS, Riverside Methodist Hospital, Columbus, Ohio; Elizabeth D. Weaver, RN, MSN, OCN®, Riverside Methodist Hospital, Columbus, Ohio; Lisa Ahonen, RN, BSN, Riverside Methodist Hospital, Columbus, Ohio; Elizabeth Roth, RN, BSN, OCN®, Riverside Methodist Hospital, Columbus, Ohio; Kathleen Grannan, RN, BSN, Riverside Methodist Hospital, Columbus, Ohio; Pauline Bauer, RN, BSN, OCN®, CBCN®, Riverside Methodist Hospital, Columbus, Ohio

**Significance and Background:** Certification is essential to assure competent care. The Commission on Cancer Accreditation

Program mandates that oncology nursing care is provided by nurses with specialized knowledge and skills. A key component of Magnet certification involves certification of nurses. Reasons cited in the literature as barriers to certification include lack of perceived benefit, costs, and fear of failure. To increase the number of certified RNs, strategies need to address perceived and actual barriers and include suggested interventions to overcome barriers.

**Purpose:** The strategy chosen to address barriers and achieve the goal of increasing certified RNs was the development and implementation of an educational program: the Certification Fair for Oncology Nurses. Lewin's Change Theory was used as the theoretical framework.

**Interventions:** Barriers were assessed by reviewing the literature and conducting an informal survey of inpatient, Infusion Center, and nurse navigator RNs. Based on these findings, representatives from outpatient and inpatient oncology areas developed educational stations to address barriers to certification. The stations included information about benefits of certification, eligibility, costs, exam content, scholarships, and test taking skills. Posters, handouts, and resource RNs were available to answer questions.

**Evaluation:** The project was evaluated by: 1) program evaluation, and 2) evaluation of the impact of the program on the number of certified RNs. Program evaluations were overwhelmingly positive. To evaluate the impact of the fair on the number of certified RNs, a baseline number of certified RNs was determined (n=32;42.5% of RNs working in oncology areas). The institution's Magnet goal was to increase certification by 2% each year. One year after the program, the total number certified RNs will be determined and compared to the goal for a 2% increase.

**Discussion:** Increasing certified RNs caring for oncology patients is imperative for competent patient care. However, perceived and actual barriers can exist to meeting this goal. Assessing barriers and developing an educational fair to overcome these barriers can be a successful tool to meet this goal.

### 136508 (Podium)

#### LET'S "HUDDLE" TOGETHER: A STRATEGY TO IMPROVE COMMUNICATION, COLLABORATION AND MAXIMIZE PATIENT SAFETY.

Natasha Ramrup, RN, MSN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Anna Schloms, RN, MSN, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** One of the Joint Commission National Patient Safety Goals is to "improve the effectiveness of communication among caregivers." Our 43 bed fast-paced Gastrointestinal Medical Oncology/Hepatopancreatobiliary Surgical Disease Management Team (DMT) implemented huddle as our communication initiative to address this goal. This collaborative process allows staff to stay abreast of activities on the unit. During huddle, the CNS disseminates important updates to staff. Council chairs are given the opportunity to provide brief updates and new policy and procedures are discussed. Huddle is also utilized to celebrate life events and announcements.

**Purpose:** Our DMT is dedicated to promoting and sustaining an organizational culture that is committed to improving communication thereby improving patient safety.

**Interventions:** Initially, huddle was met with resistance. With refinement of the process, however, staff enthusiastically embraced this new initiative. Huddle is now incorporated into the daily routine and is part of our unit's culture. The meeting is informal, time limited and coordinated by the Clinical Nurse Specialist or charge nurse. It is attended by all professional staff, ancillary staff, a unit assistant and building services staff. At the start of huddle, high acuity patients, discharges, procedural patients and potential problems are identified. Everyone is then

given the opportunity to briefly discuss their assignment. At this time, workload is assessed and adjustments are made accordingly. Resources are identified to assist with resolution of clinical issues. Huddle also serves as a vehicle for identifying patients who are at high risk for falls due to both medical issues and impulsiveness.

**Evaluation:** Patient safety is a priority for all healthcare institutions. The Institute for Healthcare Improvements recommends incorporating safety huddles into nursing practice. At the end of the day, the staff feels less overwhelmed. This initiative has also improved team work and morale, while decreasing stress, fatigue and potential “burn out.”

**Discussion:** Huddle has proven to be an effective forum for enhancing communication, collaboration and improving staff satisfaction. It provides the opportunity to streamline workflow on the unit, which optimizes patient care.

### 136646 (Poster)

**OUTPATIENT MEDICAL ONCOLOGY ACUITY GUIDELINES THROUGH ELECTRONIC REMOTE ACCESS TO PROJECT STAFFING RESOURCE ALLOCATION.** Shani Weber, BSN, RN, OCN®, UPMC Cancer Center, Pittsburgh, Pennsylvania; Amy Korinko, BSN, RN, OCN®, UPMC Cancer Center, Pittsburgh, Pennsylvania; Dan Powell, BSCS, UPMC Cancer Center, Pittsburgh, Pennsylvania; Cheryl Steele, MSN, MPM, RN, AOCN®, UPMC Cancer Center, Pittsburgh, Pennsylvania

**Significance and Background:** The University of Pittsburgh CancerCenter is a network of 25 outpatient medical oncology locations spanning 13 counties. Staffing is challenging given the physical distance between locations. The nurse managers need to access staffing schedules, treatment volumes, and acuity levels remotely to allocate staffing resources accurately. Acuity guidelines were needed to incorporate the complexity and length of patient treatments as well as other factors such as patient education to create the most accurate picture of nursing workload. Staffing ratios have been linked to patient safety outcomes.

**Purpose:** To develop outpatient medical oncology acuity guidelines to link with an established remote access electronic staffing calendar. The electronic solution allows nurse managers to accurately allocate staffing resources.

**Interventions:** The literature was reviewed to determine current information. The clinical leadership team met with the information technology (IT) professional to discuss the IT project scope and requirements. An interdisciplinary team of stakeholders was identified consisting of lead nurses, nurse managers, clinical director, IT professionals, and a quality improvement expert. The nurse managers identified the necessary components utilized when allocating staffing resources. The nurse managers and lead nurses collaborated to develop acuity guidelines. The focus was to develop objective guidelines which would be resistant to subjective interpretation.

**Evaluation:** Surveys were used to ascertain how user-friendly the web form was to enter acuity levels from the end-user perspective. A pilot was used to determine standardization and reliability to predict staff allocation several days in advance. The acuity guidelines demonstrated reliability better than the 10% goal that was set for allowable deviation from projected acuity levels. The combined location result was 1.7% deviation from the projected to the actual acuity levels. The deviation range was from a minimum of negative (-) 18 to a maximum of 37.5 acuity points.

**Discussion:** Establishing outpatient oncology acuity guidelines for the allocation of staffing resources contributes to the specialty body of knowledge (contributes to safety in the administration of antineoplastic agents). Utilization of acuity guidelines substantiates leadership allocation of staffing resources. Primary goals of leadership include patient safety and staff satisfaction resulting in retention of experienced nurses.

### 136667 (Poster)

**CAPTURING QUALITY METRICS THROUGH THE USE OF NURSING DOCUMENTATION IN AN OUTPATIENT INFUSION CENTER.** Tracy Coyne, MSN, RN, Vanderbilt-Ingram Cancer Center, Nashville, Tennessee; Leah Atwell, MSN, RN, OCN®, Vanderbilt-Ingram Cancer Center, Scottsdale, Arizona; Julia Cartwright, Nashville, Tennessee

**Significance and Background:** The outpatient infusion center was expanding in space, hours of operation and the shift of treatments originally administered inpatient to outpatient. Discussions with staff shared concerns surrounding appropriate nurse patient ratio especially with more complex treatment regimens and later infusions. During expansion, the route of administration many of the pre-medications changed from an intravenous route to oral route with thought that hypersensitivity reactions could increase but there was no mechanism to measure the true impact on nursing or events.

**Purpose:** Often practice changes are implemented without the mechanism to measure effectiveness or impact on nursing practice. Through the partnership with informatics, nursing documentation can be set up to capture events and metrics specific to nursing practice in an outpatient infusion area in an automatic report. Prior to implementation, events were captured through voluntary reporting or prevalence studies which may not capture all events or offer ability to measure practice changes. After the addition of infusion event options for nurses to select, events are automatically captured offering the opportunity to evaluate the event, the nursing intervention and patient outcomes.

**Interventions:** As bar-coded medication administration system was being implemented in an outpatient infusion center, the opportunity presented to set up nursing documentation which allows the capture of hypersensitivity reactions and IV complications. A weekly report listing all events that were stopped and not completed that includes the type of event, the nursing interventions and the patient outcomes. This allows the tracking and trending of events and ability to evaluate practice changes without manually abstracting charts.

**Evaluation:** The report was set up to capture medications administered, cycle, timing of pre-medications, nursing interventions and patient outcomes. After implementation of weekly report, the amount of events captured increased approximately 66%. Cytotoxic agents could be tracked allowing the identification of the most common agents initiating a hypersensitivity reaction, which cycle reaction occurred, the timing of pre-medication administration and patient response. Report allowed the opportunity to measure practice changes.

**Discussion:** The use of nursing documentation can be formatted to capture data that allows the tracking and trending of events, impact on staffing and effectiveness of interventions or practice changes. As health reform evolves, captured metrics allow the opportunity for reporting and evaluation.

### 136675 (Poster)

**THE IMPLEMENTATION OF A SURGICAL SHORT STAY PROGRAM TO DECREASE LENGTH OF STAY.** Sandra James, RN, MSN, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Mary Eagan, RN, MSN, NE-BC, OCN®, Memorial Sloan-Kettering Cancer Center, New York, New York; Tara Russo, RN, MSN, FNP-C, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** According to the American Cancer Society, more than a million people in the United States are diagnosed with cancer each year. These new cases annually add to the already existing need for patients to be seen at a specialized National Cancer Institute (NCI) designated Cancer Centers where high volume care leads to better outcomes.



This growing patient population has resulted in a high demand for surgical care. These procedures include thyroid, breast, and prostate and gynecological laproscopic procedures. The patients are recovered in a post anesthesia care unit and then transferred to a bed on our specialty unit for further recovery. This unit accommodates patients and their caregivers, who are essential in the discharge process. These patients must meet pre determined "discharge criteria" allowing for the nurse to independently discharge the patient from the short stay unit to home.

**Purpose:** At this NCI designated comprehensive cancer center a surgical short stay program was developed and implemented for patients requiring an overnight stay or less.

**Interventions:** Safe, high quality care is rendered to patients within a shorter timeframe while maintaining same outcomes. Press Ganey Patient Satisfaction scores remains well above the database scores in all areas. Patients' feedback supports the process across the continuum.

**Evaluation:** For 2012, over 1335 patients have recovered in this program. Readmission and emergency visits tracked post-operatively during this time records only 8 patients required readmission within 48 hours. These excellent clinical results are in part due to the re-design of pre and post operative education, expert nursing assessment; postoperative evaluation and discharge follow up.

**Discussion:** This presentation will include an overview of the program including treatment pathways, modes of patient education, nursing assessment, interventions and discharge process.

#### 136694 (Poster)

**TRANSFORMATION OF A PAPER-BASED SCHEDULING SYSTEM TO A DYNAMIC ELECTRONIC PATIENT SCHEDULING PROCESS IN AN ADULT HEMATOLOGY/ONCOLOGY RESEARCH DAY HOSPITAL.** Vivien Agbakoba, MS, BSN, OCN®, National Institutes of Health (Clinical Center), Bethesda, Maryland; Rebecca Cohen, RN, BSN, OCN®, National Institutes of Health, Bethesda, Maryland

**Significance and Background:** At the National Institutes of Health, Clinical Center, the Adult Hematology/Oncology Research Day Hospital provides care for approximately 60-100 patients a day and supports over 100 research studies. The variety of patients, studies, nursing skill set, and varied patient arrival times create a challenge to assign patients to staff. The nursing staff identified the need to change from a paper-based system known as "the barge" to a computerized workflow process "E-charge" to triage patients, allow multi-user access, provide a visual snapshot of current and future encounters, and enhance continuity of care. The process allows the charge nurse to identify patient research and care needs to facilitate equitable patient assignments, based on study and patient acuity.

**Purpose:** This project will redefine the patient scheduling workflow process through the integration of a computerized system, thus improving unit efficiency and enhancing practices to ensure patient safety.

**Interventions:** The patient scheduling process was modified to integrate the needs of patients and study requirements within an electronic system. The template features the nurse's names, work shifts, time slots for scheduled appointment details, and allows easy access for the charge nurse and administrative support personnel. Color codes indicate patient arrival times, walk-ins, discharges, cancellations, and isolation status. All modifications are viewed in real-time allowing the charge nurse to assess fluctuations in patient care needs and adjust nurse workloads accordingly. The system is located on a secured network to ensure patient confidentiality.

**Evaluation:** The E-charge has transformed our patient scheduling system into a well-organized and efficient patient flow process. The paper-based system has completely transitioned

into an electronic version. Staff values its efficiency and assignment capabilities, allowing for adequate time to consult treatment protocols, clinically evaluate patients, and provide safe and efficient treatments and patient education. Management views the system as an asset to the dynamic process of the daily functioning of the unit.

**Discussion:** The E-Barge is a novel approach to managing the dynamic workflow needs on a research hematology/oncology unit, and can be implemented in a variety of outpatient care settings. Ongoing evaluation and modification continue to maximize the system's capabilities, increase staff satisfaction, and optimize patient outcomes.

#### 136713 (Poster)

**DEVELOPMENT OF A MULTI-DISCIPLINARY SURVIVORSHIP CLINIC TO ENHANCE ACCESS TO SUPPORTIVE CARE SERVICES FOR EXISTING NURSE PRACTITIONER LED SURVIVORSHIP CLINICS.** Dori Klemanski, DNP, CNP, RN, The Arthur G. James Cancer Hospital, Columbus, Ohio

**Significance and Background:** Ferrell's Quality of Life Model Applied to Cancer Survivors illustrates the obligation of oncology nurses to holistically augment wellness in psychological, social, spiritual and physical domains during a patient's cancer journey. Oncology nurses at a Midwest Comprehensive Cancer Center (CCC) use this model to determine and influence what survivorship care is provided to patients and their caregivers. Seven disease-specific nurse practitioners (NPs) provide survivorship care in transitional and post-surveillance clinics at the CCC. The NPs in these clinics, who address patients' post-treatment needs, have inadequate resources for supportive care. These limitations reduce clinical effectiveness of achieving a wellness state for cancer survivors.

**Purpose:** In an effort to generate greater access to supportive care services for cancer survivors, a novel multi-disciplinary care-delivery model was created in a Midwest CCC's Survivorship department.

**Interventions:** Utilizing an existing survivorship business plan and an environmental scan, a small committee devised a novel care-delivery model for survivorship supportive care services. Administrative stakeholders provided executive support for a pilot project. The information technology team built the clinic infrastructure within the electronic medical record. Patients were asked for insight on what supportive services could be offered in the multi-disciplinary clinic. Cancer survivors completed a questionnaire regarding their preference of potential clinical services. Nutrition counseling (47%), counseling on herbal and vitamin supplements (44%), art therapy (29%), genetic counseling (27%) and mental health counseling (24%) were the most preferred clinical services. Based on these findings, a pilot program was initiated to meet the expressed needs of survivors, as well as those discussed in the literature.

**Evaluation:** The effectiveness of the clinic pilot project will be evaluated over 6 months through patient satisfaction questionnaires, NP feedback, and clinic metrics (i.e. appointment wait times, cancellations). The sample size will be dependent upon patient referrals to the clinic, but is projected to be approximately 50 cancer survivors.

**Discussion:** Successful implementation of the pilot project would allow (1) expansion of clinical and wellness services within the clinic, (2) broader application to survivorship programming within the CCC, and (3) potential for other CCCs to use a similar model for survivorship supportive care services.

#### 136725 (Poster)

**MERGING COMMUNITY ONCOLOGY PRACTICES WITH AN ACADEMIC CANCER CENTER: A ROADMAP FOR SUCCESS.** Constance Engelking, RN, MS, The CHE Consulting

Group, Inc., New York, New York; Monica Fradkin, BSN, MPH, Smilow Cancer Hospital at Yale New Haven, New Haven, Connecticut; Catherine Lyons, RN, MS, NEA-BC, Smilow Cancer Hospital at Yale New Haven, New Haven, Connecticut; Diane Corjulo, RN, BSN, Smilow Cancer Hospital at Yale New Haven, New Haven, Connecticut; Lisa Shomsky, RN, MS, NEA-BC, Smilow Cancer Hospital at Yale New Haven, New Haven, Connecticut; Arthur Lemay, RPh, Smilow Cancer Hospital at Yale New Haven, New Haven, Connecticut

**Significance and Background:** Community oncology practice consolidation with hospital-based cancer centers is an accelerating trend affecting future healthcare delivery models. Primary drivers of this trend include declining physician reimbursements for cancer treatment outside the hospital, increasing overhead for care delivery, and mounting shortages of oncologists available to care for a growing oncology population. When physician practices join hospital-based programs, they must comply with federal, state and accrediting body regulations – requirements for which private office practices have not historically been responsible. The resulting gap in compliance with patient safety mandates is oftentimes significant. Hospitals embarking on these mergers must establish clear methodologies for achieving regulatory alignment in candidate practices. Oncology nurses, because of their education, experience, and team membership, are ideally suited to evaluate gaps, design and implement strategies that promote compliance in newly acquired practices and, ultimately, to ensure patient safety and care quality.

**Purpose:** Bring 9 community oncology practices acquired by an academic cancer center into compliance with CMS, DPH and TJC regulatory requirements for provider-based operations. Strategies were based on Lewin's Change Theory, Kotter's Transformative Change Steps, team building and leadership principles, and compliance with TJC's 15 National Patient Safety Goals.

**Interventions:** Specific methodologies/tools were employed to: 1) assess practice pattern alignment with regulatory requirements, 2) implement needed practice and process modifications, and 3) engage private practice employees in successful organizational transition. Assessment was accomplished through focus groups and one-on-one interviews, on site observations and documentation reviews. Alignment strategies involved introduction of unique telepharmacy technology, application of novel staff and physician engagement strategies, implementation of practice-based educational programming and incorporation of new nursing leadership positions to fuel and guide needed change.

**Evaluation:** Led by newly appointed Nurse Coordinators, > 50 practice changes have been successfully implemented in all 9 practices. Mock surveys reveal rapidly increasing compliance with regulatory requirements. Periodic evaluations using regulation-derived tools are systematically reinforcing practice changes and avoiding "snapback" to legacy practices.

**Discussion:** Opportunities exist for oncology nurses to spearhead, lead and manage the change required to transition office-based practices to hospital-based operations. In these roles, they can integrate evidence-based best practices through role modeling, education and quality improvement initiatives.

### 136776 (Poster)

**USING ONS PILLARS TO DEVELOP A MULTI-DIMENSIONAL APPROACH TO QUALITY COMMUNITY ONCOLOGY NURSING CARE.** Terri Wolf, RN, MS, Cancer Care Network, University of California, Davis, Sacramento, California; Kay Harse, RN, MS, Cancer Care Network, University of California, Davis, Sacramento, California; Patricia Palmer, RN, MS, University of California, Davis Medical Center, Sacramento, California; Wilson Yen, RN, MSN, NE-BC, University of California, Davis Medical Center, Sacramento, California; Karen

Montgomery, RN, MS, Mercy Medical Center, Merced, California; Greg Rouleau, RN, MSN, Mercy Medical Center, Merced, California; Scott Christensen, MD, Cancer Care Network, University of California, Sacramento, California

**Significance and Background:** Most cancer care occurs in the community, yet academic health systems which care for 20 percent of cancer patients, have robust comprehensive programs and expertise. Many small or rural community-based oncology practices and inpatient units have limited access to resources for quality improvement and professional development. Creating a cancer care network between an academic health system and community health systems provides access to expert oncology nursing, advanced technology, education, resources, and links to similar oncology practices. Implementing standards and providing resources to independent institutions requires a multi-dimensional approach in order to respect local practices.

**Purpose:** The purpose of the Affiliate Oncology Nursing Excellence program is to improve quality through regional support and coordination of resources, education, competencies, and professional development of nurses across a network of community oncology practices. In addition the program links nurses to other network sites creating a collegueship that they might not have otherwise experienced. Aligning existing resources such as ONS Pillars provides consistency for advancement of oncology nursing.

**Interventions:** The Cancer Care Network nursing and quality coordinator assessed the sites and developed a basic structure for an Affiliate Oncology Nursing Excellence program based on the ONS Pillars: Knowledge, Leadership, Quality, and Technology. The interventions included leadership initiatives with oncology nursing self-assessments, enhanced intra-network communication including weekly phone conferences with nurse managers and monthly videoconferencing with clinical leaders and practice managers. Additionally, nursing knowledge and quality was supported by an inpatient and outpatient mentoring program; simulation and skills experience; chemotherapy and oncology nurse certification support; all-network video conference educational events; and clinical trials education. Technology initiatives included enhanced web resources for job descriptions, orientation, policies and procedures, and video-communications.

**Evaluation:** Outcomes are measured by nurse surveys, competency measurements, interviews, focus groups, and site reassessments.

**Discussion:** This multi-dimensional approach was deployed in response to assessment and frequent communication with affiliate sites. Each site reports to different community health care organizations, but the network affiliation is the one commonality among the sites. The Affiliate Oncology Nursing Excellence program, based on the ONS Pillars, links the sites in improving and measuring quality in oncology nursing.

### 136828 (Podium)

**RECOGNIZING EXCELLENCE: A SYSTEMATIC APPROACH TO DEVELOPING AND MAINTAINING PEER RECOGNITION FOR EXCELLENCE IN CLINICAL PRACTICE IN ONCOLOGY NURSING.** Megan Mikula, RN, BSN, OCN®, National Institutes of Health, Clinical Research Center, Bethesda, Maryland; Mary Fleury, RN, BSN, OCN®, National Institutes of Health, Clinical Research Center, Bethesda, Maryland; Legna Hernandez, RN, BSN, National Institutes of Health, Clinical Research Center, Bethesda, Maryland; Rebecca Cohen, RN, BSN, OCN®, National Institutes of Health, Clinical Research Center, Bethesda, Maryland

**Significance and Background:** In a fast paced, high throughput Oncology Day Hospital, there is seldom time afforded to recognize superior clinical practice. Working to achieve the

highest standards of nursing practice with a population of chronically ill oncology patients, Clinical Research Nurses risk caregiver role strain as well as burnout and need validation that their contributions positively impact patients and coworkers. High functioning groups consistently and genuinely recognize peer contributions that embody excellence in attaining the organizational mission.

**Purpose:** The purpose of "Excellence in Practice" (EIP) is to retain talented staff and praise outstanding contributions that positively affect the patient experience and the image of nursing.

**Interventions:** Unit leadership developed a peer-nominated, peer-reviewed system to acknowledge the exemplary practice of one nurse per quarter. Nurses were surveyed to assess interest in unit based peer recognition, understand personal meaning of excellent practice, explore attitudes regarding recognition methods, and solicit ideas for the award's name. A poster illustrated the breadth of 58 different adjectives and phrases staff used to describe excellent practice. Staff meetings were held to explore responses and solicit additional feedback.

**Evaluation:** The unit defined EIP qualities were grouped into the pillars of people, quality, service, safety, and leadership, creating the basis for a submission rating tool using a Likert scale. Staff valued peer nomination and defined peers on the unit as registered nurses, regardless of position on clinical ladder. Nominations were accepted on a rolling basis via anonymous paper forms, or personal discussion or in email to the committee. The highest scoring submission is awarded EIP for the quarter. Given the appreciation for collegial respect driving this award, nurses opted to recognize EIP recipients with a private staff reception and a formal accommodation letter to the personnel file.

**Discussion:** Since its inception in January 2009, 15 nurses have received EIP. The award has sustained professionalism and teamwork during management turnover, increased patient census and associated staff growth. Consistently, nurses state they value EIP and want to see it continue on the unit. Future improvement plans include an anonymous survey to reappraise the initial aims of the award and assess eventual direction of EIP.

### 136867 (Poster)

**THE IMPROVEMENT FOCUS IN A MORTALITY AND MORBIDITY CONFERENCE.** Tracy Coyne, MSN, RN, Vanderbilt-Ingram Cancer Center, Nashville, Tennessee

**Significance and Background:** Nurses often are the last safety check before the administration of an agent or treatment. In the event of a near miss or actual error, often the focus is on the actual individual and not the system or the process that lead to the event, which could result in a repeat of the event or near miss. At times, team members comments or input creates an environment of mistrust or blame instead of working together to address the issue.

**Purpose:** Topics/events are selected by a multidisciplinary team, which includes nursing. Event is presented in an objective and factual manner with the reference to job title instead of team member name. Using the Ishikawa diagram, the conference facilitator moderates conference to identify issues or processes that could have lead to the event or near miss. The facilitator then elicits conference participants to identify potential solutions and identified committee members to work on addressing issues and opportunities to improve processes.

**Interventions:** Prior to first conference, a literature search revealed MMandI conference structure best practices. MMandI planning committee also attended a MMandI conference in another department. Invitations to conference are sent to all faculty members, fellows, nursing leadership, nursing staff, pharmacy, informatics and other ancillary services or departments as indicated. At the beginning of the conference and the discussion of conference, agreements for discussions are reviewed. After the conference the conference facilitator brings together identified

committee members to discuss potential process solutions as well as facilitates committee work. Updates surrounding previous MMandI conferences are provided at subsequent MMandIs. After implementing process changes, impact on patient care are followed to determine effectiveness.

**Evaluation:** MMandI conferences have been held since 2008 and have resulted in the following process changes: Improved resident handovers through the development of an electronic tool; standardized location of pain management plan for sickle cell patients; development of electronic chemotherapy flow-sheet; quarterly mock codes in the infusion rooms; transfer of patients requiring PCA pumps and admit to hospital from off-site clinics. Multidisciplinary teams work together on a solution, promoting team work.

**Discussion:** MMandI conference structure can be used for specific events or teams. Conference provides an environment that addresses the processes involved that led to the event and decreases an environment of blame or negativity. A multidisciplinary approach often identifies multiple levels of process issues which may not have been identified if focused on the individual and promotes teamwork across all team members.

### 136932 (Poster)

**UTILIZING INFORMATION TECHNOLOGY TO HELP REDUCE CATHETER DAYS.** Nora Love-Retinger, RN, MS, CURN, CNS, Memorial Sloan-Kettering Cancer Center, New York, New York; Debra Rodrigue, RN, CNS, MA, Memorial Sloan-Kettering Cancer Center, New York, New York; Ellen Dougherty, RN, MA, CNOR, CIC, Memorial Sloan-Kettering Cancer Center, New York, New York; Iris Fernández, RN, MSN, Memorial Sloan-Kettering Cancer Center, New York, New York; Young-Shin Park, RN, MA, CNOR, CIC, Memorial Sloan-Kettering Cancer Center, New York, New York; Ji Yon Chang, RN, BSN, Memorial Sloan-Kettering Cancer Center, New York, New York

**Significance and Background:** In October 2008, an article from Infection Control and Hospital Epidemiology comprehensively provided the previously published guidelines designed to assist acute care hospitals in implementing catheter-associated urinary tract infections (CAUTI) prevention programs. In the same year, the Center for Medicare and Medicaid Service (CMS) listed CAUTI as a preventable hospital-acquired complication. As part of the 2012 National Patient Safety Goals, The Joint Commission stated that organizations were to implement evidence-based practices to prevent CAUTI. These practices should include an organization-wide program to identify and remove catheters that are no longer necessary. This challenge was met at our nationally designated comprehensive cancer center by means of Information Technology.

**Purpose:** Our organization assembled a task force which included Clinical Nurse Specialists, Infection Control nurses and inpatient staff registered nurses. Their goal was to establish a program for the prevention of CAUTI. The evidence was reviewed and a need identified focusing on the implementation of a daily reminder that would be reliable and consistent. Chart reminder notices were historically unreliable. Therefore an alternate workflow process solution was developed with collaboration from the Nursing Informatics department.

**Interventions:** Nursing Informatics created two unique processes for our program, an electronic nursing assessment flow-sheet document and a nursing algorithm. These processes allow for the efficient discontinuation of urinary catheters. Each shift, the nurse documents on the electronic Ongoing Nursing Assessment Flowsheet the presence of a urinary catheter and that it meets one of the ten approved inclusion criteria. When the patient no longer meets these criteria, the nurse follows the algorithm for the automatic discontinuation of the catheter.

**Evaluation:** The overall goal of this project is to reduce CAUTI. The use of these unique processes will efficiently track all urinary catheters as well reduce catheter days. We have collected baseline metrics identifying urinary catheter days and our CAUTI rate prior to the implementation of this program. The electronic program go-live date is January 2013. Metrics will be compared to evaluate the effectiveness of our innovative process.

**Discussion:** Due to the complexity of the oncology patient population, the need to reduce infection rates is imperative. Reducing CAUTI rates would greatly facilitate this goal.

**136941** (Poster)

**H.O.M.E. NEWS—THE HEMATOLOGY AND ONCOLOGY MEDICINE EXCLUSIVE NEWSLETTER.** Ruthlyn Greenfield-Webster, RN, BC, BSN, NYU Langone Medical Center, New York, New York

**Significance and Background:** Maintaining communication at a large academic center is challenging. Newsletters can support and reinforce educational and supportive messages as part of a larger multi-faceted effort. Newsletters also create a platform for expressing knowledge, expert opinions, and best practices or relates important information about new clinical trends. Newsletters can create a forum for strengthening relationships.

**Purpose:** An in-patient medical oncology service newsletter was developed to ensure uniform communication among the staff. The newsletter provides a venue for staff to learn about clinical practice, research trends, education, professional development opportunities and staff accomplishments.

**Interventions:** A nurse lead project to develop and implement an inpatient service based newsletter was initiated. We reviewed the literature to explore the best format and template for our newsletter. Following our shared governance model we invited unit representatives to participate in the creation of this project. We selected a template that best represented our organization. Our Hematology and Oncology Medicine Exclusive Newsletter (H.O.M.E.) was launched in 2010. Our target audience is represented on the newsletter title. H.O.M.E. includes the following sections: CLINICAL NEWS, EDUCATIONAL OPPORTUNITIES, "SPOTLIGHT ON" with a list of staff's professional achievements, "STAFF NEWS" with personal achievements, and "REMINDERS" with relevant clinical reminders. Also a "WELCOME" and a "GOODBYE" section are on the front and back with other miscellaneous postings.

**Evaluation:** The newsletter is distributed via e-mail, posted in clinical areas and is also available via hospital Intranet. Staff participation in the newsletter has increased. The newsletter quality has improved including: article summaries, social events and "must read" articles. A major benefit of the newsletter has been enhancing communication and team fostering. Interdisciplinary teams have made requests to be added to the distribution news mailing list, including our ambulatory nurses. Leadership and staff reports that they often refer back to H.O.M.E. for relevant information.

**Discussion:** The newsletter was published the first week of every month for two years reaching out to all staff and leadership in our service. Oncology nurses must find ways of sharing clinical and non clinical information. Newsletters enhance communication while fostering team work, without incurring major expenses.

**137017** (Podium)

**CALLING A CHEMO NURSE: ENSURING SAFE CHEMOTHERAPY PRACTICE OUTSIDE OF ONCOLOGY.** Monica Fradkin, RN, BSN, MPH, OCN®, Smilow Cancer Hospital at Yale New Haven, New Haven, Connecticut; Elizabeth Blasiak, RN, MSN, OCN®, Smilow Cancer Hospital at Yale New Haven, Connecticut; Sarah Eder, RN, BSN, OCN®, Smilow

Cancer Hospital at Yale New Haven, Connecticut; Kirsten Pedersen, RN, BSN, OCN®, Smilow Cancer Hospital at Yale New Haven, New Haven, Connecticut; Lisa Barbarotta, RN, BSN, OCN®, Smilow Cancer Hospital at Yale New Haven, Connecticut

**Significance and Background:** Antineoplastic agents are increasingly being used to manage autoimmune diseases and other non-oncology conditions and frequently oncology patients are managed in non-oncology settings for various reasons.

**Purpose:** To minimize risk of adverse events and enhance care quality in a large academic medical center, the Chemotherapy Pager project was implemented. Experienced oncology nurses are "on call" to serve as resources through-out the hospital for non-oncology nurses caring for patients undergoing chemo-/biotherapy administration outside of oncology units.

**Interventions:** These experts role model practice according to institutional policy, provide patient education and support the non-oncology staff with safe handling and care of patients undergoing chemo-/biotherapy. Any member of the team – physicians, pharmacists and nurses – can page an oncology nurse expert to the bedside for assistance with coordination, verification, administration, monitoring and/or educating patients and staff when chemo-/biotherapy is administered outside oncology units. Information on the Chemotherapy Pager including 24 hour/7 day a week availability of an oncology nurse expert was communicated to all disciplines.

**Evaluation:** During a 24 month period, 1220 calls were documented; pharmacists were the most frequent callers at 60% followed by 26% nurses and 14% physicians. The Chemotherapy Pager has been utilized daily around the clock for 2 years with call volume averaging 12 weekly. Consultation requests were evenly split between oncology (610) and non-oncology (610) services comprising hematology (32%), neurology (17%), solid tumor (14%), medicine (14%), rheumatology (7%), solid organ transplant (4%), gynecology (3.1%), renal (2%) and gastrointestinal (1.8%) services. Calls were received regarding assistance with drug administration, guidelines for prescribing, safe handling practices, and staff education. On call nurse experts administered 465 oral and parenteral doses of chemotherapy of which 52% were in the critical care units. Visits in response to consultative requests averaged > 30 minutes.

**Discussion:** Positive feedback was received from staff on ancillary units, physicians and pharmacy. Providing on demand expert consultation has been a well utilized resource for the management of patients undergoing chemo-/biotherapy in non-oncology settings, especially by pharmacists – the natural gatekeepers of antineoplastic orders. Collaboration across disciplines ensures patient safety and minimizes staff anxiety and increases satisfaction surrounding chemo-/biotherapy processes in the non-oncology setting.

**137031** (Poster)

**UTILIZING A TEAM MODEL TO PROMOTE A SMOOTH TRANSITION TO AN ELECTRONIC MEDICAL RECORD SYSTEM FOR ONCOLOGY NURSING STAFF.** Emily Fries, RN, BSN, OCN®, CHPN, New York University Langone Medical Center, New York, New York; Asha Monge, RN, BSN, OCN®, NYULMC, New York, New York; Klara Culmone, RN, BSN, MSN, OCN®, NYULMC, New York, New York

**Significance and Background:** In August, 2012, New York University Langone Medical Center (NYULMC), a large, urban, academic medical center, began implementation of an electronic medical record (EMR) system to improve patient safety and standardize nurse-to-nurse communication. For oncology patients, an EMR can improve care across the continuum of outpatient visits and inpatient stays. Smooth transition to an

EMR requires a paradigm shift for nurses who are accustomed to using hand-written notes, "institutional memory", verbal handoff and a printed medication administration record. NYULMC's inpatient oncology unit employed a team model, consisting of an RN "Champion" leading ten RN "Super-users", to facilitate adaptation to the EMR.

**Purpose:** The purpose of the team model was to ensure a safe transition to an EMR by promoting a culture of cooperative problem solving among the nursing staff. The team developed unit-specific training (didactic sessions as well as hands-on training); identified new workflows associated with the EMR; and facilitated end-user RN adaptation to the new system.

**Interventions:** Phase I (four months prior to implementation): RN Champion began working with the hospital-wide project team. Ten RN Super-users were recruited. Phase II (three months prior): The team attended training and began to work together to identify opportunities and challenges of the EMR. Phase III (six weeks prior): The team met weekly to review workflow changes and to design training modules. Focus areas included: shift handoff report; chemotherapy administration; practical implications for "real-time" charting; and interdisciplinary communication. Phase IV (one month prior): The team held weekly didactic and hands-on practice sessions with end-user RNs, with an emphasis on building confidence in using the EMR.

**Evaluation:** Areas to be measured include: "real-time" charting statistics, reduced use of overtime for "catch-up charting", and nursing staff's self-reported satisfaction and comfort with the new EMR. End-user competency was evaluated by a practical exam with remediation provided immediately.

**Discussion:** A successful transition to an EMR using an RN team model can positively impact oncology patient care through standardization of documentation, improved continuity of care between the ambulatory and inpatient setting, and increased patient safety. This team model can be adapted for other oncology units making the transition to an EMR.

### 137060 (Poster)

#### ONCOLOGY NURSE DRIVEN SURVIVORSHIP CARE.

Heidi Basinger, BSN, RN, The OSUCCC-The James-Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Julia Garrett, MS, RN, CNP, The OSUCCC-The James-The Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Kathleen Ries, BSN, RN, The OSUCCC-The James-Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Nicole Muscari, BSN, RN, OCN®, The OSUCCC-The James-Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Maryam Lustberg, BSN, RN, The OSUCCC-The James-Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio; Steven Kalister, MHA, MBA, The OSUCCC-The James-Stefanie Spielman Comprehensive Breast Center, Columbus, Ohio

**Significance and Background:** More than ever before, cancer survivor numbers are increasing. Estimates indicate 2.4 million breast cancer survivors. Increased patient volume creates challenges to adequately meet needs. The Institute of Medicine brought attention to survivorship as a distinct phase of care. Oncology nurses are poised to support cancer survivors who face many physical, psychological, social, financial and spiritual challenges.

**Purpose:** In line with the caring model, Relationship-Based Care, a caring and healing environment was established through transformational leadership principles. The clinic teams worked together to create an infrastructure allowing fullest scope of practice for oncologists, APNs, and RNs to care for our survivors.

**Interventions:** Pilot survivorship visits evaluated operations of the proposed model. Findings identified supportive servic-

es needed augmented including: Psychology and Psychiatry; Physical Therapy; and Nutrition. Hand-outs and shadowing education was provided to APNs and RNs. Beginning January 2013, Oncologists will focus on active treatment cancer patients and survivorship clinics/care plans will be provided by APNs and RNs. One hour survivorship visits will be scheduled after the end of active treatment, based on cancer stage. The RN ensures completion of serial screening needs assessment tools to evaluate physical, psychological, social, financial and spiritual concerns. RNs and APNs will engage in meaningful conversations with patients to address high distress concerns and make appropriate referrals. The APN will develop, review, and present the treatment summary and Survivorship Care Plan. Oncology nurses oversee the patient throughout the continuum of care.

**Evaluation:** By April 2013, measures will include: feedback from oncology RNs, patient satisfaction, numbers of survivorship visits conducted, and number of referrals. Long range goals of the survivorship clinics are appropriate management of cancer survivors through collaboration with primary care physicians, oncologists, and APNs.

**Discussion:** Survivorship care will continue to be an increasing need that requires a deeper look and commitment by oncology nurses. Today, less than half of National Cancer Institute dedicated cancer hospitals utilize a survivorship care plan for their breast patients. Utilizing all staff to practice at fullest scope provides the infrastructure and resources to meet survivorship needs.

### 137081 (Poster)

#### DEVELOPING A LAY VOLUNTEER CANCER RESOURCE NAVIGATOR PROGRAM.

Teresa Money McLaughlin, APRN, MSN, AOCN®, DNP(c), St. Vincent's Medical Center, Bridgeport, Connecticut; Cindy Czaplinski, MSN, RN, St. Vincent's Medical Center, Bridgeport, Connecticut; Patricia Gantert, MSN, RN-C, St. Vincent's Medical Center, Bridgeport, Connecticut; Dwanna Ward-Boahen, DNP, APRN, AOCNP®, St. Vincent's Medical Center, Bridgeport, Connecticut; Maureen Pelletier, MSN, RN-C, St. Vincent's Medical Center, Bridgeport, Connecticut; Betsy Rice, RN, BCCN, St. Vincent's Medical Center, Bridgeport, Connecticut; Alida Martinez, SRN, St. Vincent's Medical Center, Bridgeport, Connecticut

**Significance and Background:** As we progress in an ever changing and turbulent healthcare environment we must find ways to reach out to the growing number of cancer patients and survivors including the underserved. Cancer patient navigation can and should take on different forms in different settings. Cancer patient navigation is individualized assistance offered to patients and their families to help overcome health care system barriers and obstacles and facilitate timely access to quality medical and psychosocial care. Thus navigation should start at the patient's diagnosis into survivorship. Lay navigators work in collaboration with the professional navigator team (Nurses and social workers) within the institution. According to the ONS Position Statement in Patient Navigation that models that incorporate a multidisciplinary team among the nurse, social work and lay navigators improve patient outcomes. Our program is structured under this constitution. The ONS also underscores the need for more additional research to explore, confirm, and advance patient navigation process, roles, and identify evidenced-based outcome measures. As nurse leaders dedicated to providing the best cancer care to our patients we must be creative to do more with less everyday. This program is the start to alleviating many of the common everyday distress and frustrations our cancer patients have everyday.

**Purpose:** This nurse leadership project was grounded by a need to utilize appropriate volunteers to reinforce basic resource

information to patients and families. The theory of transitions is the conceptual model paired with relationship based care. Transitions for cancer patients and survivors are well documented and within these complex transitions are influxes in patients readiness to learn about certain resources etc. Utilization of a Lay Volunteer Resource Navigator can be beneficial to both the staff and the patients and their families. The addition of a trained volunteer to be present with a chemotherapy patient or perhaps a radiation patient is monumental. As a nurse leader one must develop programs that can maximize patient outcomes and satisfaction and at the same time not a burden to their own professional staff. This program does just that.

**Interventions:** A planning team was organized and lead by an APRN that included the director of volunteer services, the director of integrative oncology, psycho-oncology representative, nurse navigators, allied health navigator, and we collaborated with our American Cancer Society representative. A curriculum was developed and ongoing education was planned for every three months of continuing education. The kick off training program was a 3.5 hour training program that reviewed the Medical Center's Mission Statement, Core Values, the basic overview of cancer and cancer treatments, the psychosocial needs, confidentiality and HIPAA compliance policies, logistics (check-in, reporting off, scheduling, reports and documentation), cancer resources, nurse navigator overview, communication, boundaries of being a lay navigator volunteer, health disparities, culture and role play. Additional training will include shadowing in the oncology areas with the nurse and allied health navigators.

**Evaluation:** Evaluation of the project goals will be evaluated in several different ways. Patient satisfaction will be compared pre and post implementation. Attendance of cancer support programs, groups and survivorship offerings will be monitored for participation. Data will be collected and by each lay navigator daily that will be evaluated by the director of integrative oncology. Critical elements to be monitored are time spent with the patient, resources offered and discussed (including ACS, LLS, CancerCare and Cancer and Careers), zip code, cancer type, literature given to patient, and visit barriers or concerns. The COC underscores the importance of having a navigation program available for all patients and the addition of lay navigators and give an institution this insurance. The NCI defines health disparities as "differences in the incidence, prevalence, mortality, and burden of cancer that exist among specific population groups in the US". Our data will help us drill down and identify where our resources are needed are most.

**Discussion:** APRN's are implementing changes based on clinical needs and outcomes. The development and implementation like this program can be replicated in any medical center or hospital and modified to their own individual needs. The curriculum, outline, Lay Volunteer Resource Navigator job description and the training program and quality volunteer recruitment techniques are shared.

### 137101 (Poster)

**OCN<sup>®</sup> NURSES' INVOLVEMENT IN A QOPI DRIVEN PERFORMANCE IMPROVEMENT PROJECT TO IMPROVE THE CHEMOTHERAPY CONSENTING PROCESS.** Bruce Grant, RN, BSN, OCN<sup>®</sup>, Spartanburg Regional Healthcare System, Spartanburg, South Carolina; Patricia Hegedus, RN, OCN<sup>®</sup>, MBA, Spartanburg Regional Healthcare System, Spartanburg, South Carolina

**Significance and Background:** Palmetto Hematology Oncology (PHO) is the medical oncology practice of Spartanburg Regional Healthcare System (SRHS) and has participated in QOPI since 2009 and earned QOPI certification in September 2011. Our Fall 2010 QOPI Patient Consent for Chemotherapy score was

70.73%, lower than the QOPI aggregate score of 86.46%. QOPI data is abstracted by an OCN nurse auditor at our institution.

**Purpose:** QOPI data revealed the need for a uniform, system-wide chemotherapy consent process that could be implemented through our electronic medical record.

**Interventions:** An OCN nurse administrator convened a workgroup to address chemotherapy consent documentation compliance. A chemotherapy consent form specifically for our cancer center was created following an extensive literature review and benchmarking with American Society of Clinical Oncology/Oncology Nursing Society guidelines, NCI Designated Cancer Centers, NCI Community Cancer Centers Program (NCCCP) resources, and other healthcare institutions. Our chemotherapy administration policy was revised to include a "hard stop" if a signed chemotherapy consent was not available prior to administration of chemotherapy in all areas of our institution.

**Evaluation:** Patient Consent for Chemotherapy QOPI scores revealed an increase from Fall 2010 to Spring 2012 of 70.73% to 100% signifying our chemo consent process as a Best Practice. As a result of the workgroup's efforts, it was approved by our Cancer Care Committee to develop a Chemotherapy Safety Committee (CSC) to standardize chemotherapy practices throughout our system. The CSC is comprised of key staff responsible for chemotherapy preparation, administration, and spill cleanup. The CSC was instrumental in reviewing and updating policies and procedures during our QOPI certification efforts. The CSC was also responsible for the creation of Chemo Safety Packs, which are backpacks or duffel bags containing a chemo spill kit, box of gloves, and assorted N-95 respirator masks, making the transport of chemotherapy drugs uniformly safe throughout our institution.

**Discussion:** This performance improvement project resulted in chemotherapy consent document process that is operating at our institution at a Best Practice level. It has also improved patient safety by insuring the consent form is in our system or a "hard stop" is initiated preventing any patient receiving chemotherapy without the necessary consent process documentation. An OCN nurse administrator chaired the first workgroup and is still active on the Chemotherapy Safety Committee (CSC). An OCN nurse continues to perform the data abstractions for the semiannual QOPI data submissions. A focus on quality is evident in the lives of these two OCN nurses at the Gibbs Cancer Center in sunny Spartanburg, South Carolina.

### 137149 (Poster)

#### **NURSE PRACTITIONER COMMITTEE ROLE IN DEVELOPMENT OF NP ORIENTATION PROCESS FOR ONBOARDING OF NEW NURSE PRACTITIONER STAKEHOLDERS.**

Deborah Selm-Orr, RN, MS, AOCN<sup>®</sup>, CRNP, Cancer Treatment Centers of America, Philadelphia, Pennsylvania

**Underwriting or funding source:** Performance Improvement Team in Asan Medical Center

**Significance and Background:** Nurse practitioners are an integral partner in the health care team. With estimated physician shortages, their role will be even more pronounced. Care provided by NPs in collaboration with physician colleagues has demonstrated a high level of patient satisfaction as well as improved coordination of care. Definitions of internal and external factors determine role development of the NP. Formation of the nurse practitioner committee is a requirement of the Commonwealth of Pennsylvania.

**Purpose:** The NP committee meets to discuss issues pertinent to NP practice that includes assessment of environmental factors that impact on role development. This includes orientation of new stakeholders. A model of care that is participatory, evidence based, patient focused, process for advanced practice nursing role development, implementation and evaluation. This is referred to

as the PEPPA framework by Bryant-Lukosius and Dicenso. This is a nine step process that includes define patient population, identifying supporting stakeholder, determining need for model of care, identifying problems and goals to improve care, obtaining consensus, implementing strategies, initiating role implementation, evaluating role, followed by long term monitoring.

**Interventions:** The NP group meets every 2 months to discuss current issues and evaluate the onboarding process for new stakeholders. Currently, all members have been stakeholders for over 6 months. Currently, the center is considering the addition of nurses who will be transitioning from staff nurse to NP role. An orientation program has been defined by the group, but is not fully implemented.

**Evaluation:** Nurse practitioner stakeholders have identified several areas for improving orientation. As the committee identifies key barriers and facilitators of role development, processes and goals of the committee have been identified. Currently, the committee is working on a virtual web based journal club. Overall satisfaction with committee function is high. Outcomes are applicable to oncology nurse practitioners who are transitioning to new roles and sites of care. Defining the process assists in role transitioning.

**Discussion:** A program for orientation of nurse practitioners has been defined using concepts based on the PEPPA model and Oncology Nursing Society oncology nurse practitioner competencies. NPs function as providers of care and with clear orientation expectations, role clarity and role definitions assist in enhancing professional development as well as effectiveness in role transition.

### 137525 (Poster)

**BURNOUT, WHY SHOULD I CARE?** Carol Blecher, RN, MS, AOCN®, APNC, CBCN-C, CBCN®, Trinitas Comprehensive Cancer Center, Elizabeth, New Jersey; Tim Clyne, RN, BA, Trinitas Regional Medical Center, Elizabeth, New Jersey

**Significance and Background:** Oncology is a stressful profession due to complex treatments, dealing with death, communication issues, patient/family involvement. Other issues include workload, role overload and conflict, lack of control and work environment issues. Last spring we perceived that there were changes in the work environment causing stress and some element of burnout in our workplace. At that time we assessed the staff's levels of compassion fatigue and burnout and began a program to assist the staff with their coping mechanisms. An assessment was performed and sessions were held. The environment appeared somewhat improved, but no reassessment was performed. Recently there were dramatic changes within the work environment which retriggered and intensified these issues resulting in increasing dissatisfaction and decreased collaboration in the workplace.

**Purpose:** To use evidence based techniques to recreate a collaborative team in our work area and to teach team members stress management techniques.

**Interventions:** Reevaluation and assessment using the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales (Pro QOL R-IV) sharing the findings of the survey with management and staff. Reintroduction of a program of self healing to develop stress reduction strategies, inject humor into the workplace, strengthen support systems and teambuilding strategies.

**Evaluation:** Effectiveness will be assessed through administration of the ProQOL R-IV at three month intervals following the interventions. We will also evaluate effects of the intervention on the work environment and patient satisfaction.

**Discussion:** Social networks and the development of a community are protective against burnout. Our program of self healing will be designed to nurture stress management strategies and accentuate the uniqueness of the individual and their special gifts. Using team building strategies we will recreate a positive work environment.